

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/15/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175401	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/02/2023
NAME OF PROVIDER OR SUPPLIER BONNER SPRINGS NURSING & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 520 E MORSE STREET BONNER SPRINGS, KS 66012		
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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey and Complaint Investigation KS00174277, KS00181542, KS00180707, and KS00172793.	F 000			
F 582 SS=D	The 2567 was sent electronically on 08/15/23. Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is	F 582			

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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F 582	Continued From page 1 reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: The facility identified a census of 35 residents. The sample included 14 residents with three residents reviewed for beneficiary notices review. Based on record review and interviews, the facility failed to provide Resident (R)23 and R27 with completed Advanced Beneficiary Notice of Non-coverage (ABN Form CMS-10055). This deficient practice placed the residents at risk for impaired decisions and treatment options due to lack of information. . Findings Included: - A review of R23's "Beneficiary Protection Notification Review" completed on 08/01/23	F 582			

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F 582	Continued From page 2 indicated she started Medicare Part A skilled services on 05/06/23. The form designated her last covered day (LCD) was 05/30/23. The form indicated the facility initiated her discharge from skilled with benefit days remaining. The form indicated she remained in the facility and received an ABN form. A review of R23's "ABN" form indicated she maxed out her physical and occupational therapy potential for skilled service. The form noted beginning on 05/30/23, R23 may have to pay out of pocket for the cost of continued services. The form failed to list the estimated cost for continued services. The form was signed by R23 on 05/26/23. A review of R27's "Beneficiary Protection Notification Review" completed on 08/01/23 indicated he started Medicare Part A skilled services on 04/13/23. The form designated his LCD was 05/03/23. The form indicated the facility initiated his discharge from skilled with benefit days remaining. The form indicated he remained in the facility and received an ABN form. A review of R27's "ABN" form indicated he maxed out his therapy potential for skilled service. The form noted beginning on 04/13/23, R27 may have had to pay out of pocket for the cost of continued services. The form failed to list the estimated cost for continued services. The form was signed by R27 on 05/01/23. On 08/03/23 at 03:15PM Social Services X stated she would often offer to show the cost of the services if the residents requested it but did not put it on the form.	F 582			

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F 582	Continued From page 3 A review of the facility's "Resident Rights" policy revised 10/2021 indicated all residents had the right to be informed and chose services provided by the facility. The policy noted each resident would have equal access to quality care regardless of source of payment. The facility failed to provide R23 and R27 with completed ABN form which included the estimated cost of services. This deficient practice placed the resident at risk for impaired decisions and treatment options due to lack of information.	F 582			
F 585 SS=F	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution	F 585			

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F 585	Continued From page 4 of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately	F 585			

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F 585	Continued From page 5 reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: The facility identified a census of 35 residents. The sample include 14 residents. Based on observation, record review, and interviews, the facility failed to implement a system to allow residents and/or their representative to file grievances anonymously. This deficient practice placed the residents at risk for decreased psychosocial wellbeing.	F 585			

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F 585	Continued From page 6 Finding Included: -On 07/31/23 at 07:05AM an inspection of the facility revealed no designated grievance box or forms available in the areas accessible to the 35 residents of the facility or their representatives. On 08/01/23 at 10:50AM, the Resident Council members reported they were not aware if the facility provided a way to complete an anonymous grievance. The council reported they were unaware if the facility had an official grievance process. The council reported Social Services X was responsible for complaints. The council stated if they had any concerns, they told staff and staff would relay the concerns to the administrator. On 08/02/23 at 02:30 PM Certified Nurse's Aide (CNA) M stated she was not sure if the facility had a specific grievance system, but the residents could ask staff for the forms and staff would slide them under the business office door for Social Service X. On 08/02/23 at 03:16 PM Social Services X stated that facility had grievance forms at the front nurse's station that staff could give to the residents. She stated her office moved a few months ago and she was not sure where the grievance box went. She stated she was in the process of getting a new box placed. A review of the facility's "Grievance" policy revised 10/2021 indicated the facility must enable each resident the right to file grievances verbally, orally, and anonymously to the designated officer, administrator, or staff member for review.	F 585			

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F 585	Continued From page 7 The facility failed to implement a system to allow anonymous grievances. This deficient practice placed 35 residents at risk for decreased psychosocial wellbeing.	F 585			
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: The facility identified a census of 35 residents. The sample included 14 residents. Based on observation, record review, and interview the facility failed to ensure staff kept Resident (R) 36, a cognitively impaired resident, free from resident to resident abuse. This deficient practice placed R36 at risk of possible harm or injury and impaired quality of life. Finding included: - The electronic medical record (EMR) for R36 documented diagnoses of psychosis (any major mental disorder characterized by a gross	F 600			

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F 600	Continued From page 8 impairment in reality testing), Alzheimer's disease (a progressive mental deterioration characterized by confusion and memory failure), and Parkinson's disease (a chronic and progressive movement disorder that initially causes tremor in one hand, stiffness or slowing of movement). The "Significant Change Minimum Data Set" (MDS) dated 02/28/23 documented R36 had a Brief Interview for Mental Status (BIMS) score of zero which indicated severely impaired cognition. R36 exhibited behaviors of hallucinations (perceptual experiences in the absence of real external sensory stimuli) and delusions (misconceptions or beliefs that are firmly held, contrary to reality). R36 required limited to extensive assistance of one to two staff for activities of daily living (ADLs). R36 required the use of a wheelchair for mobility. R36 required the administration of antianxiety (class of medications that calm and relax people with excessive anxiety, nervousness, or tension) and an antidepressant (class of medications used to treat mood disorders and relieve symptoms of depression). R36 received hospice services. The "Quarterly MDS" dated 05/26/23 documented R36 had a BIMS score of zero which indicated severely impaired cognition. R36 exhibited behaviors of hallucinations. R36 required limited to extensive assistance of one to two staff for ADLs. R36 required the use of a wheelchair for mobility. R36 received antianxiety medication during the lookback period. The "Communication Care Area Assessment" dated 02/28/23 documented R36 triggered for impaired ability to make self understood through verbal and non-verbal expression of ideas/wants	F 600			

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F 600	Continued From page 9 and impaired ability to understand others through verbal content. The "Safety Care Plan" revised 06/03/23 for R36 directed that staff were educated on being aware of R36's whereabouts. Staff was directed to administer medications as directed and monitor/document for side effects and effectiveness. Staff was to distract R36 from wandering by offering pleasant diversions, structured activities, food, conversation, television or a book. Staff was to check placement and functionality of wander alert bracelet each shift for monitoring. Staff was to intervene before agitation escalated and to guide R36 away from sources of distress. Staff was to analyze times of day, places, circumstances, triggers and what de-escalated behavior and document. A "Facility Investigation" documented an incident between R36 and R18 (BIMS of 15 indicating intact cognition) occurred on 11/26/22. Staff was alerted that R36 was on the floor in R18's room. Upon entry to R18's room, staff observed R18 had a hold of R36's shirt. Staff asked R18 to let go of R36's shirt and the nurse immediately assessed R36. No injuries were noted but R36 did have red marks on her neck that appeared to be from where her shirt rubbed when it had been pulled by R18. R18 stated R36 was going through his stuff and he had been trying to get R36 out of his room. R18 then stated he grabbed R36's shirt to try to move R36 out of his room and then R36 fell to the floor. A "Facility Investigation" documented an incident which occurred on 01/02/23 between R36 and R19. The report documented Certified Nurse Aide (CNA) N observed the incident in the main	F 600			

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F 600	Continued From page 10 common area at approximately 05:25 PM while serving in the dining room. R19's wheelchair was next to R36's wheelchair. R19 was seen holding R36's hand to his groin area rubbing his groin with his other hand and saying to R36 he wanted her to rub his private area. CNA N immediately separated the residents prior to notifying the charge nurse and the director of nursing (DON). R19 was immediately placed on one-on-one supervision. The representative for both residents were notified. R36 was assessed immediately after incident. A "Facility Investigation" documented an incident which occurred on 05/27/23 between R36 and R12, a resident with a BIMS of five which indicated severely impaired cognition, was reported to the Administrative Staff A by Maintenance Staff U. Maintenance Staff U witnessed R12 gently and slowly pat R36's shoulder to get her attention. R36 responded by pulling away from R12 and telling R12 to stop. Maintenance Staff U told R12 to stop and R12 said OK, but R12 reached out to R36's shoulder again. Maintenance Staff U stayed with the two residents until nursing staff intervened and separated the two residents. No prior incidents had been reported with the two residents. A "Facility Investigation" documented an incident which occurred on 06/22/23 between R20, a resident with a BIMS of six indicating severely impaired cognition, and R36 was reported to the state agency. According to the report R36 had been sitting at a table in the dining room in her Broda chair (a specialty chair that allowed for both tilting and reclining) and CNA O was passing out drinks to residents at another table across the dining room. R20 entered the dining room,	F 600			

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F 600	Continued From page 11 walking with her walker, and walked by R36. R36 had her fingers in her mouth at the time and R20 grabbed R36's hand and pulled it away from R36's mouth and then R20 took her other hand and slapped R36 across the face and told R36 not to do that again. CNA O immediately intervened and removed R20 from the table area R36 was at and notified the nurse of the incident. The nurse assessed R36, and no injury was noted. Staff asked R20 why she hit R36, R20 stated she only touched her and R36 shouldn't have her fingers in her mouth like that. R20 acknowledged she should not hit others and would not like it if someone else hit her. R20 was removed from the dining area. R36's physician and guardian were notified of incident. R20 was placed on one-on-one supervision and a referral was made to geri-psych inpatient stay. On 08/01/23 at 11:45 PM R36 sat in her Broda chair at the dining table with staff at table near resident. On 08/02/23 at 02:30 PM CNA M stated R36 had a history of wandering and behaviors in the past, but since her decline and being in the Broda chair she has not been the cause of any altercations with other residents. CNA M stated R36 had been involved with resident-to-resident altercations recently with two different residents in the dining area and were quickly separated. CNA M stated staff were to make sure those residents were kept away from R36 for her safety. On 08/02/23 at 02:54 PM Licensed Nurse (LN) G stated R36 used to have behaviors but since her recent decline a few months ago and her being in the Broda chair she did not have many behaviors. LN G stated there had been a few instances in	F 600			

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F 600	Continued From page 12 the last few months where other residents had touched or had an altercation with R36 and were immediately separated. LN G stated that staff had to assist R36 in the dining room at times and were to keep her safely away from the other residents. R36 was to in sight of staff while she was out of her room. LN G stated R36 had not had any prior incidents with the other residents before. On 08/02/23 at 03:21 PM Administrative Nurse D stated she had only been here a short time but R36 had not been involved in any resident-to-resident altercations since she had been here. Administrative Nurse D stated that R36 did have interventions in place to keep her safe from other residents. R36 was in a Broda chair and should be in an area where staff could visualize her at all times while she was out of her room/bed. The facility policy "Abuse Investigation and Reporting" revised 10/21 documented: all allegations of abuse, neglect, exploitation, mistreatment and/or injuries of unknown source, and any reasonable suspicion of a crime shall be promptly reported to local, state, and federal agencies and thoroughly investigated by facility management. Finding of the above investigations would also be reported. The Administrator would keep the resident and his/her representative informed of the progress of the investigation. The Administrator would ensure that any further potential abuse, neglect, exploitation or mistreatment was prevented. The Administrator would inform the resident and his/her representative of the status of the investigation and measures taken to protect the safety and privacy of the resident.	F 600			

