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THE HEALTHCARE RESORT OF OLATHE	21250 WEST 151ST STREET OLATHE, KS 66061

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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey and Complaint Investigation #KS00177655, KS00173730, and KS00172806. The 2567 was sent electronically on 08/22/23.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.	F 550		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 08/22/2023

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

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§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 61 residents. The sample included 15 residents with one resident reviewed for dignity. Based on observation, record review, and interviews, the facility failed to ensure Resident (R) 103's window blinds/curtain that open to a street was closed during peri-care and wound treatment to coccyx area. This deficient practice placed R103 at risk for impaired dignity and decreased psychosocial well-being.

Findings included:

- R103's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), and malnutrition (lack of proper nutrition, caused by not having enough to eat, not eating enough of the right things, or being unable to use the food that one does eat).

The "Admission Minimum Data Set" (MDS) was in progress.

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R103's "Care Area Assessment" (CAA) was in progress.

R103's "Baseline Care Plan" dated 08/04/23 documented staff would engage in simple, structured activities that avoid overly demanding tasks.

On 08/08/23 at 03:33 PM R103's window blinds remained open the street during peri-care and wound care to his coccyx (tailbone area) area.

On 08/09/23 at 02:11 PM Certified Nurse Aide (CNA) M stated the door to the hallway, and curtain/blinds to the window should be closed during cares, or if a semiprivate room the privacy curtain should be pulled to provide privacy.

On 08/09/23 at 02:50 PM Licensed Nurse (LN) J stated staff should explain to the resident what they were going to do before doing anything. LN J stated staff should close the door and close the window blinds when staff provide any personal care.

On 08/09/23 at 03:53 PM Administrative Nurse D stated staff should close the door to the hallway and close the window blinds in the resident's room when they provide any personal care. Administrative Nurse D stated staff should keep the resident covered as much as possible when providing any personal hygiene.

The facility's "Dignity' policy last revised 10/2015 documented it was the policy of this facility that all residents be treated with kindness, dignity, and respect. Privacy of a Resident's body shall be maintained during toileting, bathing, and other activities of personal hygiene, except when staff

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F 550	Continued From page 3 assistance is needed for the Resident's safety. The facility failed to ensure R103's window blinds/curtains were closed during peri-care and wound care of R103's coccyx area. This deficient practice placed R103 at risk for impaired dignity and decreased psychosocial well-being.	F 550		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: The facility identified a census of 61 residents and the sample included 15 residents. Based on observation, record review, and interviews, the facility failed to ensure Resident (R)31's call light was within reach. This deficient practice placed R31 at risk for preventable accidents and injuries. Findings Included: - The electronic medical record (EMR) for R31 documented diagnoses of hemiplegia (paralysis of one side of the body) and hemiparesis (muscular weakness of one half of the body) following a cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain) affecting right dominant side, speech and language deficits following cerebral infarction, and generalized muscle weakness.	F 558		

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R31's "Significant Change Minimum Data Set" (MDS) dated 04/21/23 documented a staff interview which indicated the resident had short-term and long-term memory problems. R31 was extensive assistance and required two-person physical assistance with many of his activities of daily living (ADL).

The "Cognitive Loss / Dementia Care Area Assessment (CAA)" dated 04/21/23, documented R31 had severe impairment in decision making which may result in unsafe behavior and potential for injury or difficulty with performance of ADL.

A review of R31's "Care Plan" with an intervention dated 11/28/20 directed staff to be sure the call light was within reach and encourage R31 to use it to call for assistance as needed. The "Care Plan" with an intervention dated 12/09/20 directed staff to keep R31's call light in reach.

On 08/07/23 at 10:02 AM an observation revealed R31 laid in his bed and his call light was placed on the far end of his night stand out of reach of R31.

On 08/07/23 at 10:18 AM two unidentified staff members came out of R31's room. At 08/07/23 at 10:27 AM observation revealed R31 had been moved to his Broda chair (specialized wheelchair with the ability to tilt and recline). R31's chair was placed approximately one to two feet from the mid-point of his bed. His bed was on his right side. His call light was on his bed and was near the foot of the bed, out of reach of R31.

On 08/09/23 at 02:11 PM Certified Nurse Aide (CNA) M stated R31 had right sided weakness

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and that it would not be appropriate for his call light to be sitting on his nightstand. CNA M stated that he places it on R31's lap so that R31 can access it. CNA M further stated that if R31 had been sitting in his chair near the mid-point of his bed and the call light was laying on R31's bed closer to the foot of the bed, that R31 would probably not be able to reach it if needed. CNA M stated that R31 was unable to communicate vocally and that he used a laminated paper that he pointed to that says yes or no on it. He stated that R31 was likely not able to holler out/yell to get anyone's attention if he needed help and could nott reach his call light.

On 08/09/23 at 02:50 PM Licensed Nurse (LN) J stated R31 would not be able to reach his call light if he was laying in bed and the call light was on his nightstand. She stated that staff should keep it attached to him or keep it on his lap. She further stated that his call light should not be on his bed while he is sitting in his chair. LN J stated that she didn't think R31 could let anyone know that he needed help if he was unable to reach his call light. She stated that she didn't believe he could make loud enough noises to let anyone know and that he needs to have his call light in reach. She further stated that requesting staff keep a resident's call light in reach can be entered on the resident's care plan so that everyone would know to put his call light on him or in reach of him. She stated that R31 can and does use the call light when he needs something.

On 08/09/23 at 03:48 PM Administrative Nurse D stated that he would like R31's call light to be clipped to him or on his bedside table. He stated that he would not want staff to place R31's call light outside of his reach.

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F 558	Continued From page 6 The facility's "Accommodation of Needs" policy, revised on 04/2009, directed staff to have resident's call light in reach. The facility failed to ensure R31's call light was within reach. This deficient practice placed R31 at risk for preventable accidents and injuries.	F 558		
F 576 SS=C	Right to Forms of Communication w/ Privacy CFR(s): 483.10(g)(6)-(9) §483.10(g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense. §483.10(g)(7) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to: (i) A telephone, including TTY and TDD services; (ii) The internet, to the extent available to the facility; and (iii) Stationery, postage, writing implements and the ability to send mail. §483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to: (i) Privacy of such communications consistent with this section; and (ii) Access to stationery, postage, and writing implements at the resident's own expense.	F 576		

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§483.10(g)(9) The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research.
(i) If the access is available to the facility
(ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident.
(iii) Such use must comply with State and Federal law.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 61 residents. The sample included 15 residents. Based on record review, and interviews, the facility failed to provide mail services on Saturdays.

Findings included:

- On 08/08/23 at 01:49 PM in a private interview with Resident Council members, a member reported the facility did not provide mail services for the residents on Saturdays at that time. The council member reported that the weekend receptionist had left and most of the mail had not been passed on Saturday since then. The resident reported that had been about a month or longer.

On 08/09/23 at 11:26 AM Activities Director Z stated the weekend receptionist was responsible for passing the resident's mail on the weekend. Activities Director Z stated the receptionist had been gone for a month and no other staff person was responsible to pass the mail on Saturdays.

The facility was unable to provide a policy related to mail delivery on Saturday's.

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F 576	Continued From page 8 The facility failed to provide mail services on Saturdays.	F 576		
F 577 SS=F	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: The facility identified a census of 61 residents. The sample included 15 residents. Based on observation, record review, and interviews, the facility failed to post the previous state inspection information in a location accessible to residents	F 577		

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F 577	Continued From page 9 and visitors, which placed the residents at risk for impaired rights. Findings included: - On 08/08/23 01:49 PM review of the state agency results book that was available in the lobby area lacked the Statement of Deficiencies which included citations from a complaint survey conducted on 06/26/23. On 08/09/23 at 11:58 AM Administrative Staff A stated she was responsible for ensuring the most recent state inspection results were placed into the book and available to residents and family. The facility was unable to provide a policy related to posting of state inspection results. The facility failed to post state inspection results of the recent complaint survey on 06/26/23 for residents and families. This deficient practice placed the residents at risk for impaired rights.	F 577		
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.	F 585		

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§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 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

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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 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

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decision.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 61 residents. The sample include 15 residents. Based on observation, record review, and interviews, the facility failed to implement a system to allow residents and/or their representatives to file grievances anonymously. This deficient practice placed the residents at risk for decreased psychosocial wellbeing.

Findings Included:

- On 08/08/23 at 11:50 AM during Resident Council, Resident (R)22 stated that he was not aware of a way to file a grievance without staff assistance/anonymously.

On 08/09/23 at 11:26 AM Activity Z stated residents reported grievances to her, but she was not aware of a way that residents, or families, could file a grievance anonymously.

On 08/09/23 at 02:50 PM Licensed Nurse (LN) J stated that grievance forms were in a folder at the desks/nurse's stations on each hall and residents could ask staff for the forms. She stated that she was not aware if there were boxes that residents could put the completed forms in without giving directly to a staff member.

The facility's "Grievances" policy revised on 01/2022, documented that part of the grievance process is to address resident concerns without fear of discrimination or reprisal and ensure information regarding how to file a grievance is made available to the resident, either individually or through postings in prominent areas

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F 585	Continued From page 13 throughout the facility, and includes the name and contact information of who to file a grievance and policy. The facility failed to implement a system to allow residents and/or their representatives to file grievances anonymously. This deficient practice placed the residents at risk for decreased psychosocial wellbeing.	F 585		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in 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	F 623		

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be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

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

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and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

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

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 61 residents. The sample included 15 residents with two residents reviewed for hospitalization. Based on observation, record review, and interviews, the facility failed to provide a written notification of transfers with the required information to Resident (R)18 or to their family/durable power of attorney (DPOA- legal document that named a person to make healthcare decisions when the resident was no longer able to) in a practicable

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amount of time for a facility-intiated transfer. This deficient practice had the risk of miscommunication between facility and resident/family and possible missed opportunity for healthcare service for R18.

Findings included:

- The "Diagnoses" tab of R18's Electronic Medical Record (EMR) documented diagnoses of spondylosis (a condition in which there is abnormal wear on the cartilage and bones of the neck), chronic respiratory failure with hypoxia (a serious condition that makes it difficult to breathe on your own), and congestive heart failure (a serious condition in which the heart doesn't pump blood as efficiently as it should).

The "Admission Minimum Data Set (MDS)" dated 10/12/22, documented R18 had a Brief Interview for Mental Status (BIMS) score of 14 which indicated intact cognition. R318 required extensive assistance to total dependence on staff of one to two staff for activities of daily living (ADLs).

The "Quarterly MDS" dated 04/14/23 for R18 documented he had a BIMS score of 14 which indicated intact cognition. R18 required extensive assistance to total dependence one or two (two or more for transfers and bed mobility) staff for her ADLs.

Thee "ADL Care Area Assessment (CAA)" dated 10/24/22 for R18 documented he needed help with ADLS and mobility. Related risk factors impacting ADL status included opioid (class of drugs used to reduce pain) use, limitation in range of motion (ROM), and potential for further

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decline in ADLS and mobility. R18 was admitted for a short stay rehabilitation. Nursing provided ADL, mobility, and transfer assistance as needed.

The "Mood Problem Care Plan" revised 08/02/23 for R18 directed staff to administer medications as ordered and to monitor/document for side effects and effectiveness. Staff was to assist to identify strengths, positive coping skills and reinforce. Staff was directed to monitor/report to the physician mood patterns, signs and symptoms of depression, anxiety, or sad mood. Staff was directed that R18 needed encouragement/assistance/support to maintain as much independence and control as possible.

R18 admitted to the facility on 10/11/22, R18 was transferred to the hospital and admitted on the following dates 04/03/23, 05/26/23, and 07/08/23.

Upon request, the facility was unable to provide proof of written notification of transfer/discharge for R18's transfers on 04/03/23, 05/26/23, and 07/08/23.

On 08/09/23 at 11:57 AM Administrative Staff A stated that no written notification of transfer or discharge form was completed or mailed to the DPOA only the bed hold for was completed. Administrative Staff A was unaware a written notification was needed upon transfer.

The facility policy "Discharge Policy" revised May 2017 documented: it was the policy of this facility to set forth the circumstance and conditions under which the facility may require the resident to be involuntary transferred, discharged, or evicted. The policy had not been revised to reflect current discharge regulations for written

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F 623	Continued From page 18 notification of transfer/discharge. The facility failed to provide a written notification of transfers with the required information to R18 or to their family/DPOA in a practicable amount of time for facility-intiated transfers. This deficient practice had the risk of miscommunication between facility and resident/family and possible missed opportunity for healthcare service for R18.	F 623		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which	F 625		

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specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 61 residents. The sample included 15 with two reviewed for bed holds. Based on record review, observations, and interviews, the facility failed to provide a bed hold for Resident (R)202 when hospitalized. This deficient practice placed R202 at risk of delayed care or uninformed choices.

Findings Included:

- The "Medical Diagnosis" section within R202's Electronic Medical Records (EMR) included chronic kidney disease, type two diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), congestive heart failure (a condition with low heart output and the body becomes congested with fluid), dementia (progressive mental disorder characterized by failing memory, confusion), and dysphagia (swallowing difficulty).

A review of R202's EMR revealed she admitted on 06/06/22.

A review of R202's "Discharge Minimum Data Set (MDS)" indicated she discharged to an acute care facility on 06/14/22.

R202's "Care Plan" initiated 06/07/23 indicated she had oxygen therapy due to her medical diagnoses and history of pneumonia (inflammation of the lungs). The plan noted she would return home with family support upon completion of rehab.

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F 625	Continued From page 20 R202's EMR under "Progress Notes" revealed a "Nursing" note on 06/14/22 indicating she was sent to an acute care facility due to bilateral arm pain and increased edema (swelling resulting from an excessive accumulation of fluid in the body tissues) in her lower extremities. The plan noted she was at risk for impaired cognitive function related to her dementia diagnosis. R202's EMR lacked evidence a bed hold was issued related to her hospitalization on 06/14/22. The facility did could provide R202's bed hold requested on 08/09/23. On 08/09/23 at 11:58 AM Administrative Staff A stated she was unable to locate the bed hold for R202's transfer from the facility to the hospital. The facility did not provide a policy related to bed holds as requested on 08/09/23. The facility failed to provide bed hold for R202's hospitalization. This deficient practice placed R202 at risk of delayed care or uninformed choices.	F 625		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive	F 656		

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assessment. The comprehensive care plan must describe the following -
(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(iii) Be culturally-competent and trauma-informed.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 61 residents. The sample included 15 residents. Based on

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observation, record review, and interviews, the facility failed to develop person-centered comprehensive care plan for Resident (R) 104 related to her ability to participate in activities of daily living (ADLs) and storage /use of her nebulizer (an electrically powered machine that turns liquid medication into a mist so that it can be breathed directly into the lungs through a face mask or mouthpiece) mouthpiece. This deficient practice placed R104 at risk of lack of care related to ADL's, possible injuries, skin breakdown, uncommunicated needs, or possible further respiratory infections.

Findings included:

- R104's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness), pneumonia (inflammation of the lungs), muscle weakness, and need for care with personal care.