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F 600	Continued From page 13	F 600			
F 623 SS=D	The facility failed to ensure staff appropriately monitored and ensured R36, a resident with severely impaired cognition, was kept safe from other residents. This placed R36 at risk of possible harm and or injuries. 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 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	F 623			

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F 623	Continued From page 14 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 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	F 623			

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F 623	Continued From page 15 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). This REQUIREMENT is not met as evidenced by: The facility identified a census of 35 residents. The sample included 14 residents with four residents reviewed for hospitalization. Based on observation, record review, and interviews, the facility failed to provide written notification of the reason and location for the facility-initiated transfer for Resident (R) 32. This deficient practice placed the resident at risk of delayed care or uncommunicated care needs. Findings included: - R32's Electronic Medical Record (EMR) from	F 623			

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F 623	Continued From page 16 the "Diagnoses" tab documented diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), hypertension (elevated blood pressure), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), and psychosis (any major mental disorder characterized by a gross impairment in reality testing). The "Annual Minimum Data Set" (MDS) dated 06/16/23 documented a Brief Interview of Mental Status (BIMS) score of zero which indicated severely impaired cognition. The MDS documented that R32 required extensive assistance of two staff members for activities of daily living (ADLs). R32's "Cognitive Loss Care Area Assessment" (CAA) dated 06/20/23 documented R32 was unable to understand reality most of the time and staff would help redirect him. R32's "Care Plan" dated 08/01/22 documented staff would present one thought, idea, question, or command at a time. Review of the EMR under "Progress Notes" tab documented a "Health Status Note" on 01/19/23 at 08:46 PM R32 was sent to the hospital for an evaluation related to change of condition and was admitted. On 06/20/23 at 01:27 PM an "Alert Note" documented R32 was sent to the hospital for a mental health evaluation and was admitted.	F 623			

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F 623	Continued From page 17 On 08/01/23 at 03:00 PM R32 was asleep on the couch in the common area. On 08/02/23 at 09:30 AM Administrative Staff A stated the facility did not provide written notification to the resident's responsible party of the transfer to the hospital. Administrative Staff A stated the facility notified the resident's responsible party by phone. The facility's "Discharge Summary and Plan" policy last revised 10/21 lacked documentation of a written notification would be provided to the resident or responsible party. The facility failed to provide written notification of the reason and location for the facility-initiated transfer to the hospital to R32 or h representative. This deficient practice placed R32 at risk of delayed care.	F 623			
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	F 657			

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F 657	Continued From page 18 the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: The facility identified a census of 35 residents. The sample included 14 residents. Based on observation, record review and interview, the facility failed to ensure a care plan was revised to address Resident (R) 14's skin care needs. This deficient practice placed R14 at risk for skin breakdown and possible skin infections. Findings included: - The electric medical record (EMR) for R14 documented diagnoses of hypertension (HTN- an elevated blood pressure), carcinoma of skin (a cancer that forms in tissues that line most organs and skin), nephropathy (deterioration of kidney function), and diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made, or the body cannot respond to the insulin). The "Annual Minimum Data Set" (MDS) dated 10/22/22 for R14 documented a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. R14 required limited assistance of one staff member for activities of	F 657			

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F 657	Continued From page 19 daily living (ADLs) and utilized the use of a wheelchair for mobility. R14 was at risk of developing pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction). R10 had a pressure reducing device for his chair and bed. R14 received application of ointments to the skin as a treatment. The "Quarterly MDS" dated 06/11/23 documented a BIMS score of 14 which indicated intact cognition R14 required limited assistance to extensive assistance of one staff member for ADLs and utilized the use of a wheelchair for mobility. R14 was at risk of developing pressure ulcers. R10 had a pressure reducing device for his chair and bed. R14 received application of ointments to the skin as a treatment. The "Pressure Ulcer Care Area Assessment" (CAA) dated 11/01/22 for R14 documented a potential for breakdown due to fragile skin, impaired physical mobility, incontinent episodes with some control, and diagnosis of DM. No pressure ulcers were noted. Moisturizer lotion was applied to skin as prescribed. The "Care Plan" for R14 initiated 12/22/19 and revised 03/20/20 lack a care area for skin care. A "Braden Scale for Predicting Pressure Sore Risk" dated 06/11/23 documented a score of 19 which indicated a low risk of pressure sore. Under the "Orders" tab was an order dated 07/22/22 for R14 to moisturize skin with lotion once per day every day shift.	F 657			

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F 657	Continued From page 20 Under the "Orders" tab was an order dated 07/27/23 to apply barrier cream to area on left side of buttock due to moisture associated skin damage (MASD) two times a day for redness. Review of the "Assessments" tab lacked evidence of "Weekly Licensed Nurse [LN] Skin Assessment" or routine skin assessment since R14's return to the facility on 06/10/23 from a hospital stay. A "Health Status Note" dated 07/27/23 at 04:00 PM for R14 documented R14's coccyx was red with an area measuring 0.5 centimeters (cm) x 0.5cm on his buttock caused by MASD. An order for barrier cream placed on the "Treatment Administration Record" (TAR). Director of Nursing (DON) was notified. On 07/31/23 at 10:14 AM R14 stated he had red area to his bottom that the aide noticed a few days ago. R14 stated there was no pain to the area and staff had been putting cream on him when toileted. On 08/01/23 at 02:53 PM R14 sat at the dining table in his wheelchair, cushion present to seat of wheelchair, playing bingo with other residents. On 08/02/23 at 03:21 PM Administrative Nurse D stated each resident should be getting a weekly skin assessment done by a nurse. Administrative Nurse D stated the skin assessment for R14 might have been inadvertently omitted upon his readmission and verified the care plan should have been updated. The facility policy "Comprehensive Assessments and the Care Delivery Process" revised October	F 657			

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F 657	Continued From page 21 2021 documented comprehensive assessments will be conducted to assist in developing person-centered care plans. Comprehensive assessments (baseline, comprehensive MDS, etc.) were maintained in the resident's active record for a minimum of 15 months. These assessments are used to develop, review and revise the resident's comprehensive care plan. The facility failed to ensure a skin care area was initiated and revised to address skin issues and possible breakdown or infection R14. This deficient practice placed R14 at risk for skin breakdown and possible skin infection.	F 657			
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident	F 661			

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F 661	Continued From page 22 representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: The facility identified a census of 35 residents. The sample included 14 residents with one resident reviewed for discharge. Based on observation, record review, and interviews, the facility failed to document a discharge summary and recapitulation of the facility stay upon discharge from the facility for Resident (R) 40, which placed R40 at risk for an interruption in the continuity of care. Findings included: - R40 was admitted on 05/19/23 and discharged on 05/21/23. R40's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of reduced mobility, generalized muscle weakness, and major depressive disorder (major mood disorder). The "Admission Minimum Data Set" (MDS) was not completed. R40's "Care Area Assessment" (CAA) was not completed. R40's "Baseline Care Plan" dated 05/19/23 documented R40's goal was to return to the community.	F 661			

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F 661	Continued From page 23 Review of the EMR under "Progress Notes" tab revealed a "Discharge Summary" note dated 05/22/23 at 11:44 AM documented R40 discharged home on 05/21/23 per her request with spouse. The facility was unable to provide the recapitulation of R40's stay. On 08/02/23 at 11:10 AM Administrative Staff A stated the nurse on duty on the 05/21/23 had completed the incorrect form for R40's discharge that did not included the correct information for a discharge summary or recapitulation of her stay and disposition of her medication. The facility's "Discharge Summary and Plan" policy last revised 10/21 documented a resident's discharge was anticipated, a discharge summary and post-discharge plan would be developed to assist the resident to adjust to his/her new living environment. The discharge summary would include a recapitulation of the resident's stay at this facility and a final summary of the resident's status at the time of the discharge in accordance with established regulations governing release of resident information and as permitted by the resident. The discharge summary would include a description of the resident's: a. current diagnosis; b. medical history; c. course of illness, treatment and/or therapy since entering the facility; d. current laboratory, radiology, consultation, and diagnostic test results; e. physical and mental functional status; f. ability to perform activities of daily living. As part of the discharge summary, the nurse would reconcile all pre-discharge medication with the resident's post-discharge medications. The medication reconciliation will be	F 661			

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F 661	Continued From page 24 documented.	F 661			
F 677 SS=D	The facility failed to document a recapitulation for R40's stay at the facility after her discharge to another facility. This placed her at risk for an interruption in the continuity of care. ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: The facility identified a census of 35 residents. The sample included 14 residents with four resident reviewed activities of daily living (ADL). Based on observation, record review, and interviews, the facility failed to ensure a shower/bath was provided for Resident (R) 24, R16, and R11 who required extensive assistance with ADLs. This deficient practice placed these residents at risk for the potential to cause skin breakdown and/or skin complications due to poor personal hygiene and impaired psychosocial wellbeing. Findings included: - R24's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of need for assistance with personal care, Huntington's disease (rare abnormal hereditary condition characterized by progressive mental deterioration; a disabling central nervous system movement disorder), and psychosis (any major mental disorder characterized by a gross	F 677			

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F 677	Continued From page 25 impairment testing). The "Significant Change Minimum Data Set" (MDS) dated 04/11/23 documented a Brief Interview of Mental Status (BIMS) score of four which indicated severely impaired cognition. The MDS documented that R24 was dependent on staff member assistance for ADL. The MDS documented R24 required physical assistance of one staff member for bathing during the look back period. The "Quarterly MDS" dated 07/07/23 documented a BIMS score of zero which indicated severely impaired cognition. The MDS documented that R24 was dependent on one staff member assistance of for ADL. The MDS documented R24 was dependent on one staff members assistance for bathing during the look back period. R24's "Cognitive Loss Care Area Assessment" (CAA) dated 04/21/23 documented R24 preferred certain nursing staff to assist him. R24's "Care Plan" dated 10/16/20 documented staff would check, trim and clean fingernails on bath days as needed, along provide R24 with a sponge bath when a full bath/ shower could not be tolerated. The "Care Plan" dated 11/01/22 documented R24 required extensive assistance with his bathing activity, and he preferred evenings, but had no preference on the day of the week. Review of the EMR under "Reports" tab for bathing reviewed from 05/01/23 to 07/31/23 (92 days) revealed R24 received seven baths/showers on following dates: 05/16/23,	F 677			

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F 677	Continued From page 26 05/17/23, 06/02/23, 06/05/23, 06/13/23, and 06/27/23. The clinical record lacked documentation of a refusals. On 08/02/23 at 09:00 AM R24 sat in a recliner next to the bed in his room, the room and bed smelled of urine. On 08/03/23 at 02:30PM, Certified Nurse Aide (CNA) M stated each time a resident received a bath the staff should have documented it in the EMR under bathing. CNA M stated some agency staff may not know to put the bathing episodes in the EMR. CNA M stated each resident should get two baths weekly unless they were on hospice. CNA M stated staff would bath R24 if hospice was unable to bathe him. CNA M stated residents who were receiving hospice services should get their baths/showers provided by the facility along with hospice if the baths did not coincide on the same days. On 08/03/23 at 02:55PM, Licensed Nurse (LN) G stated she did not believe R24 received baths/showers from the nursing staff at the facility; he only received his showers from hospice. LN G stated each resident had assigned bathing days and staff were expected to report to the nurse if a refusal occurred. LN G stated the nurse would approach the resident to find the cause of the refusal. On 08/02/23 at 03:21 PM Administrative Nurse D stated everyone including agency staff had access to review the Kardex (a medical information system used by nursing staff to communicate important information on their patients. It is a quick summary of individual patient needs that is updated at every shift	F 677			

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F 677	Continued From page 27 change) for each resident. Administrative Nurse D stated she was not sure if everyone had access to documents in PCC. Administrative Nurse D stated shower sheets had been implemented prior to her arrival on 07/09/23. Administrative Nurse D stated the shower sheets were part of the resident's clinical record and filed in the resident's paper chart which was kept in her office. Administrative Nurse D stated if a resident refused their shower/bath the nurse was to follow up with that resident to find out the reason for the refusal, along with education of why the resident should not refuse their shower/bath. Administrative Nurse D stated alternatives should be offered to the resident. Administrative Nurse D stated the facility should be bathing/ showering the residents who were receiving hospice services unless the resident had chosen to only receive their showers/baths for the hospice provider. Administrative Nurse D stated that would be care planned. She stated staff were expected to complete bath forms and turn them into the nurse for review. Administrative Nurse D stated staff were expected to ensure each resident was bathed per their assigned day and the documentation be completed and reviewed by the nurse. The facility's "Activities of Daily Living" policy revised 03/2018 indicated the facility would ensure appropriate service care and services would be provided for residents who are unable to carry out hygiene, mobility, toileting, dining, and communication. The facility failed to provide consistent bathing for R24 who was dependent on staff for all ADL. This deficient practice placed R24 at risk to cause skin breakdown and/or skin complications due to	F 677			

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F 677	Continued From page 28 poor personal hygiene and impaired psychosocial wellbeing. - The "Medical Diagnosis" section within R16's Electronic Medical Records (EMR) included diagnoses of insomnia (difficulty sleeping), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), senile degeneration of the brain, local infection of the skin, atherosclerosis (hardening of the blood vessels), major depressive disorder (major mood disorder), and kidney disorder. R16's "Quarterly Minimum Data Set (MDS)" completed 05/03/23 noted a Brief Interview for Mental Status (BIMS) score was not completed due to severe cognitive impairment. The MDS indicated she required total dependence from two staff for transfers, bed mobility, grooming, personal hygiene, bathing, and dressing. The MDS indicated she was always incontinent of bowel and bladder. The MDS noted preventative skin treatments of pressure reducing devices, nutrition/hydration interventions, and application of ointments. R16's "Activities of Daily Living Care Area Assessment (CAA)" completed 10/05/22 indicated she required extensive assistance from staff with her ADL. The CAA indicated she was alert of self but could not make her needs known. The CAA indicated staff were to anticipate her needs. R16's "Urinary Incontinence CAA" completed 10/05/22 indicated she was incontinent of bowel and bladder. The CAA indicated staff were to anticipate her needs. The CAA indicated staff were to provide peri-care and incontinence briefs.	F 677			

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F 677	Continued From page 29 R16's "Care Plan" created 12/12/19 indicated she had a self-care deficit related to her limited mobility and medical diagnoses. The plan noted she propelled herself around facility as desired but needed foot pedals when assisted. The plan noted she required extensive to total assistance with bathing but had no assigned preference of day or times (12/12/19). The plan instructed staff to provide education related to skin breakdown (08/19/22) The plan indicated she was at risk for skin breakdown and staff were to administer treatments as ordered (11/08/22). The plan instructed staff to complete weekly skin assessment and document treatments (08/19/22). The plan noted she had a history of fungal infections. R16's "Weekly Skin Assessment" completed 07/18/23 indicated she developed a rash on her chest and arms. The report indicated she had a yeast infection under both armpits and her breast. R16's EMR under "Physician's Orders" indicated she started Nystatin cream (antifungal medication) on 07/18/23 for skin irritation two times daily until healed. R16's "Weekly Skin Assessment" completed 08/01/23 indicated her the rash under her arms remained but her chest rash healed. R16's EMR revealed her last documented bathing occurrence occurred on 06/27/23, over one month ago. R16's paper chart lacked bathing documentation. On 08/01/23 at 07:10 AM at R16 rested in her	F 677			

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F 677	Continued From page 30 bed. R16 had bilateral (both arms) redness in her armpits. Her hair was greasy and unwashed. Her nails were trimmed. Her room smelled of urine. On 08/02/23 at 11:20AM R16 was transferred back to her bed after receiving a shower by staff. R16 still had bilateral redness under her arm pits. On 08/03/23 at 02:30PM, Certified Nurse Aide (CNA) M stated each time a resident received a bath the staff should have documented it in the EMR under bathing. She stated some agency staff may not know to put the bathing episodes in the EMR. She stated each resident should get two baths weekly unless they were on hospice. She stated R16 would never refuse her baths, but she did have incontinence and may have had bed baths that were not marked. On 08/03/23 at 02:55PM, Licensed Nurse (LN) G stated R16 currently had redness on her arms and chest. She stated R16 gets rashes from time to time. She stated each resident had assigned bathing days and staff were expected to report to the nurse if a refusal occurred. She stated R16 was currently taking an antifungal to treat her rash. On 08/01/23 at 02:30PM Administrative Nurse D stated the facility's bathing documentation for the month of June and July of 2023 would be in the resident's physical charts due to issues with the EMR system. She stated staff were expected to complete bath forms and turn them into the nurse for review. She stated the forms were filed with the resident's physical (paper) charts. She stated staff were expected to ensure each resident was bathed per their assigned day and the documentation be completed and reviewed by the	F 677			

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F 677	Continued From page 31 nurse. A review of the facility's "Activities of Daily Living" policy revised 03/2018 indicated the facility will ensure appropriate service care and services will be provided for residents who are unable to carry out hygiene, mobility, toileting, dining, and communication. The facility failed to provide consistent bathing for R16. This deficient practice placed R16 at risk for complication related to hygiene and decreased psychosocial well-being. - The electronic medical record (EMR) for R11 documented diagnoses of hypertension (HTN - an elevated blood pressure), muscle wasting and atrophy (significant shortening of the muscle fibers and a loss of overall muscle mass), and cerebral vascular accident (CVA-a disruption in the blood flow to the brain), hemiplegia (paralysis of one side of the body). The "Annual Minimum Data Set" (MDS) dated 05/19/23 for R11 documented a Brief Interview for Mental Status (BIMS) score of nine which indicated a moderately impaired cognition. R11 required the assistance of one staff member for ADL. R11 required assistance of one staff with bathing. The "Quarterly MDS" dated 07/06/23 for R11 documented a BIMS score of five which indicated a severely impaired cognition. R11 required supervision for eating and limited to extensive assistance of one with ADL. R11 required assistance of one staff with bathing. The "ADL Care Area Assessment" (CAA) dated 06/02/23 documented R11 had the potential for	F 677			

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F 677	Continued From page 32 alteration in ADL activities due to requiring supervision to physical assistance with care needs due history of right-sided hemiplegia post CVA. R11 could feed herself with setup help as needed. R11 was non-ambulatory and used a wheelchair with assistance for locomotion, toileting, hygiene, positioning, and shower needs to extent needed. R11 would attempt to transfer self but was unable to do so safely without help. R11 can hold onto grab bar in the bathroom with help. The "ADL Care Plan" for R11 revised 09/08/21 directed staff that R11 required extensive assist with bathing. R11's "Documentation Survey Report" for April 2023 documented R11 received a bath on 04/01/23, 04/12/23, and 04/27/23. R11's "Documentation Survey Report" for May 2023 documented R11 received a bath on 05/06/23, 05/10/23, 05/17/23, and 05/24/23. R11's "Documentation Survey Report" for June 2023 documented R11 received a bath on 06/03/23. R11's "Documentation Survey Report" for July lacked a "bathing" task for the month. On 07/31/23 at 07:45 AM R11's room had a distinct urine odor in the room. On 08/03/23 at 02:30PM, Certified Nurse Aide (CNA) M stated each time a resident received a bath the staff should have documented it in the EMR under bathing. CNA M stated some agency staff may not know to put the bathing episodes in	F 677			

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F 677	Continued From page 33 the EMR. CNA M stated each resident should get two baths weekly unless they were on hospice. CNA M stated staff would bath R11, and she enjoyed getting her baths. On 08/03/23 at 02:55PM, Licensed Nurse (LN) G stated she did not believe R11 received baths/showers from the nursing staff at the facility and at times R11 would refuse showers. LN G stated each resident had assigned bathing days and staff were expected to report to the nurse if a refusal occurred. LN G stated the nurse would approach the resident to find the cause of the refusal. On 08/02/23 at 03:21 PM Administrative Nurse D stated everyone including agency staff had access to review the Kardex (a medical information system used by nursing staff to communicate important information on their patients. It is a quick summary of individual patient needs that is updated at every shift change) for each resident. Administrative Nurse D stated she was not sure if everyone had access to document in PCC. Administrative Nurse D stated shower sheets had been implemented prior to her arrival on 07/09/23. Administrative Nurse D stated the shower sheets were part of the resident's clinical record and filed in the resident's paper chart was kept in her office. Administrative Nurse D stated if a resident refused their shower/bath the nurse was to follow up with that resident to find out the reason for the refusal, along with education of why the resident should not refuse their shower/bath. Administrative Nurse D stated alternatives should be offered to the resident. Administrative Nurse D stated the facility should be bathing/ showering the residents who were receiving hospice	F 677			

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F 677	Continued From page 34 services unless the resident had chosen to only receive their showers/baths for the hospice provider. Administrative Nurse D stated that would be care planned. She stated staff were expected to complete bath forms and turn them into the nurse for review. Administrative Nurse D stated staff were expected to ensure each resident was bathed per their assigned day and the documentation be completed and reviewed by the nurse. The facility's "Activities of Daily Living" policy revised 03/2018 indicated the facility would ensure appropriate service care and services would be provided for residents who are unable to carry out hygiene, mobility, toileting, dining, and communication. The facility failed to provide consistent bathing for R11 who was dependent on staff for all ADL. This deficient practice placed R11 at risk to cause skin breakdown and/or skin complications due to poor personal hygiene and impaired psychosocial wellbeing.	F 677			
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:	F 684			

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F 684	Continued From page 35 The facility identified a census of 35 residents. The sample included 14 residents. Based on observation, record review, and interviews, the facility failed to follow a physician order for daily weights to monitor for fluid overload for Resident (R) 33. The facility also failed to ensure weekly nurse skin assessments were completed for R14, who developed moisture associated skin damage (MASD). These deficient practices placed these residents at risk for delay in treatment related to fluid overload, skin related complications and untreated illness. Findings included: - R33's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of congestive heart failure (CHF - a condition with low heart output and the body becomes congested with fluid, heart failure (severe failure of the heart to function properly), kidney failure, and fluid overload. The "Annual Minimum Data Set" (MDS) dated 07/05/23 documented a Brief Interview of Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS documented that R33 required extensive assistance of one staff member for activities of daily living (ADL). R33's "ADL Functional/Rehabilitation Potential Care Area Assessment" (CAA) dated 07/17/23 documented R33 required extensive assistance from staff. R33's "Care Plan" dated 02/01/23 documented staff would monitor R33's weight as ordered by the physician.	F 684			