The "Admission Minimum Data Set" (MDS) dated 07/27/23 documented cognition was not assessed. The MDS documented that R104 was dependent on two staff members assistance for activities of daily living (ADLs). The MDS documented the activity of bathing had occurred during the look back period for R104.

R104's "Communication Care Area Assessment" (CAA) dated 08/02/23 documented the resident was at risk for a problem of potential for miscommunication of safety cues and instructions

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during therapy sessions, which may impede progress in ADL, related to her communication deficit.

R104's "Care Plan" lacked documented, or direction related to ADLs and storage of nebulizer equipment.

Review of the "Reports" tab, in the EMR, for bathing reviewed from 07/14/23 to 07/18/23 (five days) and 07/24/23 to 08/07/23 (15 days) revealed R104 had not received a bath/shower during this time frame. The "Bathing" task was documented "Not Applicable" (NA) on three occasions on the following dates: 07/16/23, 07/30/23, and 08/02/23. The clinical record lacked documentation of resident's refusal for bathing.

Review of the EMR under "Orders" tab revealed physician orders:

Ipratropium-albuterol solution (bronchodilators-a drug that causes widening of the bronchi, e.g., any of those taken by inhalation for the alleviation of asthma) 0.5-2.5 (3) milligrams (mg)/3 milliliters (ml) 3ml inhale orally every four hours as needed for shortness of breath via nebulizer dated 07/24/23.

On 08/08/23 at 07:16 AM R104 laid on her right side on the bed, her hair was uncombed and had an oily appearance.

On 08/09/23 at 07:32 AM R104 sat in a reclined Broda chair (specialized wheelchair with the ability to tilt and recline) chair without a pressure reducing cushion next to her bed. R104's nebulizer mouthpiece sat uncovered and undated

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on the bedside table next to the bed.

On 08/09/23 at 01:28 PM R104 sat reclined in a Broda chair without a pressure reducing cushion. R104's nebulizer mouthpiece was uncovered and undated on her bedside table.

On 08/09/23 at 02:11 PM Certified Nurse Aide (CNA) M stated oxygen and nebulizer equipment should be stored in a clear bag when not in use. CNA M stated he believed the oxygen equipment was changed weekly. CNA M stated everyone had access to the care plan and Kardex and staff would refer to the Kardex to find out how to care for the residents.

On 08/09/23 at 02:35 PM Certified Nurse Aide (CNA) N stated everyone had access to the care plan and the Kardex (a medical information system used by nursing staff as a way to communicate important information on their patients). CNA N stated the care plan information/interventions would be what direct the staff from the Kardex. CNA N stated bathing information for each resident was found on the Kardex and each resident had assigned days of week for their bath/shower. CNA N stated each resident were to receive or offered a bath/shower two times a week. CNA N stated she had never bathed R104 and was not sure if she had ever refused a bath/shower.

On 08/09/23 at 02:50 PM Licensed Nurse (LN) J stated oxygen and nebulizer equipment should be stored in a specific place when not in use. LN J stated she would discard old tubing and replace the nebulizer equipment if soiled or touched the floor. LN J stated she was not sure how often and when the nebulizer tubing or mouthpiece was

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changed. LN J the Kardex provided the information to the staff for each resident.

On 08/09/23 at 03:21 PM Licensed Nurse (LN) H stated every resident had assigned bath schedule for two times a week. LN H stated alternatives had been offered to resident that refused a bath. LN H stated if a resident had refused the CNA was to notify the nurse and the nurse was to find out why the resident had refused their bath/shower. LN H stated the CNA would document the refusal in the EMR. LN H stated the staff was not supposed to chart NA for the bathing task. LN H stated he was not sure if R104 had ever refused a bath/shower. LN G stated everyone had access to the care plan/Kardex and bathing should be included.

On 08/09/23 at 03:53 PM Administrative Nurse D stated each resident was interviewed at the time of their admission to find out what their preference was for bathing. Administrative Nurse D stated each resident was scheduled for at least two baths per week. Administrative Nurse D stated the resident's scheduled days were listed in the EMR under the bathing task, which would then show up the scheduled days on the Kardex. Administrative Nurse D stated the CNAs would report to the nurse if a resident refused their bath/shower and the nurse would interview the resident to find out why they refused. Administrative Nurse D stated the staff would document the bath/show or the refusal in the EMR. Administrative Nurse D stated bathing activity should be on the care plan. Administrative Nurse D stated oxygen and nebulizer equipment should be stored in a plastic bag when not in use. Administrative Nurse D stated nebulizer equipment was changed weekly and was

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F 656	Continued From page 26 documented on the Treatment Administration Record and should be dated. The facility's "Comprehensive Person-Centered Care Planning" policy last revised 08/2017 documented it was the facility's policy that the interdisciplinary team (IDT) would develop a comprehensive person-centered care plan for each resident that includes measurable objectives and time frames to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment. The IDT team w would also develop and implement a baseline care plan for each resident, within 48 hours of admission, that includes minimum healthcare information necessary to properly care for each resident and instructions needed to provide effective and person-centered care that meet professional standards of quality care. The comprehensive care plan would be developed by the IDT within seven days of completion of the resident's MDS and will include resident's needs identified in the comprehensive assessment, any specialized services and desired outcomes, preferences for future discharge and discharge plans. The facility failed to develop person-centered comprehensive care plan for R104. This deficient practice placed R104 at risk of lack of care related to her unmet or uncommunicated needs.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of	F 657		

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the comprehensive assessment.
(ii) Prepared by an interdisciplinary team, that includes but is not limited to--
(A) The attending physician.
(B) A registered nurse with responsibility for the resident.
(C) A nurse aide with responsibility for the resident.
(D) A member of food and nutrition services staff.
(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.
(F) Other appropriate staff or professionals in 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 61 residents. The sample included 15 residents with 15 reviewed for care plan revisions. Based on observations, interviews, and record reviews, the facility failed to revise Resident (R)27's care plan to reflect her timed toileting schedule. This deficient practice placed R27 at risk for complications related to uncommunicated care needs.

Finding Included:

-The "Medical Diagnosis" section within R27's Electronic Medical Records (EMR) included

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diagnoses of reduced mobility, need with help for personal cares, anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), insomnia (difficulty sleeping), type two diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), chronic kidney disease, osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain), muscle weakness, and dementia (progressive mental disorder characterized by failing memory, confusion).

R27's "Quarterly Minimum Data Set (MDS)" completed 06/20/23 noted a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. The MDS noted she required extensive assistance from one staff for transfers, dressing, toileting, and bathing. The MDS indicated she had occasional bladder and frequent bowel incontinence with no toileting program in place. The MDS noted she had non-injury falls since her last assessment. The MDS indicated she had frequent bladder incontinence and occasional bowel incontinence but no toileting program.

R27's "Urinary Incontinence Care Area Assessment (CAA)" completed 12/27/22 noted she required extensive assistance for toileting. The CAA noted she had occasional urinary incontinence.

R27's "Care Plan" initiated 12/21/22 indicated she had an ADL deficit related to her medical diagnoses. The plan indicated she required assistance from one staff for toileting, transfers, bed mobility, personal hygiene, dressing, and bathing (03/29/23). The plan indicated R27 had a

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history of falls related to self-transferring and not calling for assistance when needed. The care plan lacked documentation or interventions related to her bowel and bladder incontinence.

A review of R27's EMR under "Order Summery" revealed an order dated 12/30/22 instructing staff to provide toileting before/after meals and every two hours to prevent accidents (incontinent episodes).