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F 684	Continued From page 36 Review of the EMR under "Orders" tab revealed physician orders: Fluid restriction 1500 cubic centimeters (cc) per day: Kitchen: 250cc per meal = 1,000 cc Nursing: 125cc breakfast, 125cc lunch and 125cc for dinner every shift dated 08/25/22. Weigh daily. Notify physician/cardiologist of weight gain of two pounds (lbs.) or more in one day or five lbs. or more in one week for monitoring dated 11/07/22. Review of the "Treatment Administration Record" (TAR) from 05/01/23 to 07/31/23 (92 days) revealed no weights were obtained(seven days) on following dates 05/06/23, 05/10/23, 06/02/23, 06/04/23, 06/09/23, 07/11/23, and 07/12/23. Documented weight gains greater than (>) two lbs. (12 days) on following dates 05/26/23, 05/29/23, 05/30/23, 06/10/23, 06/13/23, 06/21/23, 06/24/23, 07/27/23, 07/13/23, 07/18/23, 07/27/23, and 07/28/23. The clinical record lacked documentation of physician notification. On 08/01/23 at 01:42 PM R33 sat in a wheelchair next to her bed and watched TV. On 08/02/23 at 02:30 PM Certified Nurses Aide (CNA) M stated the charge will let the staff know who needs daily weights. CNA M stated the staff report the weight to the nurse. On 08/02/23 at 02:54 PM Licensed Nurse (LN) G stated R33 was a daily weight and on a fluid restriction related to heart failure. LN G stated she was not always compliant. LN G was to be notified of a weight gain and that notification would be documented in the clinical record under the progress note.	F 684			

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F 684	Continued From page 37 On 08/02/23 at 03:21 PM Administrative Nurse D stated the physician should be notified of weight gain as ordered by the physician and it should be documented in the clinical record. The facility's "Change in a Resident's Condition or Status" last revised 10/21 documented the facility would promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status. The nurse would record in the resident's medical record information relative to changes in the resident's medical/mental condition or status. The facility failed to follow a physician order for daily weights to monitor weight gain for fluid overload for R33. This deficient practice placed R33 at risk of adverse side effects for unnecessary medication or complications related to fluid overload. - The electric medical record (EMR) for R14 documented diagnoses of hypertension (HTN- an elevated blood pressure), carcinoma of skin (a cancer that forms in tissues that line most organs and skin), nephropathy (deterioration of kidney function), and diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made, or the body cannot respond to the insulin). The "Annual Minimum Data Set" (MDS) dated 10/22/22 for R14 documented a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. R14 required limited assistance of one staff member for activities of daily living (ADL) and utilized the use of a wheelchair for mobility. R14 was at risk of developing pressure ulcers (localized injury to the			F 684			

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F 684	Continued From page 38 skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction). R10 had a pressure reducing device for his chair and bed. R14 received application of ointments to the skin as a treatment. The "Quarterly MDS" dated 06/11/23 documented a BIMS score of 14 which indicated intact cognition R14 required limited assistance to extensive assistance of one staff member for ADLs and utilized the use of a wheelchair for mobility. R14 was at risk of developing pressure ulcers. R10 had a pressure reducing device for his chair and bed. R14 received application of ointments to the skin as a treatment. The "Pressure Ulcer Care Area Assessment" (CAA) dated 11/01/22 for R14 documented a potential for breakdown due to fragile skin, impaired physical mobility, incontinent episodes with some control, and diagnosis of DM. No pressure ulcers were noted. Moisturizer lotion was applied to skin as prescribed. A "Braden Scale for Predicting Pressure Sore Risk" dated 06/11/23 documented a score of 19 which indicated a low risk of pressure sore. Under the "Orders" tab was an order dated 07/22/22 for R14 to moisturize skin with lotion once per day every day shift. Under the "Orders" tab was an order dated 07/27/23 to apply barrier cream to area on left side of buttock due to MASD two times a day for redness. Review of the "Assessments" tab lacked			F 684			

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F 684	Continued From page 39 evidence of "Weekly Licensed Nurse [LN] Skin Assessment" or routine skin assessment since R14's return to the facility on 06/10/23 from a hospital stay. A "Health Status Note" dated 07/27/23 at 04:00 PM for R14 documented R14's coccyx (small triangular area at the base of the spine) was red with an area measuring 0.5 centimeters (cm) x 0.5cm on his buttock caused by MASD. An order for barrier cream was placed on the "Treatment Administration Record" (TAR). Director of Nursing (DON) was notified. On 07/31/23 at 10:14 AM R14 stated he had a red area to his bottom that the aide noticed a few days ago. R14 stated there was no pain to the area and staff had been putting cream on him when he was toileted. On 08/01/23 at 02:53 PM R14 sat at the dining table in his wheelchair, cushion present to seat of wheelchair, playing bingo with other residents. On 08/02/23 at 02:30 PM Certified Nurse Aide (CNA) M stated R14 the aides looked at the skin when giving residents a bath and would let the nurse know if any new skin issues had been noted. CNA M stated R14 did get a barrier cream applied to his bottom due to an area of redness he had. CNA M stated the nurse should be doing a weekly skin check on all residents. On 08/02/23 at 02:45PM LN G stated the aides checked the skin over during bathing and notified the nurses if any skin issue was noted. LN G stated all residents should be getting a weekly skin check by a nurse and then the assessment would be charted under "Assessments" in the	F 684			

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F 684	Continued From page 40 EMR. LN G stated she was not aware that R14 had not been getting a weekly nurse skin assessment but would make sure that the skin assessment was added to R14's EMR. On 08/02/23 at 03:21 PM Administrative Nurse D stated each resident should be getting a weekly skin assessment done by a nurse. Administrative Nurse D stated the skin assessment for R14 might have been inadvertently omitted upon his readmission. Administrative Nurse D stated she would make sure the skin assessment was added to R14's EMR. The facility failed to provide a policy for preventing skin damage/breakdown. The facility failed to ensure weekly nurse skin assessments were completed for R14 who developed MASD to his coccyx. This deficient practice placed R14 at risk for skin breakdown and possible skin infections.	F 684			
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility had a census of 35 residents. The sample included 14 residents with seven residents reviewed for accidents and/or hazards.	F 689			

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F 689	Continued From page 41 Based on observation, record review, and interview, the facility failed to secure hazardous materials in a safe, locked area, and out of reach of the seven cognitively impaired, independently mobile residents. The facility additionally failed to safely transfer Resident (R)7 utilizing the appropriate mechanical lift and staff. This deficient practice placed the residents at risk for preventable accidents and injuries. Findings Included: - On 08/01/23 at 07:09AM an inspection of the facility's west hallway revealed an unsecured emergency treatment cart. The cart contained a full sealed bottle of Tylenol 325 milligram (mg) tablets (medication used for pain relief) and Geri-Dryl 25mg tablets (geriatric brand Benadryl-allergy medication) in the top drawer. The second drawer contained packaged (unused) insulin (hormone which regulates blood sugar) syringes and a small portable Sharps container (bin to place used needles and lancets) with four used syringes. Administrative Nurse D stated the cart could not be secured and the hazardous materials and medication should have not been stored there. She removed items from the cart. On 08/01/23 at 03:02PM a facility walkthrough revealed the "West Hall" shower door had been left propped open. An inspection of the room revealed a unsecured cabinet with a padlock left on the counter. The cabinet contained mildew remover spray bottle and heavy-duty room deodorizer. Both products contained the warning, "Keep out of reach of children, hazardous to humans can cause eye irritation, harmful if swallowed." An over-filled Sharps bin was mounted on the wall next to the cabinet. An	F 689			

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F 689	Continued From page 42 inspection of two large electrical switch boxes in the shower room revealed no lock securing the boxes marked "Electrical Warning" on the inside compartment. The room was immediately secured by staff after being alerted by survey team. On 08/02/23 at 02:30 PM, Certified Nurse Aide (CNA) M stated the shower room should always be locked to prevent residents from going in and slipping on the floors or getting into things that may be stored in there. She stated the residents should never have access to cleaning chemicals or items that may harm them. On 08/02/23 at 03:42 PM, Administrative Nurse D stated staff were expected to ensure the shower room and cleaning products were locked up when not in use. She was not aware that the electrical panels in the shower room did not secure. A review of the facility's "Accident Prevention" policy revised 10/2021 indicated the facility will identify and prevent accidents related to environmental hazards, medications, and provide preventative interventions to reduce the risk of injuries and falls. The facility failed to secure hazardous materials in a safe, locked area, and out of reach of the seven cognitively impaired, independently mobile residents. This placed the affected residents at risk for preventable accidents - The "Medical Diagnosis" section within R7's Electronic Medical Records (EMR) included diagnoses of chronic kidney disease, restlessness, agitation, dysphagia (swallowing difficulty), anxiety disorder (mental or emotional	F 689			

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F 689	Continued From page 43 reaction characterized by apprehension, uncertainty, and irrational fear), cognitive communication deficit, and atherosclerotic heart disease (hardening of the blood vessels in the heart). R7's "Quarterly Minimum Data Set (MDS)" completed 04/24/23 noted a Brief Interview for Mental Status (BIMS) score of one indicating severe cognitive impairment. The MDS indicated he required total dependence from two staff for transfers, locomotion, toileting, and bathing. The MDS indicated he had a history of falls but none since the last assessment. A review of R7's "Activities of Daily Living (ADL) Care Area Assessment (CAA)" completed 07/23/23 indicated he required extensive to total assistance from staff for ADL related to his medical diagnoses, impaired cognition, and limited mobility. The CAA indicated he required a Hoyer lift (mechanical full body lift) and two staff for all transfers. A review of R7's "Falls CAA" completed indicated he was a fall risk related to his non-ambulatory status, confusion, and fall history. The CAA indicated he had a history of falls related to self-transferring attempts. A review of R7's "Care Plan" initiated 08/28/21 indicated he had an alteration in self-cares and required extensive to total assistance from staff related to his impaired physical mobility. The plan noted he required a Hoyer lift and two staff for all transfers (08/28/21). The plan noted he had a non-injury fall on 06/16/22 and reminded staff to ensure two staff were present when using the Hoyer lift.	F 689			

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F 689	Continued From page 44 A review of a "Fall Investigation" completed on 06/16/22 indicated R7 fell while being transferred from the shower chair back to his wheelchair. The report indicated a Sit-to-stand lift (medical device that assists individuals with limited mobility in standing up from a seated position) was used to transfer R7 with only one staff present. The report noted R7's leg strength gave out during the transfer, and he slid out of the straps to the floor. The reported indicated staff were educated that two staff must be present during the lift transfer but failed to acknowledge the wrong type of lift was being used for the transfer. On 08/01/23 at 07:06 AM R7 sat in his bed. Certified Nurse Aide (CNA) N and CNA O cleaned the Hoyer lift and moved the lift to R7's bedside. Both staff completed hand hygiene and positioned R7's sling underneath him. CNA O attached the sling to the lift. CNA N lifted R7 while CNA O guided R7 away from the bed and into his wheelchair. Both staff removed the sling. The lift was cleaned and moved back into its storage position. R7 was then assisted during personal hygiene and prepared for breakfast. On 08/02/23 at 02:30 PM, CNA M stated she had been with the facility since R7's admission and he had always required a Hoyer Lift for transfers. She stated two staff were required for all mechanical lift transfers. She stated staff were required to review each resident's care needs in the Kardex (condensed care instructions pulled from the care plans) before completing cares or transfers. She stated some new agency staff may not have access to the EMR until the facility could give them a log-on.	F 689			

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F 689	Continued From page 45 On 08/02/23 at 02:54 PM, Licensed Nurse (LN) G stated R7 required a Hoyer lift due to his weakness and fall history. She stated two staff were always required for Hoyer lift transfers. She stated he had never required a Sit-to-stand lift due to his medical diagnoses and total care needs. On 08/02/23 at 03:42 PM Administrative Nurse D stated staff were expected to review and follow each resident's care plan. She stated were expected to verify what type of lift and transfer each resident required before attempting to move them. She stated all agency staff had access to the Kardex care cards to review each resident's care requirements. A review of the facility's "Fall / Accident Prevention for Lifts" policy revised 07/2017 indicated staff will follow the facility's requirements related to safe transferring and fall prevention. The policy indicated staff will identify and use the appropriate level of supervision and equipment to ensure each residents safety during transfers. The facility failed to safely transfer R7 utilizing the appropriate mechanical lift and staff. This deficient practice placed R7 at risk for preventable accidents and injuries.	F 689			
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical	F 690			

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F 690	Continued From page 46 condition is or becomes such that continence is not possible to maintain. §483.25(e)(2) For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: The facility identified a census of 35 residents. The sample included 14 residents with two residents reviewed for bowel and bladder incontinence. Based on observation, record review, and interviews, the facility failed to ensure Resident (R) 32 received treatment and services to maintain or improve his urinary continence to the highest extent possible. This deficient practice	F 690			

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F 690	Continued From page 47 placed R32 at risk of urinary related complications, for the potential skin breakdown and/or skin complications due to poor personal hygiene, and impaired psychosocial wellbeing. Findings included: - R32's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), hypertension (elevated blood pressure), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), and psychosis (any major mental disorder characterized by a gross impairment in reality testing). The "Annual Minimum Data Set" (MDS) dated 06/16/23 documented a Brief Interview of Mental Status (BIMS) score of zero which indicated severely impaired cognition. The MDS documented that R32 required extensive assistance of two staff members for activities of daily living (ADLs). The MDS documented R32 was frequently incontinent (seven or more episodes of urinary incontinence, but at least one episode of continent voiding). R32's " Urinary Incontinence and Indwelling Catheter Care Area Assessment" (CAA) dated 06/20/23 documented R32 was at risk for alteration in elimination related to incontinent episodes of bowel and bladder pattern. R32 was provided incontinent care and toileting with staff assistance.	F 690			

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F 690	Continued From page 48 R32's "Care Plan" dated 08/01/22 documented staff would present one thought, idea, question, or command at a time. The "Care Plan" dated 01/24/23 documented staff would provide peri-care after each incontinent episode and nursing staff would encourage fluids during the day to promote prompted voiding responses. Review of the EMR under "Assessment" tab revealed a "Bowel and Bladder" assessment dated 09/21/22 that documented R32 was a good candidate for retraining. R32's clinical record lacked evidence the facility responded to the assessment and implemented retraining. The "Bladder/Bowel" section under the "Admission/Readmission" screen assessment dated 01/24/23 and 06/30/23 lacked direction or indication of possible retraining for bladder incontinence. On 08/01/23 at 03:00 PM R32 was asleep on the couch in the common area. On 08/02/23 at 02:30 PM Certified Nurse Aide (CNA) M stated everyone that was able to utilize the toilet was toileted every two hours. CNA M stated R32 was incontinent of bladder and toileted himself at other times. CNA M stated she was not aware of any resident that individualized toileting plans or any assessment/monitoring that was done to identify a resident's pattern for voiding. On 08/02/23 at 03:21 PM Administrative Nurse D stated the incontinence evaluation was completed at the time of admission and readmission. Administrative Nurse D stated the evaluation	F 690			

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F 690	Continued From page 49 would include a post void bladder scan, monitoring voiding, reviewing diagnosis, history of incontinence, and family interview. Administrative Nurse D stated the evaluations have not started yet. The facility's "Activities of Daily Living" policy revised 03/2018 documented residents' would be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out ADLs. The facility would ensure appropriate service care and services would be provided for residents who are unable to carry out hygiene, mobility, toileting, dining, and communication. The facility failed to ensure R32 received treatment and services to maintain or improve his urinary continence to the highest extent possible. This deficient practice placed R32 at risk of urinary related complications, for the potential skin breakdown and/or skin complications due to poor personal hygiene, and impaired psychosocial wellbeing.	F 690			
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: The facility identified a census of 35 residents. The sample included 14 residents with one resident, Resident (R) 10, sampled for dialysis (a	F 698			

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F 698	Continued From page 50 type of treatment that helps your body remove extra fluid and waste products from your blood when the kidneys are not able to). Based on observation, record review and interview, the facility failed to ensure dialysis communication with the dialysis center regarding R10's health status with each procedure. This deficient practice placed R10 at risk for complications related to dialysis. Findings included: - The electronic medical record (EMR) for R10 documented diagnosis of dependence on renal dialysis, 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 a regular course of long-term dialysis or a kidney transplant to maintain life), hypertension (HTN-elevated blood pressure), and neuropathy (weakness, numbness and pain from damage to the nerves usually in the hands or feet). The "Annual Minimum Data Set" (MDS) for R10 documented a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. R10 was independent with his activities of daily living (ADL). R10 was on dialysis services. The "ADL Care Area Assessment" (CAA) for R10 documented resident was independent with ADL activities with supervision/setup help as needed. R10 ambulated for short distances and used a wheelchair for locomotion for longer distances. R10 had neuropathy and received dialysis three times a week due to ESRD. R10 was highly involved with activities daily.	F 698			

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F 698	Continued From page 51 The "Dialysis Care Plan" revised 10/21/21 for R10 directed staff to encourage resident to go for scheduled dialysis appointments. The care plan directed staff to communicate with the dialysis center. The "Order Summary Report" for R10 documented an order dated 10/25/22 for dialysis on Monday, Wednesday, and Friday. Review of "Dialysis Communication Sheets" for R10 revealed numerous missing dialysis communication upon return to the facility from the dialysis center including: 04/19/23, 04/28/23, 05/08/23, 05/12/23, 05/26/23, 06/07/23, 06/23/23, 06/26/23, 06/28/23, 06/30/23, 07/7/23, 07/09/23, 07/21/23, 07/24/23, and 07/27/23. On 08/01/23 at 02:58 PM R10 sat in his wheelchair in the dining room calling bingo. On 08/02/23 at 10:15 PM R10 stated to that he did not feel well that morning so he missed his dialysis appointment but said he called the dialysis center to tell them he would go the next day. On 08/02/23 at 02:54 PM Licensed Nurse (LN) G stated R10 was not always good at bringing the communication sheets back after his dialysis appointment. LN G stated that the dialysis center was not always willing to fax over the communication sheets so at times the facility had to request them many times. LN G stated some of the communication sheets had been scanned into the EMR but not all of them. On 08/02/23 at 03:21 PM Administrative Nurse D	F 698			

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F 698	Continued From page 52 stated R10 was not always good about bringing the communication sheets back or he would leave them in the transportation van. Administrative Nurse D stated the facility did call the dialysis clinic to have them fax the sheet over but at times had thrown them away so the facility would have to wait to receive the summary report from the clinic. The facility did not provide a policy for dialysis. The facility failed to ensure dialysis communication from the dialysis center regarding R10's health status with each procedure. This deficient practice placed R10 at risk for complications related to dialysis.	F 698			
F 699 SS=D	Trauma Informed Care CFR(s): 483.25(m) §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is not met as evidenced by: The facility identified a census of 35 residents. The sample included 14 residents with one reviewed for trauma informed care. Based on observation, record review, and interviews, the facility failed to complete screening on Resident (R)25 to provide trauma informed care. This deficient practice placed R25 at risk for decreased psycho-social wellbeing and increased behaviors.	F 699			

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F 699	Continued From page 53 Findings Included: - The "Medical Diagnosis" section within R25's Electronic Medical Records (EMR) included diagnoses of vascular dementia (progressive mental disorder characterized by failing memory, confusion), adjustment disorder (difficulty in managing the stressful life changes), major depressive disorder (major mood disorder), and psychosis (any major mental disorder characterized by a gross impairment in reality). R25's "Quarterly Minimum Data Set (MDS)" completed 07/06/23 noted a Brief Interview for Mental Status (BIMS) score of 13 indicating no cognitive impairment. The MDS indicated no recent behaviors noted. The MDS indicated he required supervision from one staff for bed mobility, transfers, locomotion off the unit, dressing, toileting, and bathing. The MDS indicated he had antipsychotic medication (class of medications used to treat psychosis and other mental emotional conditions) on a routine basis. The MDS indicted he had no falls since his last assessment. R25's "Activities of Daily Living (ADL) Care Area Assessment (CAA)" completed 04/02/23 indicated he had a history of rejection of cares. The CAA indicated staff were to encourage to complete his ADLs. The CAA indicated R25 would self-transfer without assistance but should be encouraged by staff for assistance. R25's "Falls CAA" completed 04/02/23 indicated he was at risk for falls related to his fall history, unsteady balance, and medical diagnoses. The CAA instructed staff to monitor R25 for	F 699			

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F 699	Continued From page 54 non-compliance with ADL assistance. R25's "Care Plan" initiated 04/21/22 indicated he was independent with supervision and setup help for his ADLs. The care plan noted he had an alteration in cognition related to his thought processes and had numerous encounters with other residents. The care plan noted for staff to encourage him to use his call light for assistance (04/21/22). R25's plan instructed staff to cue, orient, and supervise him as needed (04/21/22). The plan noted on 10/12/22 for staff to provide clusters in care overnight to avoid waking him. The care plan noted on 07/11/22, R25 was re-educated to call staff for assistance instead of getting physical with other residents if they wandered into his room. The plan noted R25 complained he would call 911 if he needed to. The care plan noted he was placed on one-to-one supervision temporarily on 05/27/23 and 06/12/23 related to physical encounters with other residents. The plan indicated he was sent out to an acute care facility on 06/13/23 for behavioral treatment. The plan lacked documentation related to him blocking off cares for his roommate. R25's EMR revealed no screening to assess for and/or identify post-traumatic stress disorder (PTSD-psychiatric disorder characterized by an acute emotional response to a traumatic event or situation involving severe environmental stress, such as natural disaster, military combat, serious automobile accident, airplane crash or physical torture) and identify trauma informed cares. A review of the R25's "Admission Social Service Assessment" completed 07/21/22 revealed no questions or sections covering PTSD or trauma screening.	F 699			

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F 699	Continued From page 55 On 08/02/23 at 02:00PM Administrator D stated documentation could not be found showing R25 was screened for trauma informed care and existing PTSD triggers. She stated the facility used a social service assessment for screening upon admission that may have had trauma information. On 08/02/23 at 03:16PM Social Service X stated the facility uses the admission assessment under social services along with psychiatric assessment to make care plan interventions. She stated assessment does not specifically cover PTSD. The facility failed to complete screening on R25 to provide trauma informed care related to his history of behaviors. This deficient practice placed R25 at risk for decreased psycho-social wellbeing and increased behaviors.	F 699			
F 740 SS=D	Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is not met as evidenced by: The facility identified a census of 35 residents. The sample included 14 residents with one	F 740			

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F 740	Continued From page 56 reviewed for behavior management. Based on observation, record review, and interviews, the facility failed to implement behavioral care interventions to prevent identified triggers for Resident (R)25. This deficient practice placed R25 at risk for behavioral outburst and injuries. Findings Included: - The "Medical Diagnosis" section within R25's Electronic Medical Records (EMR) included diagnoses of vascular dementia (progressive mental disorder characterized by failing memory, confusion), adjustment disorder (difficulty in managing the stressful life changes), major depressive disorder (major mood disorder), and psychosis (any major mental disorder characterized by a gross impairment in reality). R25's "Quarterly Minimum Data Set (MDS)" completed 07/06/23 noted a Brief Interview for Mental Status (BIMS) score of 13 indicating no cognitive impairment. The MDS indicated no recent behaviors noted. The MDS indicated he required supervision from one staff for bed mobility, transfers, locomotion off the unit, dressing, toileting, and bathing. The MDS indicated he had antipsychotic medication (class of medications used to treat psychosis and other mental emotional conditions) on a routine basis. The MDS indicted he had no falls since his last assessment. R25's "Activities of Daily Living (ADL) Care Area Assessment (CAA)" completed 04/02/23 indicated he had a history of rejection of cares. The CAA indicated staff were to encourage to complete his ADLs. The CAA indicated R25 would self-transfer without assistance but should	F 740			