On 08/07/23 at 11:15AM R27 sat in her wheelchair in her room. R27 stated she had concerns with incontinence, but staff usually would provide bathroom checks for her. She stated she did have concerns with being toileted at nighttime and still had episode of incontinence. She staff were not always quick to respond to the call lights and she had fallen in the past. R27's call light was on her and functioned properly when tested.

On 08/09/23 at 09:30AM Certified Nurse's Aide (CNA) N stated R27 required extensive assistance during transfers and a gait belt. She stated R27 had a history of falls and would often attempt to self-transfer without calling for help. She stated staff should help with frequent checks to make sure she was okay. She stated all staff had access to view the care planned interventions for each resident in the Kardex (a medical information system used by nursing staff to communicate important information on their patients).

On 08/09/23 at 02:53PM Licensed Nurse (LN) J stated R27 had a history of falling. She stated R27 should have a fall mat in her room and a yellow star on her door indicating she was a fall

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F 657	Continued From page 30 risk. She stated staff also should have toileted the residents frequently to prevent night falls. She stated R27 would often use her call light for assistance, but staff should provide reminders. She stated all staff were to review each resident's care need in the Kardex before assuming care. On 08/09/23 at 03:45PM Administrative Nurse D indicated staff were expected follow the interventions listed in the care plans. He stated staff were expected to provide frequent checks on each resident and ensure needed items remained within reach. He stated staff should encourage R27 to utilize her call light when needing assistance. He said care plans were to be reviewed and updated by the interdisciplinary team after falls or changes in status. A review of the facility's "Person Centered Care Planning" policy revised 08/2017 indicated care plans will be reviewed and updated by the interdisciplinary team to reflect goals, treatments, and changes to the resident's care with appropriate revision reviewed. The facility failed to revise R27's care plan to reflect her timed toileting schedule. This deficient practice placed R27 at risk for complicationsrelated to uncommunicated care needs	F 657		
F 677 SS=D	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	F 677		

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by:
- R104's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness), pneumonia (inflammation of the lungs), muscle weakness, and need for care with personal care.

The "Admission Minimum Data Set" (MDS) dated 07/27/23 documented cognition was not assessed. The MDS documented that R104 was dependent on two staff members assistance for activities of daily living (ADLs). The MDS documented the activity of bathing had occurred during the look back period for R104.

R104's "Communication Care Area Assessment" (CAA) dated 08/02/23 documented the resident was at risk for a problem of potential for miscommunication of safety cues and instructions during therapy sessions, which may impede progress in ADL, related to her communication deficit.

R104's "Care Plan" lacked documented, or direction related to ADLs.

Review of the "Reports" tab, in the EMR, for bathing reviewed from 07/14/23 to 07/18/23 (five days) and 07/24/23 to 08/07/23 (15 days) revealed R104 had not received a bath/shower during this time frame. The "Bathing" task was documented "Not Applicable" (NA) on three occasions on the following dates: 07/16/23, 07/30/23, and 08/02/23. The clinical record

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lacked documentation of resident's refusal for bathing.

On 08/08/23 at 07:16 AM R104 laid on her right side on the bed, her hair was uncombed and had an oily appearance.

On 08/09/23 at 02:35 PM Certified Nurse Aide (CNA) N stated everyone had access to the care plan and the Kardex (a medical information system used by nursing staff as a way to communicate important information on their patients). CNA N stated the care plan information/interventions would be what direct the staff from the Kardex. CNA N stated bathing information for each resident was found on the Kardex and each resident had assigned days of week for their bath/shower. CNA N stated each resident were to receive or offered a bath/shower two times a week. CNA N stated she had never bathed R104 and was not sure if she had ever refused a bath/shower.

On 08/09/23 at 03:21 PM Licensed Nurse (LN) H stated every resident had assigned bath schedule for two times a week. LN H stated alternatives had been offered to resident that refused a bath. LN H stated if a resident had refused the CNA was to notify the nurse and the nurse was to find out why the resident had refused their bath/shower. LN H stated the CNA would document the refusal in the EMR. LN H stated the staff was not supposed to chart NA for the bathing task. LN H stated he was not sure if R104 had ever refused a bath/shower. LN G stated everyone had access to the care plan/Kardex and bathing should be included.

On 08/09/23 at 03:53 PM Administrative Nurse D

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stated each resident was interviewed at the time of their admission to find out what their preference was for bathing. Administrative Nurse D stated each resident was scheduled for at least two baths per week. Administrative Nurse D stated the resident's scheduled days were listed in the EMR under the bathing task, which would then show up the scheduled days on the Kardex. Administrative Nurse D stated the CNAs would report to the nurse if a resident refused their bath/shower and the nurse would interview the resident to find out why they refused. Administrative Nurse D stated the staff would document the bath/show or the refusal in the EMR. Administrative Nurse D stated bathing activity should be on the care plan.

The facility's "Bath, Shower" policy last revised 05/2007 documented bathing was the policy of the facility to promote cleanliness, stimulate circulation and assist in relaxation. To assist resident to shower and to document all appropriate information in medical record.

The facility failed to ensure staff provided a shower/bath for R104, who was dependent on staff assistance with ADLs, which had the potential to cause skin breakdown and/or skin complications due to poor personal hygiene and impaired psychosocial wellbeing.
The facility identified a census of 61 residents. The sample included 15 residents with five reviews activities of daily living (ADLs). Based on observations, interviews, and record reviews, the facility failed to provide consistent bathing opportunities to Residents (R)209 and R104. This deficient practice placed both residents at risk for infections and skin breakdown.

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Finding Included:

- The "Medical Diagnosis" section within R209s Electronic Medical Records (EMR) included diagnoses of cellulitis of let lower legs (skin infection caused by bacteria characterized by heat, redness and swelling), atrial fibrillation (rapid, irregular heart beat), osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain), cognitive communication deficit, reduced mobility, morbid obesity (severely overweight), need for assistance with personal care, and anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear).

A review of R209's EMR revealed he admitted on 07/27/23.

R209's "Admission Minimum Data Set" completed 07/31/23 noted a Brief Interview for Mental Status (BIMS) score of 11 indicating moderate cognitive impairment. The MDS indicated he required limited assistance from one staff for bed mobility, transfers, dressing, and personal hygiene. The MDS noted he required extensive assistance for toileting and bathing. The MDs indicated he was at risk for pressure injuries /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). The MDS noted he had a surgical wound but no pressure ulcers. The MDS noted he required pressure reducing devices for his bed and chair.

A review of R209's "Pressure Ulcer Care Area Assessment (CAA)" 08/07/23 indicated he was at

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risk for skin breakdown related to decreased mobility, left knee surgical incision, and need for assistance with personal cares. The CAA noted there was no evidence of skin breakdown. The CAA instructed staff to provide incontinence cares and repositioning. The CAA noted he required prn (as needed) moisture barrier cream, a wheelchair cushion, and a specialty mattress.

R209's "ADL CAA" completed 08/07/23 noted he required assistance with personal cares related to his total knee arthroplasty (joint replacement in the knee), reduced mobility, and difficulty walking.

R209's "Care Plan" created 07/28/23 indicated he was he was a risk for impaired skin integrity and pressure ulcers related to decreased mobility. The plan instructed staff to educate R209 as to causes of skin breakdown and provide education on repositioning, transferring, and good nutrition. The plan instructed struct to report new areas of skin breakdown noted during his bathing or daily cares. The plan indicated he had a pressure reducing mattress and device in his chair. The plan indicated he was at risk for impaired cognitive function and staff were to keep his routine consistent. The plan indicated he required assistance from one staff for bed mobility, transfers, personal hygiene, dressing, toileting, and bathing.