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F 740	Continued From page 57 be encouraged by staff for assistance. R25's "Falls CAA" completed 04/02/23 indicated he was at risk for falls related to his fall history, unsteady balance, and medical diagnoses. The CAA instructed staff to monitor R25 for non-compliance with ADL assistance. R25's "Care Plan" initiated 04/21/22 indicated he was independent with supervision and setup help for his ADLs. The care plan noted he had an alteration in cognition related to his thought processes and had numerous encounters with other residents. The care plan noted for staff to encourage him to use his call light for assistance (04/21/22). R25's plan instructed staff to cue, orient, and supervise him as needed (04/21/22). The plan noted on 10/12/22 for staff provide clusters in care overnight to avoid waking him. The care plan noted on 07/11/22, R25 was re-educated to call staff for assistance instead of getting physical with other residents if they wandered into his room. The plan noted R25 complained he would call 911 if he needed to. The care plan noted he was placed on one-to-one supervision temporarily on 05/27/23 and 06/12/23 related to physical encounters with other residents. The plan indicated he was sent out to an acute care facility on 06/13/23 for behavioral treatment. The plan lacked documentation related to him blocking off cares for his roommate. R25's EMR revealed no screening to assess for and/or identify post-traumatic stress disorder (PTSD-psychiatric disorder characterized by an acute emotional response to a traumatic event or situation involving severe environmental stress, such as natural disaster, military combat, serious automobile accident, airplane crash or physical	F 740			

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F 740	Continued From page 58 torture) or trauma informed care concerns. R25 EMR on 07/09/22 indicated another resident entered R25's room. R25 would not let the unidentified resident exit the room and stated, "he needs to learn to stay out of my room." Staff informed R25 that his behavior was inappropriate. The "Facility Investigation" dated 07/27/22 indicated R25 was resting in his room. The report noted R32 (severely cognitively impaired resident) entered his room. The report indicated R25 yelled to R32 to "get out of his room" and a physical altercation occurred between the residents in R25's room. The report indicated R25 received scratches on his arm from the altercation. R25's EMR on 08/14/22 revealed a "Progress Note" indicating R25 blocked his door to prevent staff from answering his roommate's call light. The note indicated R25 stated "his roommate would need to let him know before staff could answer the call light". R25's EMR on 10/14/22 revealed a "Progress Note" indicating R25 blocked his door off preventing staff assisting his roommate with cares. R25's EMR on 11/29/22 revealed a "Progress Note" indicating R25 placed his wheelchair in front of the door to block entry. The note indicated R25 pushed the direct care staff upon trying to enter the room. The note indicated staff re-educated R25 not to block his door. AA "Fall Investigation" dated 03/02/23 indicated R25 was in his room resting when R32 came into	F 740			

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F 740	Continued From page 59 the room and sat on R25's bed. The note indicated R25 yelled for him to leave his room but blocked R32 from leaving the room. The report noted R32 walked over to him and grabbed R25's arm. The report indicated R25 jerked his arm away causing his wheelchair to tip over and both residents fell to the ground. The report noted staff re-educated R25 to use his call light when other residents enter his room. On 07/31/23 at 08:13AM R25 sat his room. R25 reported he had concerns with people coming into and out of his room. He stated he had issues with certain resident entering his room and touching his stuff. He stated R32 would frequently wander into his room and not leave. He stated it has not happened in a while. He stated nothing has gone missing or stolen by another resident and didn't feel unsafe, but he was annoyed by it. He stated he threatened to call the police if he felt unsafe. On 08/02/23 at 02:30 PM, Certified Nurse's Aide (CNA) M stated R25 had been known to have aggressive behaviors towards other peers. She stated R25 did have behaviors when other residents entered his personal spaces or approached him in his room. She stated staff should close his door and monitor wandering residents to prevent them from entering his room. She stated she should encourage him to call for help instead of moving residents out of his room and re-orient him if he was confused. On 08/02/23 at 02:54PM Licensed Nurse (LN) G stated R25 has been known to have behaviors but has improved since returning from his behavioral care facility stay. She stated he had new medication to help with his behaviors. She	F 740			

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F 740	Continued From page 60 stated staff should prevent him from being around other resident's that trigger him and prevent residents from wandering into his room. On 08/02/23 at 02:54PM Administrative Nurse D stated that R25 had recently returned from an acute care facility for behaviors. She stated R25 has not had behaviors since his return. A review of the facility's "Behavioral Assessment, Intervention, and Monitoring" policy revised 08/2021 indicated the facility will provide ongoing evaluation and monitoring for residents with unidentified behaviors. The policy noted behavioral interventions will be individualized to relieve and prevent the resident's stress distress. The policy indicated behavioral symptoms will be closely monitored and interventions will be adjusted based on the resident's care needs. The facility failed to implement behavioral care interventions to prevent identified triggers for R25. This deficient practice placed R25 at risk for behavioral outburst and injuries.	F 740			
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures	F 755			

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F 755	Continued From page 61 that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: The facility identified a census of 35 residents. Based on record review, observation, and interview, the facility failed to ensure narcotic reconciliation which included regular narcotic counts of all narcotics, including the narcotics scheduled for destruction or a system which required two qualified staff for access to a fixed and locked medication bin. This deficient practice placed the residents at risk for misappropriation and drug diversion. Findings included: - Review of the "Controlled Medication Count Verification Forms" dated 07/01/23 - 08/02/23, in a binder on the west hall medication cart revealed medication counts that were not signed off by a	F 755			

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F 755	Continued From page 62 second staff member on the following days (6): 07/06/23, 07/12/23, 07/21/23, 07/25/23, 07/26/23, and 07/31/23. The following days (4) lacked a recorded entry that counts were completed by any staff member on at least one shift: 07/09/23, 07/14/23, 07/19/23, and 07/24/23. The following day (1) lacked a recorded entry that counts were completed by any staff member on both day and evening shift 07/08/23. Review of the "Controlled Medication Count Verification Forms" dated 07/01/23 - 08/02/23, in a binder on the east hall medication cart revealed medication counts that were not signed off by a second staff member on the following days (6): 07/06/23, 07/12/23, 07/23/23, 07/24/23, 07/25/23, and 07/30/23. The following days (7) lacked a recorded entry that counts were completed by any staff member on at least one shift: 07/07/23, 07/08/23, 07/09/23, 07/14/23, 07/19/23, 07/21/23, and 07/22/23. On 08/02/23 at 02:42 PM an observation in the facility's medication room revealed a large, black metal box on a countertop. The box was attached to the countertop and was locked with a single padlock that required a key. There were no noted slots or openings on the box. The box had a label which indicated it was used as the storage box for narcotics that were to be destroyed. On 08/02/23 at 02:54 PM Licensed Nurse (LN) G stated that medication counts were to be done every shift at the beginning and end of the shift. LN G stated a staff from each shift were required to complete counts and both staff were expected to sign the count sheet once the count was completed. LN G further stated that the Director of Nursing (DON) had the only key to the black	F 755			

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F 755	Continued From page 63 locked box, that was found in the medication room, used to store narcotic medications until they could be destroyed. She stated that the DON puts the medications in the locked box and that no one else had access to get inside of the box. She stated that medications stored in the box were no longer counted as only the DON could access the medications inside once they were placed in the box. On 08/02/23 at 03:20 PM Administrative Nurse D stated that the facility had a sheet with a list of how many narcotics should be in the drawers on the medication carts and the refrigerator in the medication room. She stated staff were expected to first count the medications locked in the refrigerator, and the medications in the narcotic drawers on the carts. She further stated the number on the narcotic sheets must match what was counted and that staff were expected to count and sign off each shift. Administrative Nurse D stated that if staff found a discrepancy, that she was to be notified/called and that staff had to remain at the facility until she arrived and was able to find out what happened to the medication. She stated that narcotic medications that were meant to be destroyed were placed in a locked box in the medication room. She stated that the box had a slot in it that allowed the nurses to place the medications inside. She stated that a nurse and the pharmacist each had a key and that it required them both to access it. She stated that she did not have a key to the box. On 08/02/23 at 04:29 PM LN G and Administrative Nurse D entered the medication room to clarify the process of storing narcotic medications that were to be destroyed. Administrative Nurse D stated that she believed	F 755			

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F 755	Continued From page 64 the box had a slot for medications to be placed in by the nurses and believed it had more than one lock on it. She stated that she was not aware that it was locked with only a single padlock and had no access slots. LN G stated that DONs in the past kept the key and were the only staff that could access the box and that medications would be placed in there and destroyed when the pharmacist came in. Administrative Nurse D stated that she was not notified of that process by the previous DON before she left. She stated that nothing was in the box as she had not used it since arriving at the facility. She stated that she would have to ask about the key and was not able to access it at that time. Administrative Nurse D stated that she thought the pharmacist may have taken the discontinued narcotics out of the medication carts and destroyed them and stated that the pharmacist came once a month to look through the medication carts and the medication room. LN G stated that the pharmacist had not taken any narcotic medications out of the medication carts and that staff were currently still counting the discontinued narcotic medications in the medication carts. On 08/03/23 at 01:30 PM Consultant GG stated that when she arrived at the facility, any narcotic medications that needed to be destroyed were locked in a narcotic storage box in the medication room. She stated that any medications that needed to be destroyed would be written up on a tag and the medication would be in the box. She stated that she did not have access to the box herself and that the DON had the key, and she would watch the DON open the box and then they would begin destroying the medications. She further stated that she checked the medication carts and medication room for expired	F 755			

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F 755	Continued From page 65 medications; however, she stated that she did not take medications that had been discontinued out of the medication carts as she had no way of knowing what had been discontinued and what needed to be removed. The facility policy "Controlled Substances" revised April 2019 recorded controlled substances were reconciled upon receipt, administration, disposition, and at the end of each shift. The facility failed to ensure narcotic reconciliation which included regular narcotic counts of all narcotics, including the narcotics scheduled for destruction or a system which required two qualified staff for access to a fixed and locked medication bin. This deficient practice placed the residents at risk for misappropriation and drug diversion.	F 755			
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.	F 756			

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F 756	Continued From page 66 (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: The facility identified a census of 35 residents. The sample included 14 residents with five residents sampled for medication review. Based on observation, record review and interview, the facility failed to ensure the physician responded to the Consultant Pharmacist (CP) recommendation that Resident (R)10 required an appropriate indication for use, or the required physician documentation, for the antipsychotic (a class of medications used to treat psychosis and other mental emotional conditions) medication Seroquel (quetiapine). This deficient practice placed this resident at risk of unnecessary medication administration and possible adverse side effects.	F 756			

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F 756	Continued From page 67 Findings included: - The electronic medical record (EMR) for R10 documented diagnosis of adjustment disorder with mixed anxiety and depressed mood (unwanted emotional and behavioral changes that can affect your mood, anxiety level, and ability to relate to others), dependence on renal dialysis (a type of treatment that helps your body remove extra fluid and waste products from your blood when the kidneys are not able to), 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 a regular course of long-term dialysis or a kidney transplant to maintain life), hypertension (HTN-elevated blood pressure), and neuropathy (weakness, numbness and pain from damage to the nerves usually in the hands or feet). The "Annual Minimum Data Set" (MDS) dated 06/16/23 for R10 documented a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. R10 was independent with his activities of daily living (ADL). R10 received an antipsychotic medication and antidepressant (class of medications used to treat mood disorders and relieve symptoms of depression) medication. The "Psychotropic Care Area Assessment" (CAA) dated 06/18/23 for R10 documented a risk for adverse reaction and received psychotropic (aripiprazole and quetiapine) medications daily related to personality disorder. The "Black Box Warning Care Plan" revised 06/11/21 directed staff to review pharmacy consultant recommendations and follow up as	F 756			