On 08/08/23, R209's EMR under "Task" revealed his preferred bathing occurred on Wednesdays and Saturdays during the day shift. The EMR, as of 08/08/23 documented the resident received a bath on 07/28/23, 07/29/23, and 08/01/23. The EMR indicated he refused bathing on one occasion (07/29/23) but received a bath later in the shift. Shower task was marked not applicable

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on 07/30/23, 07/31/23 (7 days with no bathing).

On 08/07/23 at 08:09AM R209 report he had not received his bath since the previous week. He reported he was to have two baths a week but had not been consistently getting them since his arrival two weeks ago. He stated that the cellulitis in his legs and constant sweating caused in him have redness and sore areas in his groin area due to not being bathed properly. R209's skin was dry and flaky around his legs and feet. His toenails were untrimmed and dirty. His hair was uncombed and oily.

On 08/07/23 at 01:56PM R209's representative reported since R209 arrived at the facility, he had a rash develop in his groin and buttock areas. She said she placed Calmoseptine ointment (used to treat minor skin irritation) on to prevent it from worsening. She stated she told staff last week to make sure R209 was showered but she was not sure it was done. She stated R209 will not always ask for cares or report skin issues, but said the redness or skin irritation should have been caught if staff had bathed him. She was not aware if the facility knew about his rash.

On 08/09/23 at 07:40AM R209 reported he still had not received his bath. He reported his groin area still was sore and had a rash.

On 08/09/23 at 07:45AM Licensed Nurse (LN) I reported that he had assessed R209 on 08/08/23 and found some redness. He stated he applied ointment to R209 at that time but had not seen him today. (A review of R209's EMR revealed no documented skin concerns since his admission.)

On 08/09/23 at 09:50AM Administrative Nurse D

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assessed R209's for skin issues. Administrative Nurse D identified some pink areas under R209's groin but no rash or skin breakdown was present upon assessment. R209 reported he had some tenderness in the groin area that may have been healed because his representative used ointment on the area. Administrative Nurse D stated he would have ointment available for staff to give during cares.

On 08/09/23 at 02:35 PM Certified Nurse Aide (CNA) N stated everyone had access to the care plan and the Kardex (a medical information system used by nursing staff as a way to communicate important information on their patients. It is a quick summary of individual patient needs that is updated at every shift change). CNA N stated care plan interventions would be what direct the staff from the Kardex. CNA N stated bathing information for each resident was found on the Kardex and each resident had assigned days of week for their bath/shower. CNA N stated each resident were to receive or offered a bath/shower two times a week. CNA N stated R209 required assistance of one staff and gait belt for transfers. He stated R209 chose to use a bedside urinal at night and evenings, but staff should perform frequent checks on his skin.

A review of the facility's "Skin Management" policy revised 12/2019 indicated direct care staff would report skin concerns during bathing to the licensed nurse on duty.

On 08/09/23 at 03:45PM Administrative Nurse D indicated staff were expected to bath each resident based upon their preferred bathing days listed on the bath schedule. He stated staff were

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F 677	Continued From page 38 expected to monitor skin during cares and report concerns to the nurse. He stated bathing should be documented in each resident's EMR under "Tasks." On 08/10/23 the facility provided a bath sheet and an updated "TAsk:Bathing" report which indicated R209 refused his shower on 08/05/23. A review of the facility's "Bathing" policy revised 05/2007 indicated the facility would promote cleanliness, relaxation, and stimulate circulation by providing consistent bathing opportunities. The policy indicated all bathing occurrences would be documented by staff. The policy indicated reddened areas or skin break would be reported during bathing to the licensed nurse. He stated if a resident refused bathing or could not be bathed, staff would attempt to reschedule it at a more convenient time for the resident. The facility failed to provide consistent bathing opportunities to R209 per his preference. This deficient practice placed the resident at risk for infections and skin breakdown.	F 677		
F 679 SS=E	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence	F 679		

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and interaction in the community.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 61 residents. The sample included 15 residents. Based on observation, record review, and interviews, the facility failed to provide resident-centered activities for cognitively impaired residents on weekends. This deficient practice placed eight cognitively impaired residents at risk for decreased psychosocial wellbeing.

Findings Included:

- The facility's "Activity Calendar" for June, July, and August of 2023 revealed Movie Matinee at 02:00PM on Saturdays and Independent Game Groups on Sundays. The Calendars had no staff led activities noted on the weekends.

On 08/08/23 at 01:00PM, the Resident Council reported the facility did not provide staff-led activities on the weekends. The council reported residents could complete independent games and puzzles provided by the facility. The council reported staff would put a movie in the movie player for residents to watch on Saturdays to watch. The council reported the residents just had to push the play button on the player. The council reported that facility had no specific activities set up for residents with cognitive impairment, but other residents would often try to include them in games and other activities.

On 08/09/23 at 02:00PM Activities Coordinator (AC) Z led residents in funnel cakes and game activity.

On 08/09/23 at 02:20PM AC Z reported that staff

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F 679	Continued From page 40 were responsible for ensuring impaired residents had activities over the weekend and joined the provided games. She stated a movie was left in the movie player for the resident to watch. She stated staff should help start and monitor the activities on the weekend. AC Z stated she did not come in on weekends. On 08/09/23 03:45PM Administrative Nurse D sated he was not sure who covered activities on weekend but he stated the direct care staff should work closely with the cognitively impaired residents and the facility had volunteers to come in every now and then. A review of the facility's "Activity Program" policy revised 07/2007 indicated each resident will be provided with activities that are designed to stimulate and support the resident's mental and physical capabilities to maintain their highest attainable social, physical, and emotional functioning. The facility failed to provide resident-centered activities for cognitively impaired residents on weekends. This deficient practice placed eight cognitively impaired residents at risk for decreased psychosocial wellbeing.	F 679		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure	F 686		

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ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 61 residents. The sample included 15 residents with three residents reviewed for pressure ulcer/injury (localized injury to the skin and/or underlying tissue usually over a bony prominence, because of pressure, or pressure in combination with shear and/or friction). Based on observation, record review, and interviews, the facility failed to ensure pressure reducing measures were placed on Resident (R) 104's bilateral lower extremities to prevent pressure ulcers. The facility also failed to ensure R103's pressure reducing boots on when in bed and to ensure staff implemented appropriate infection control practices during wound care, who was on an antibiotic (medication used to treat bacterial infections). This placed these residents at increased risk for pressure ulcer development and worsening of current wounds.

Findings included:

- R104's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness),

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pneumonia (inflammation of the lungs), muscle weakness, and need for care with personal care.

The "Admission Minimum Data Set" (MDS) dated 07/27/23 documented cognition was not assessed. The MDS documented that R104 was dependent on two staff members assistance for activities of daily living (ADLs). The MDS documented the activity of bathing had occurred during the look back period for R104. The MDS documented R104 was at risk for development of pressure ulcers/injuries. The MDS documented R104 would have a pressure reducing devices for her bed and chair.

R104's "Pressure Ulcer Care Area Assessment" (CAA) dated 08/02/23 documented R104 required assistance with bed mobility from staff. R104 had pressure reducing devices in place.

R104's "Care Plan" dated 07/24/23 documented R104 required pressure relieving devices on her bed and chair. The "Care Plan" lacked direction for pressure relieving measures for her bilateral lower extremities (BLE).

Review of the EMR under the "Assessment" tab revealed a Braden scale (a standardized tool to assess pressure ulcer risk) which documented R104 was at moderate risk for skin breakdown.

R104's EMR lacked documentation of a therapy assessment determining R104 did not need a pressure reducing device/cushion in her Broda (specialized wheelchair with the ability to tilt and recline) chair.