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F 756	Continued From page 68 indicated. Staff was to monitor R10 for possible signs and symptoms of adverse drug reactions. The "Orders" tab of the EMR documented an order dated 11/25/21 for quetiapine (Seroquel) 50milligrams (mg) by mouth two times a day for unspecified psychosis give with 100mg for a total of 150mg. The "Orders" tab of R10's EMR documented an order dated 05/22/22 for quetiapine 100 mg by mouth two times a day related to personality disorder and adjustment disorder with mixed anxiety and depressed mood. The CP's 03/27/23 "Medication Regimen Review" (MRR) to the physician made the recommendation for an evaluation for gradual dose reduction of R10's Seroquel with a supporting rationale if contraindicated. The CP had also made a recommendation, that R10 lacked an allowable diagnosis/condition for the use of Seroquel. The CP did not receive a response from the physician regarding the 03/27/23 recommendation. R10's EMR lacked evidence of the physician rationale which included unsuccessful attempts for nonpharmacological symptom management and risk versus benefit for the medication use of Seroquel. On 08/01/23 at 02:58 PM R10 sat in his wheelchair in the dining room calling bingo. On 08/02/23 at 03:54 PM Licensed Nurse (LN) G stated R10 took an antipsychotic medication	F 756			

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F 756	Continued From page 69 daily. LN G could not state for certain what an appropriate diagnosis was for Seroquel use but did know that dementia was not one. On 08/02/23 at 03:21 PM Administrative Nurse D stated that herself and some other nursing staff had begun to go through all the medication orders and try to get them cleaned up by trying to get the physician to get rid of or do a dose reduction of the antipsychotic medications unless the medication was deemed necessary by the physician or psychiatrist. Administrative Nurse D stated she had noted that several of the residents including R10 did not have a diagnosis that warranted the used of an antipsychotic medication. The facility policy "Medication Regimen Review" revised October 2021 documented the CP provided a written report to the attending physicians for each resident identified as a having a non-life-threatening medication irregularity. An "irregularity" refers to the use of medication that was inconsistent with accepted pharmaceutical services standard of practice; was not supported by medical evidence; and/or impedes or interferes with achieving the intended outcomes of pharmaceutical services. It may also include the use of medication without indication, without adequate monitoring, in excessive doses, and in the presence of adverse consequences. The facility failed to ensure the physician made timely response to the CP's recommendation that R10 required an appropriate indication for use, or the required physician documentation, for the antipsychotic medication Seroquel. This deficient practice placed this resident at risk of unnecessary medication administration and	F 756			

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F 756	Continued From page 70	F 756			
F 757 SS=D	possible adverse side effects. 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 identified a census of 35 residents. The sample included 14 residents with five residents reviewed for unnecessary medications. Based on observation, record review, and interviews, the facility failed to identify and notify physician of antihypertensive (treat high blood pressure) medication not administered as ordered and given for inappropriate indication for Resident (R) 32. This deficient practice placed R32 at risk for unnecessary medication	F 757			

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F 757	Continued From page 71 administration thus leading to possible harmful side effects. Findings included: - R32's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), hypertension (elevated blood pressure), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), and psychosis (any major mental disorder characterized by a gross impairment in reality testing). The "Annual Minimum Data Set" (MDS) dated 06/16/23 documented a Brief Interview of Mental Status (BIMS) score of zero which indicated severely impaired cognition. The MDS documented that R32 required extensive assistance of two staff members for activities of daily living (ADL). The MDS documented R32 had received antianxiety (class of medications that calm and relax people with excessive anxiety, nervousness, or tension) medication for seven days during the look back period. R32's "Cognitive Loss Care Area Assessment" (CAA) dated 06/20/23 documented R32 was unable to understand reality most of the time and staff would help redirect him. R32's "Care Plan" dated 11/02/22 documented staff would administer medication as ordered and monitor for side effects and document	F 757			

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F 757	Continued From page 72 effectiveness. Review of the EMR under "Orders" tab revealed physician orders: Hydralazine (antihypertensive) oral tablet 25 milligram (mg) give one tablet by mouth every six hours related to hypertension. Hold for systolic (SBP-relating to the phase of the heartbeat when the heart muscle contracts and pumps blood from the chambers into the arteries) less than (<) 110 millimeters of mercury (mmHg) dated 11/30/22 and discontinued 06/30/23. Hydralazine oral tablet 25mg give one tablet by mouth three times a day; hold if SBP <110 mmHg dated 07/05/23. The order satted the medication was being given for "mood." Review of the "Medication Administration Record" (MAR) from 05/01/23 to 05/30/23 (124 opportunities) revealed hydralazine was not administered 46 times: "Sleeping" 23 times, "Vitals Outside of Parameters for Administration" six times, "Refused" eight times, "Held Blood Pressure was outside parameters" eight times and one opportunity of no documentation. Review from 06/01/23 to 06/20/23 (80 opportunities) revealed hydralazine was not administered 30 times: "Sleeping" 15 times, "Refused" seven times, "Vitals Outside of Parameters for Administration" two times, "Held Blood Pressure was outside parameters" four times, and no documentation for two opportunities. Review from 07/01/23 to 07/31/23 (92 opportunities), hydralazine was not administered 24 times: "Sleeping" four times, "Held Blood Pressure was outside parameters" 19 times and refused one time. The clinical record lacked documentation the physician was	F 757			

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OMB NO. 0938-0391

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F 757	Continued From page 73 notified of medication not administered as ordered or the repeated episodes of blood pressure outside of parameters. On 08/01/23 at 03:00 PM R32 was asleep on the couch in the common area. On 08/02/23 at 02:54 PM Licensed Nurse (LN) G stated the physician should be notified of R32's medication not administered as ordered. LN G stated the notification would be documented in the clinical record under the progress note tab. LN G stated every medication should have an indication for administration of that medication. On 08/02/23 at 03:21 PM Administrative Nurse D stated she was not aware of R32's antihypertensive medication was held for sleep and the physician should be notified when an antihypertensive medication was held frequently. Administrative Nurse D stated the nurse would document that notification under the progress notes in the resident's clinical record. Administrative Nurse D stated every medication should have an appropriate indication for administration. Administrative Nurse D stated mood was not an appropriate indication for an antihypertensive medication. The facility's "Charting and Documentation" policy last revised 10/21 documented all services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional, or psychosocial condition, shall be documented in the resident's medical record. The medical record would facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. The date and	F 757			

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F 757	Continued From page 74 time the procedure/treatment was provided. The name and title of the individual(s) who provided the care. The assessment data and/or any unusual findings obtained during the procedure/treatment. How the resident tolerated the procedure/treatment. Whether the resident refused the procedure/treatment. Notification of family, physician, or other staff, if indicated, and the signature and title of the individual documenting.	F 757			
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented	F 758			

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F 758	Continued From page 75 in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: The facility identified a census of 35 residents. The sample included 14 residents with five residents sampled for medication review. Based on observation, record review and interview, the facility failed to ensure Resident (R)10 and R32 had an appropriate indication for use, or the required physician documentation, for the antipsychotic (a class of medications used to treat psychosis and other mental emotional conditions)	F 758			

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F 758	Continued From page 76 medication Seroquel (quetiapine). This deficient practice placed this resident at risk of unnecessary medication administration and possible adverse side effects. Findings included: - The electronic medical record (EMR) for R10 documented diagnosis of adjustment disorder with mixed anxiety and depressed mood (unwanted emotional and behavioral changes that can affect your mood, anxiety level, and ability to relate to others), dependence on renal dialysis (a type of treatment that helps your body remove extra fluid and waste products from your blood when the kidneys are not able to), 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 a regular course of long-term dialysis or a kidney transplant to maintain life), hypertension (HTN-elevated blood pressure), and neuropathy (weakness, numbness and pain from damage to the nerves usually in the hands or feet). The "Annual Minimum Data Set" (MDS) dated 06/16/23 for R10 documented a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. R10 was independent with his activities of daily living (ADL). R10 received an antipsychotic medication and antidepressant (class of medications used to treat mood disorders and relieve symptoms of depression) medication. The "Psychotropic Care Area Assessment" (CAA) dated 06/18/23 for R10 documented a risk for adverse reaction and received psychotropic (aripiprazole and quetiapine) medications daily	F 758			

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F 758	Continued From page 77 related to personality disorder. The "Black Box Warning Care Plan" revised 06/11/21 directed staff to review pharmacy consultant recommendations and follow up as indicated. Staff was to monitor R10 for possible signs and symptoms of adverse drug reactions. The "Orders" tab of the EMR documented an order dated 11/25/21 for quetiapine (Seroquel) 50milligrams (mg) by mouth two times a day for unspecified psychosis give with 100mg for a total of 150mg. The "Orders" tab of R10's EMR documented an order dated 05/22/22 for quetiapine 100 mg by mouth two times a day related to personality disorder and adjustment disorder with mixed anxiety and depressed mood. R10's EMR lacked evidence of the physician rationale which included unsuccessful attempts for nonpharmacological symptom management and risk versus benefit for the medication use of Seroquel. On 08/01/23 at 02:58 PM R10 sat in his wheelchair in the dining room calling bingo. On 08/02/23 at 03:54 PM Licensed Nurse (LN) G stated R10 took an antipsychotic medication daily. LN G could not state for certain what an appropriate diagnosis was for Seroquel use but did know that dementia was not one. On 08/02/23 at 03:21 PM Administrative Nurse D stated that herself and some other nursing staff had begun to go through all the medication orders and try to get them cleaned up by trying to get the	F 758			

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F 758	Continued From page 78 physician to get rid of or do a dose reduction of the antipsychotic medications unless the medication was deemed necessary by the physician or psychiatrist. Administrative Nurse D stated she had noted that several of the residents including R10 did not have a diagnosis that warranted the used of an antipsychotic medication. The facility policy "Antipsychotic Medciation Use" revised October 2021 documented:antipsychotic medications shall generally be used only for conditions/diagnoses as documented in the record, consistent with the definitions in the "Diagnostic and Statistical Manual of Mental Disorders". Diagnoses aloe did not warrant the use of antipsychotic medication. The Physician shall respond appropriately by changing or stopping problematic doses or medications, or clearly documenting (based on assessing the situation) why the benefits of the medication outweigh the risks or suspected or confirmed adverse consequences. The facility failed to ensure R10 had an appropriate indication for use, or the required physician documentation, for the antipsychotic medication Seroquel. This deficient practice placed this resident at risk of unnecessary medication administration and possible adverse side effects. - R32's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), hypertension (elevated blood pressure), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear),	F 758			

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F 758	Continued From page 79 depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), and psychosis (any major mental disorder characterized by a gross impairment in reality testing). The "Annual Minimum Data Set" (MDS) dated 06/16/23 documented a Brief Interview of Mental Status (BIMS) score of zero which indicated severely impaired cognition. The MDS documented that R32 required extensive assistance of two staff members for activities of daily living (ADL). The MDS documented R32 had received antianxiety (class of medications that calm and relax people with excessive anxiety, nervousness, or tension) medication for seven days during the look back period. R32's "Psychotropic Drug Use Care Area Assessment" (CAA) dated 06/20/23 documented R32 was at risk for adverse side effects from medications he received. R32's "Care Plan" dated 11/02/22 documented staff would administer medication as ordered and monitor for side effects and document effectiveness. Review of the EMR under "Orders" tab revealed physician orders: Mirtazapine (antidepressant medication) oral tablet 15 milligrams (mg) give one tablet by mouth at bedtime for sleep dated 06/30/2023. Quetiapine fumarate (antipsychotic medication) oral tablet 100mg give one tablet by mouth at bedtime for mood dated 06/30/23. Quetiapine fumarate oral tablet 50mg give 50mg by mouth at bedtime for mood dated 06/30/23.	F 758			