On 08/07/23 at 01:30 PM R104 laid on her right on the bed with her BLE resting directly on the

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mattress.

On 08/08/23 at 07:16 AM R104 laid on her right side on the bed, her hair was uncombed and had an oily appearance, her BLE rested directly on the mattress.

On 08/09/23 at 07:32 AM R104 sat in a reclined Broda chair, without a pressure reducing cushion, next to her bed. R104's nebulizer mouthpiece sat uncovered and undated on the bedside table next to the bed.

On 08/09/23 at 01:28 PM R104 sat reclined in a Broda chair,without a pressure reducing cushion. R104's nebulizer mouthpiece was uncovered and undated on her bedside table.

On 08/09/23 at 02:11 PM Certified Nurse Aide (CNA) M stated the resident's pressure reducing devices would show on the Kardex (a medical information system used by nursing staff to communicate important information on their patients) for the staff to know what each resident's needs.

On 08/09/23 at 03:21 PM Licensed Nurse (LN) H stated a resident at moderate risk should have preventive pressure relieving measures in place to prevent the development of pressure ulcer /injury occurring. LN H stated the facility did not have a protocol for what was put in place for a resident who was at risk for development of pressure ulcer/injury.

On 08/09/23 at 03:53 PM Administrative Nurse D stated R104's Broda chair did not need a pressure reducing cushion, as physical therapy had assessed R104's Broda chair. Administrative

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Nurse D stated a Braden scale assessment did not always correctly indicate a resident's risk for skin breakdown or development of pressure ulcers/injuries.

The facility's "Skin Management System" policy last revised 12/2019 documented it was the facility's policy that any resident who enters the facility without pressure ulcers would have appropriate preventive measures taken to ensure that the resident did not develop pressure ulcers, or that residents admitted with wounds would not develop signs and symptoms of infection, unless the resident's clinical condition made the development unavoidable. Residents would have a head-to-toe skin assessment by a licensed nurse at the time of admission. Any skin lesions would be documented on the Nursing Admission Assessment. A treatment order would be obtained from the attending physician for areas requiring treatment. (i.e., pressure injury, surgical wounds, open skin tears, abrasions, lacerations etc.). A Braden Scale Assessment would also be completed on admission to identify residents at risk for skin breakdown. A score of 10 or lower is considered high risk and would have a plan of care developed to address particular elements of the assessment that put resident at risk for breakdown. A plan of care would also be initiated to address areas of actual skin breakdown. The plan of care would be reviewed and revised as needed. Residents would have ongoing head to toe assessment done weekly, incorporated into the LN Weekly Summary review by the licensed nursing staff. CNAs would complete a Body Shower Check Sheet daily on every resident and turn it in to the charge nurse for possible follow up of any new skin concerns. A report of all wounds and their progress would be updated by the

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treatment nurse weekly. When any signs and symptoms of infection, the licensed nurse would be responsible for notifying the resident's physician regarding assessment findings and completing a change of condition form.

The facility failed to implement pressure reducing measures for R104 who was dependent on two staff members assistance for bed mobility and transfers. This deficient practice placed R104 at risk of development of pressure ulcers/injuries.

- R103's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), and malnutrition (lack of proper nutrition, caused by not having enough to eat, not eating enough of the right things, or being unable to use the food that one does eat).

The "Admission Minimum Data Set" (MDS) was in progress.

R103's "Care Area Assessment" (CAA) was in progress.

R103's "Baseline Care Plan" dated 08/04/23 documented R103 required pressure reducing devices in the chair and on the bed but lacked documentation or direction for application/provision of pressure reducing measures for lower extremities.

Review of the EMR under "Assessment" tab lacked an admission wound assessment for R103's for bilateral heels, right shin and right

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buttocks that included measurements.

Review of the "Physician Progress Note" dated 08/06/23 documented bilateral heel wounds, left unstageable worse than right. Continue with wound care.

Review of the EMR under "Orders" tab revealed physician orders:
Santyl (a sterile enzymatic debriding ointment) external ointment 250 units/gram (gm), apply y to left heel topically every day for wound dated 08/04/23 and discontinued 08/08/23.

Cleanse left and right heel with normal saline or wound cleanser, apply Santyl nickel thickness, cover with hydrofera blue (a type of moist wound dressing), dressing, kerlix (gauze bandage dressing) wrap and ace wrap (an elasticated bandage used to restrict blood flow to the site of an injury) from toe to knee every day dated 08/04/23 (discontinued 08/08/23).

Pressure reducing cushion in wheelchair as needed dated 08/04/23. Pressure reducing mattress as needed dated 08/04/23.

Ertapenem sodium (a broad-spectrum antibiotic) injection solution reconstituted one gram (gm), use one gram intravenously at bedtime bacteremia (viable bacteria in the blood stream) for 10 days dated 08/04/23.

Cleanse left and right heel with normal saline or wound cleanser, apply Silvadene cream (sulfa antibiotic cream), cover with hydrofera blue, wrap with kerlix gauze and ace wrap from toe to knees daily for wound care. Notify physician of any signs/symptoms of infection dated 08/08/23.

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Review of the pharmacy delivery list from 08/04/23 and 08/05/23 lacked evidence R103's Santyl was filled and delivered to the facility.

Review of R103's "August 2023 Medication Administration Record/Treatment Administration Record" (MAR/TAR) revealed staff signed off Santly as administered on 08/05/23 and 08/06/23 and staff signed off the dressing to the left heel which included Santyl on 08/05/23 and 08/06/23.

On 08/08/23 at 07:15 AM R103 laid on the bed with his bilateral lower extremities rested directly on the mattress. His pressure reducing boots laid on the chair, unused.

On 08/08/23 at 03:33 PM Licensed Nurse (LN) G and LN H entered R103's room. LN G explained the procedure to R103, and he agreed to allow staff to change his wound dressings. LN G and LN H washed hands donned gloves. LN G removed R103's teeth from the bedside table and placed them into a denture cup. LN G doffed gloves then donned new gloves without performing hand hygiene. LN G placed a clean barrier onto the bedside table, then placed her wound care supplies onto the clean barrier. LN H removed pressure relieving boots from R103's lower extremities, LN H doffed gloves and washed hands. LN H left the room and returned to room with a chux, donned new gloves and placed the chux under R103's lower extremities. LN G removed the ace wraps, dry kerlix gauze and soiled dressing from left heel pressure wound. LN H supported R103's left leg. LN G doffed soiled gloves, then donned new gloves with no hand hygiene preformed. LN G cleansed left heel wound with wound cleaner. LN G doffed

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gloves, but did not perform hand hygiene. LN G donned new glove,s applied Silvadene cream to R103's left heel wound with a cotton applicator, and covered left heel with dressing, LN H held the dressing in place as LN G wrapped R103's left lower extremity with kerlix gauze and covered kerlix with an ace wrap.

On 08/09/23 at 09:24 AM R103 laid on the bed asleep, his bilateral heels rested directly on the mattress and his pressure reducing boots were on the chair in room.

On 08/08/23 at 03:33 PM Licensed Nurse (LN) G stated R103 had not received Santyl as a treatment to his heels at the facility but had received Santyl at the hospital. LN G stated the facility did not use Santyl, it was not in the facility's medication formula and the facility used Silvadene cream instead. LN G stated R103 had received a pain pill before his wound care because the treatment caused him so much pain.

On 08/09/23 at 02:11 PM Certified Nurse Aide (CNA) M stated the care plan/Kardex (a medical information system used by nursing staff as a way to communicate important information on their patients. It is a quick summary of individual patient needs that is updated at every shift change) was where the staff would know what pressure relieving measures each resident had in place to prevent skin breakdown.