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F 758	Continued From page 80 Seroquel (quetiapine fumarate) oral tablet 50mg, give 50mg by mouth two times a day for mood dated 07/19/23. R32's clinical record lacked evidence the prescribing physician documented thoroughly the indication for the medication including the benefits versus risks, and the multiple attempts to implement care-planned, non-pharmacological approaches. On 08/01/23 at 03:00 PM R32 was asleep on the couch in the common area. On 08/02/23 at 02:54 PM Licensed Nurse (LN) G stated every medication should have an indication for administration of that medication LN G stated she was not for sure what the appropriate indication for antipsychotic medication was. On 08/02/23 at 03:21 PM Administrative Nurse D stated every medication should have an appropriate indication for administration. Administrative Nurse D stated mood was not an appropriate indication for an antipsychotic medication. Administrative Nurse D stated she was working with the prescribing physician to document the risk verse benefit and an appropriate indication for use for each resident who was receiving any antipsychotic medications. The facility's "Antipsychotic Medication Use" policy last revised 10/21 documented antipsychotic medications may be considered for residents with dementia but only after medical, physical, functional, psychological, emotional psychiatric, social, and environmental causes of behavioral symptoms have been identified and addressed. Diagnosis of a specific condition for	F 758			

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F 758	Continued From page 81 which antipsychotic medications are necessary to treat would be based on a comprehensive assessment of the resident. The facility failed to ensure an appropriate indication for use for the antipsychotic medications for R32. This failure had to potential of unnecessary antipsychotic medication use and related side effects for R32.	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 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	F 761			

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F 761	Continued From page 82 by: The facility had a census of 35 residents. The sample included 14 residents. Based on observation, interview, and record review, the facility failed to discard expired insulin (hormone which regulates blood sugar) vial for Resident (R)13, albuterol sulfate (used to prevent and treat breathing difficulties) for R23, tuberculin vial (injection used in testing for tuberculosis - an illness that mainly affects the lungs) and failed to secure medications on a treatment cart. This placed the affected residents at risk for injury and ineffective medications. Findings included: - On 08/01/23 at 07:09AM an inspection of the facility's west hallway revealed an unsecured emergency treatment cart. The cart contained a full sealed bottle of Tylenol 325 milligram (mg) tablets (medication used for pain relief) and Geri-Dryl 25mg tablets (geriatric brand Benadryl-allergy medication) in the top drawer. On 08/02/23 at 12:42 PM, an observation of the east hall medication cart revealed R23's albuterol sulfate had expired on 4/23/23. On 08/02/23 at 12:55 PM, an observation of the insulin/wound care cart revealed R13's Levemir (long-acting insulin) vial opened on 06/13/23 and expired on 07/25/23. On 08/02/23 at 02:39 PM, an observation of the medication room refrigerator revealed one tuberculin vial opened on 06/01/23 and lacked date of expiration. On 08/02/23 at 01:00 PM Licensed Nurse G	F 761			

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F 761	Continued From page 83 stated that she believed the Levemir could only be kept for 30-45 days after it was opened. She acknowledged that R13's vial of Levemir and R23's albuterol had passed the expiration dates and removed them from the cart. On 08/02/23 at 02:39 PM LN G stated the tuberculin vial found in the medication room refrigerator was good for 30 days once opened and that the vial should have been removed from the refrigerator and discarded. LN G removed the vial from the refrigerator. On 08/02/23 at 02:54 PM LN G stated it was both nurses and Certified Medication Aides (CMA) responsibility to check for expired medications. On 08/02/23 at 03:20 PM Administrative Nurse D stated that she expected every nurse to know that they need to look for dated medications and if they were expired, to remove them from the cart. She further stated that the pharmacist checks the medication carts and medication storage room once a month as well. Administrative Nurse D further stated that insulin should be destroyed if opened longer than 28 days and that tuberculin vials should be discarded after 30 days. Administrative Nurse D stated the emergency treatment cart could not be secured and the hazardous materials and medication found in it should not have been stored there. She removed the items from the cart. The facility did not provide a policy on medication storage. The facility failed to discard expired insulin vial for R13, albuterol sulfate for R23, tuberculin vial and failed to secure medications on a treatment cart.	F 761			

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F 761	Continued From page 84	F 761			
F 851	This placed the affected residents at risk for injury and ineffective medications.				
SS=C	Payroll Based Journal CFR(s): 483.70(q)(1)-(5)	F 851			
	§483.70(q) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(q)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(q)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175401	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/02/2023
NAME OF PROVIDER OR SUPPLIER BONNER SPRINGS NURSING & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 520 E MORSE STREET BONNER SPRINGS, KS 66012		
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F 851	Continued From page 85 (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(q)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(q)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(q)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is not met as evidenced by: The facility identified a census of 35 residents. Based on interview, and record review the facility failed to submit complete and accurate staffing information to the federal regulatory agency through Payroll Based Journaling (PBJ), when the facility failed to submit staffing hour data for all nursing personnel by the required deadline. Findings included: - The PBJ report provided by the Centers for Medicare & Medicaid Services (CMS) for Fiscal Year (FY) 2022 Quarter three documented the	F 851			

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F 851	Continued From page 86 facility failed to have staff Registered Nurse (RN) hours on 04/15/22, 05/10/22, 05/11/22, 05/12/22, 05/13/22, 05/27/22. The facility failed to have Licensed Nursing Coverage 24 hours/day on 04/02/22, 04/03/22; 04/05/22, 04/07/22, 04/08/22, 04/10/22, 04/12/22 - 04/18/22, 04/21/22, 04/22/22, 04/26/22 - 04/30/22, 05/01/22, 05/04/22 - 05/15/22, 05/21/22 - 05/29/22, 06/03/22 - 06/11/22, 06/18/22, 06/19/22, 06/21/22 -06/26/23, 06/28/22 - 06/30/22. The PBJ report provided by the CMS for FY 2022 Quarter four documented the facility had a one-star staffing rating and excessively low weekend staffing. The facility failed to have Licensed Nursing Coverage 24 hours/day on the following days: 07/01/22 -07/05/22, 07/09/22, 07/12/22 - 07/14/22, 07/16/22, 07/17/22, 07/18/22 - 07/31/22, 08/01/22 - 08/07/22, 08/09/22, 08/13/22, 08/14/22, 08/16/22, 08/20/22, 08/30/22, 09/02/22, 09/03/22, 09/05/22, 09/10/22, 09/11/22, 09/13/22, 09/14/22, 09/15/22, 09/17/22, 09/18/22, 09/21/22, 09/24/2, 09/25/22, 09/27/22, 09/30/22. The PBJ report provided by the CMS for FY 2023 Quarter one documented the facility had a one-star staffing rating and excessively low weekend staffing. The facility failed to have RN coverage on during the months of October, November, and December. The facility failed to have Licensed Nursing Coverage 24 Hours/Day for all days the month of October, November, and December. The PBJ report provided by the CMS for FY 2023 Quarter three documented the facility had a one-star staffing rating and excessively low weekend staffing. There were no RN hours on the	F 851			

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F 851	Continued From page 87 following dates: 01/15/23, 01/21/23, 01/24/23, 01/25/23, 01/28/23, 01/29/23 - 02/02/23, 02/07/23, 02/08/23, 02/14/23, 02/15/23, 02/18/23 - 02/28/23, 03/01/23 - 03/05/23, 03/07/23; 03/11/23 - 03/31/23. The facility to have Licensed Nursing Coverage 24 Hours/Day 01/01/23, 01/05/23, 01/06/23, 01/08/23, 01/09/23, 01/12/23, 01/14/23, 01/15/23, 01/21/23, 01/23/23, 01/24/23, 01/27/22, 01/28/23, 01/29/23, 02/04/23, 02/07/23, 02/11/23- 02/19/23, 02/22/23 - 02/28/23, 03/01/23 - 03/05/23, 03/07/23 - 03/09/23, 03/11/23 - 03/15/23, 03/20/23 - 03/31/23. Upon review of printed staffing punch times of facility staff and agency staff provided by the facility for the dates above it was revealed that the facility had proof of RN hours and LN hours for all dates. On 08/01/23 at 10:10 AM Administrative Staff A stated that Human Resources sent all hours worked to the corporate office and that was who submits all the nursing hour data to CMS for the PBJ report. On 08/02/23 at 04:45 PM Administrative Staff B stated corporate had realized that they had not been submitting the nursing hours correctly and that the error should be fixed now. The facility policy "Reporting Direct-Care Staffing Information (Payroll-Based Journal) revised October 2021 documented: direct-care staffing and census information would be reported electronically to CMS through the PBJ system. Direct-care staffing information included staff hired directly by the facility, those hired through an agency and contract employees. Staffing information was collected daily and reported for	F 851			

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F 851	Continued From page 88 each fiscal quarter no later than 45 days after the end of the reporting quarter. Staffing data included the number of hours worked each day by each staff member. The facility failed to submit complete and accurate staffing information to the federal regulatory agency through PBJ, when the facility failed to submit/provide RN staffing hour data for all nursing personnel by the required deadline.	F 851			
F 880 SS=E	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,	F 880			

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F 880	Continued From page 89 but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be 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.	F 880			

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F 880	Continued From page 90 This REQUIREMENT is not met as evidenced by: The facility identified a census of 35 residents. The sample included 14 residents with three residents identified by the facility on enhanced barrier precautions. Based on record review, observations, and interviews, the facility failed to maintain sanitary infection control practices related to laundry delivery and trash removal. This deficient practice placed the residents at risk for complications related to infectious diseases. Findings Included: - On 07/31/23 at 07:04AM a walkthrough of the facility revealed three small-sized trash bags on the floor of the east hallway and two small trash bags sat on the west hallway floor filled with trash with no bin or protective barrier. On 07/31/23 at 02:12PM Housekeeping Staff V pushed a laundry cart filled with multiple resident's personal clean clothing down the west hall with no cover. On 08/01/23 at 07:21AM Maintenance Staff U stated he was not aware the laundry basket needed to be covered in transport in the facility. He stated staff should take the trash bag directly to the large trash receptacle and not place the bags directly on the ground. On 08/03/23 at 02:30PM Certified Nurse's Aide (CNA) M stated trash bags should never be left directly on the floor due to germs and contamination. She stated the bags should either be placed in the receptacles in the room or in the large bin to be taken outside.	F 880			

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F 880	Continued From page 91 On 08/03/23 at 03:21PM Administrative Nurse D stated staff should not place trash bags on the ground due to the risk of transmitting infectious waste. She stated the facility held frequent in-services to educate staff on the importance of preventing the spread of contaminants. A review of the facility's "Infection Control" policy revised 10/2021 indicated laundry should always be transported with a protective cover to prevent environmental contamination between different areas. The policy noted protective barriers should also be used for transporting trash and medical waste. The policy noted trash bags should always be placed in a receptacle or bin and not exposed directly to the environment. The facility failed to maintain sanitary infection control practices related to laundry delivery and trash removal. This deficient practice placed the residents at risk for complications related to infectious diseases.	F 880			