On 08/09/23 at 02:50 PM Licensed Nurse (LN) J stated the admission nurse completed the initial skin assessment at the time of the admission. LN J stated the resident's pressure relieving measures was listed on the "Treatment Administration Record (TAR), the resident's care

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plan and Kardex.

On 08/09/23 at 03:21 PM Licensed Nurse (LN) H stated a Braden scale was filled out on each resident at the time of admission. LN H stated a resident that was scored at moderate risk for skin breakdown should have preventive skin measures in place. LN H stated the pressure reducing measures in place would be listed on the TAR, care plan and Kardex. LN H stated a skin assessment was not always completed at the time of admission that included measurements. LN H stated the facility relied on the wound care company to complete the wound assessment.

On 08/09/23 at 03:53 PM Administrative Nurse D stated a Braden scale score did not always indicate a resident that could be at risk, the interdisciplinary team (IDT) would decide what pressure relieving measure would be initiated for each resident. Administrative Nurse D stated therapy had stated a Broda chair did not require an added pressure reliving cushion to prevent pressure ulcer/injuries. Administrative Nurse D stated the admission nurse would review a new resident's wounds and the wound care team came to the facility weekly to complete the assessment with an evaluation, with measurements. Administrative Nurse D stated measurements are not completed by the admission nurse. Administrative Nurse D stated LN G had missed spoke about the Santyl for R103. Administrative Nurse D stated the wound care physician preferred to use Silvadene cream for wounds.

The facility's "Skin Management System" policy last revised 12/2019 documented it was the

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facility's policy that any resident who enters the facility without pressure ulcers would have appropriate preventive measures taken to ensure that the resident did not develop pressure ulcers, or that residents admitted with wounds would not develop signs and symptoms of infection, unless the resident's clinical condition made the development unavoidable. Residents would have a head-to-toe skin assessment by a licensed nurse at the time of admission. Any skin lesions would be documented on the Nursing Admission Assessment. A treatment order would be obtained from the attending physician for areas requiring treatment. (i.e., pressure injury, surgical wounds, open skin tears, abrasions, lacerations etc.). A Braden Scale Assessment would also be completed on admission to identify residents at risk for skin breakdown. A score of 10 or lower is considered high risk and would have a plan of care developed to address particular elements of the assessment that put resident at risk for breakdown. A plan of care would also be initiated to address areas of actual skin breakdown. The plan of care would be reviewed and revised as needed. Residents would have ongoing head to toe assessment done weekly, incorporated into the LN Weekly Summary review by the licensed nursing staff. CNAs would complete a Body Shower Check Sheet daily on every resident and turn it in to the charge nurse for possible follow up of any new skin concerns. A report of all wounds and their progress would be updated by the treatment nurse weekly. When any signs and symptoms of infection, the licensed nurse would be responsible for notifying the resident's physician regarding assessment findings and completing a change of condition form.

The facility failed to follow wound care as ordered

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F 686	Continued From page 51 by the physician when staff omitted Santyl, failed to ensure pressure reducing devices where in place and failed to ensure staff implemented appropriate infection control practices during wound care, who was on an antibiotic for a blood infection. This placed R103 at increased risk for wound worsening and complications related to infections.	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility identified a census of 61 residents. The sample included 15 residents with five reviewed for accidents/falls. Based on observations, interviews, and record reviews, the facility failed to identify causative factors and implement fall interventions related to Resident (R)27's non-injury fall. This deficient practice placed R27 at risk for further falls and injuries. Finding Included: - The "Medical Diagnosis" section within R27's Electronic Medical Records (EMR) included diagnoses of reduced mobility, need with help for personal cares, anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear),	F 689		

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insomnia (difficulty sleeping), type two diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), chronic kidney disease, osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain), muscle weakness, and dementia (progressive mental disorder characterized by failing memory, confusion).

R27's "Quarterly Minimum Data Set (MDS)" completed 06/20/23 noted a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. The MDS noted she required extensive assistance from one staff for transfers, dressing, toileting, and bathing. The MDS indicated she had occasional bladder and frequent bowel incontinence with no toileting program in place. The MDS noted she had non-injury falls since her last assessment.

R27's "Urinary Incontinence Care Area Assessment (CAA)" completed 12/27/22 noted she required extensive assistance for toileting. The CAA noted she had occasional urinary incontinence.

R27's MDS CAA indicated she was not triggered for Activities of Daily Living (ADLs).

R27's "Care Plan" initiated 12/21/22 indicated she had an ADL deficit related to her medical diagnoses. The plan indicated she required assistance from one staff for toileting, transfers, bed mobility, personal hygiene, dressing, and bathing (03/29/23). The plan noted she was at risk and had a history of falls. The plan instructed staff to provide a safe environment (12/21/22), ensure appropriate footwear (12/21/22), ensure

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needed items were within reach (12/21/22), provide R27 with fall prevention education, and ensure she used her call light for assistance (12/21/22). The plan noted she had a fall on 03/01/23 and instructed staff to encourage R27 to call for assistance and ensure the floor was free from clutter. The plan indicated R27 had a fall on 04/07/23 and noted a fall mat was placed next to her bed. The plan lacked documentation and interventions related to her fall on 10/28/22.

A review of R27's "Fall Report" completed 10/28/22 noted staff heard R27 yell for help and found her on the floor in her room. The report noted her lower extremities were underneath the bed and her head rested on the floor. The note indicated R27 was unable to recall what caused the fall but had bruising on her forehead. The note indicated R27 was sent out to an acute care facility for assessment and returned with no injuries. The report lacked interventions related to the fall.

A review of R27's "Fall Report" on 04/07/23 indicated she was found on the floor next to her bed by staff. The note indicated she was unwilling to tell staff what caused her fall. The report indicated a fall mat was added to her fall interventions to prevent injuries.

On 08/07/23 at 11:15AM R27 sat in her wheelchair in her room. She stated she had concerns about how the facility handled her falls. She stated she had some falls related to staff not always responding quick enough to her call light. R27's call light was on her and functioned properly when tested. The fall mat was in her room.

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On 08/09/23 at 09:30AM Certified Nurse's Aide (CNA) N stated R27 required extensive assistance during transfers and a gait belt. She stated R27 had a history of falls and would often attempt to self-transfer without calling for help. She stated staff should help with frequent checks to make sure she was okay. She stated all staff had access to view the care planned interventions for each resident in 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).

On 08/09/23 at 02:53PM Licensed Nurse (LN) J stated R27 had a history of falling. She stated R27 should have a fall mat in her room and a yellow star on her door indicating she was a fall risk. She stated staff also should have toileted the resident frequently to prevent night falls. She stated R27 would often use her call light for assistance, but staff should provide reminders. She stated all staff were to review each resident's care need in the Kardex before assuming care.

On 08/09/23 at 03:45PM Administrative Nurse D indicated staff were expected follow the interventions listed in the care plans. He stated staff were expected to provide frequent checks on each resident and ensure needed items remained within reach. He stated staff should encourage R27 to utilize her call light when needing assistance. He stated care plans were reviewed and updated by the interdisciplinary team after falls or changes in status.

A review of the facility's "Fall Management System" policy indicated the facility was to assess

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F 689	Continued From page 55 and provide interventions for each resident's identified fall concerns to minimize accidents and injuries. The policy indicated the care plan would be updated after fall occurrences. The facility failed to identify causative factors and implement fall interventions related to R27's non-injury fall on 10/28/22. This deficient practice placed R27 at risk for further falls and injuries.	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: The facility identified a census of 61 residents. The sample included 15 residents with five residents reviewed for respiratory care. Based on observation, record review, and interviews, the facility failed to store Resident (R) 104's nebulizer (an electrically powered machine that turns liquid medication into a mist so that it can be breathed directly into the lungs through a face mask or mouthpiece) mouthpiece in a sanitary manner. This deficient practice placed R104, who was being treated for pneumonia (inflammation of the lungs), at increased risk to develop other respiratory infections or delay of recovery. Findings included:	F 695		

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- R104's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness), pneumonia, muscle weakness, and need for care with personal care.

The "Admission Minimum Data Set" (MDS) dated 07/27/23 documented cognition was not assessed. The MDS documented that R104 was dependent on two staff members assistance for activities of daily living (ADLs). The MDS documented the activity of bathing had occurred during the look back period for R104.

R104's "Communication Care Area Assessment" (CAA) dated 08/02/23 documented the resident was at risk for a problem of potential for miscommunication of safety cues and instructions during therapy sessions, which may impede progress in ADL, related to her communication deficit.

R104's "Care Plan" dated 08/01/23 documented staff was to administer medication as ordered.

Review of the EMR under "Orders" tab revealed physician orders:
Ipratropium-albuterol solution (bronchodilators-a drug that causes widening of the bronchi, e.g., any of those taken by inhalation for the alleviation of asthma) 0.5-2.5 (3) milligrams (mg)/3 milliliters (ml) 3ml inhale orally every four hours as needed for shortness of breath via nebulizer dated

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07/24/23.

On 08/09/23 at 07:32 AM R104 sat in a reclined Broda chair (specialized wheelchair with the ability to tilt and recline) chair without a pressure reducing cushion next to her bed. R104's nebulizer mouthpiece sat uncovered and undated on the bedside table next to the bed.

On 08/09/23 at 01:28 PM R104 sat reclined in a Broda chair with out a pressure reducing cushion. R104's nebulizer mouthpiece was uncovered and undated on her bedside table.

On 08/09/23 at 02:11 PM Certified Nurse Aide (CNA) M stated oxygen and nebulizer equipment should be stored in a clear bag when not in use. CNA M stated he believed the oxygen equipment was changed weekly.

On 08/09/23 at 02:50 PM Licensed Nurse (LN) J stated oxygen and nebulizer equipment should be stored in a specific place when not in use. LN J stated she would discard old tubing and replace the nebulizer equipment if soiled or touched the floor. LN J stated she was not sure how often and when the nebulizer tubing or mouthpiece was changed.

On 08/09/23 at 03:53 PM Administrative Nurse D stated oxygen and nebulizer equipment should be stored in a plastic bag when not in use. Administrative Nurse D stated nebulizer equipment was changed weekly and was documented on the "Treatment Administration Record." He said it should be dated.

The facility's "Oxygen Equipment" policy last revised 01/2022 documented it was the facility's

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F 695	Continued From page 58 policy to maintain all oxygen therapy equipment in a clean and sanitary manner and to use humidifiers, tubing, masks and cannulas for residents receiving oxygen. This equipment was to be discarded after use by a resident. The facility wouldl maintain clean tanks, connectors and concentrators. Nebulizer equipment generates aerosols small enough to be readily deposited in the lungs. Careful technique is required to prevent infecting the resident. Medication would be added to the nebulizer immediately before use and after each use dismantle entire breathing assembly, rinse well and ensure parts are dry, then reassemble pieces and store clean, and dry until next use covered. The facility failed to store nebulizer mouthpiece in accordance with professional standards of practice placing R104 who has pneumonia at risk for a delayed recovery or further respiratory infections and/or illness.	F 695		
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	F 756		

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(d) of this section for an unnecessary drug.
(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.
(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.

§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 61 residents. The sample included 15 residents with five sampled for unnecessary medications. Based on observation, record review and interview, the facility failed to ensure the Consultant Pharmacist (CP) identified and reported Resident (R)16's Zyprexa (anti-psychotic -class of medications used to treat psychosis and other mental emotional conditions) medication had an appropriate indication for use, or the required physician documentation. This deficient practice placed R16 at risk of unnecessary psychotropic (alters mood or thought) medication administration and possible adverse side effects.

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Findings included:

- The "Diagnoses" tab of R16's Electronic Medical Record (EMR) documented diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), anxiety disorder (mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), and major depressive disorder (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness and hopelessness).

The "Annual Minimum Data Set (MDS)" dated 09/30/22 documented R16's Brief Interview for Mental Status (BIMS) score was not assessed and the staff assessment for mental status was not completed. R16 showed no signs or symptoms of delirium (sudden severe confusion, disorientation and restlessness). R16 was independent to supervision for her activities of daily living (ADLs). R16 required the administration of an antipsychotic medication on seven of seven days during the lookback period.

The "Quarterly MDS" dated 05/31/23 documented R16 had a BIMS score of 11 which indicated moderately impaired cognition. R16 required supervision to limited assistance of one staff for her ADLs. R16 required the administration of an antipsychotic medication seven of seven days during the lookback period. A gradual dose reduction (GDR) was last attempted on 05/20/23.

Thee "Psychotropic Drug Use Care Area Assessment (CAA)" dated 10/13/22, documented R16 triggered due to daily antidepressant,

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antianxiety and antipsychotic medications. R16 received Zyprexa for anxiety and dementia. Her mood was stable and she did not report nor exhibit any adverse side effects. Medications were reviewed by pharmacy routinely with recommendations for GDR shared with the physician as indicated.

The "Psychotropic Care Plan" for R16 revised 03/01/22 directed staff to monitor episodes of psychotic behavior. Staff was directed to speak in a calm manner, ensure to explain what staff was doing when R16 displayed episodes of agitation. Staff was directed to provide non-pharmacological interventions.

Under the "Orders" tab for R16 was an order dated 07/15/22 for Zyprexa 2.5 milligram (mg) tablet by mouth in the evening for anxiety with psychosis.

Review of the CP's Medication Regimen Review (MRR) from August 2022 to July 2023 noted on 12/09/22 the CP had a recommended a GDR for the Zyprexa. The Physician's response on 12/15/22 indicated a GDR could cause decompensation as R16 had intermittent hallucinations (sensing things while awake that appear to be real, but the mind created).

Review of the CP's MMR from August 2022 to July 2023 lacked a recommendation to the physician for appropriate indication for use or the required physician documentation/rationale for the use of Zyprexa.

R16's EMR lacked evidence of the physician rationale which included unsuccessful attempts for nonpharmacological symptom management

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and risk versus benefit for the medication use of Zyprexa.

On 08/08/23 at 09:44 AM R16 sat in her wheelchair in her room visiting with the social worker.

On 08/09/23 at 02:50 PM Licensed Nurse (LN) J stated that she only documented the nursing recommendations and Administrative Nurse E dealt with the MRR and responses from the physician.

On 08/09/23 at 03:54PM Administrative Nurse D stated that the pharmacist came monthly to do the MRR and would fax the recommendations to the facility and the physicians. The physicians would typically respond to the recommendations within a week or so. Administrative Nurse D stated he was not aware that R16 did not have an appropriate indication for use for her Zyprexa but did know that antipsychotics should only be used for certain diagnoses. Administrative Nurse D stated he did not recall the pharmacist ever making a recommendation for a R16's Zyprexa.

On 08/10/23 at 03:54PM Consultant GG stated a GDR had been recommended. Consultant GG stated a recommendation made in June 2022 specifically mentioned R16's Alzheimer's diagnosis and the increased risk of cardiac death with the use of Zyprexa.

The facility policy "Medication (Drug) Regimen Review MRR" revised January 2022 documented the MRR included identification of irregularities, medication-related errors, adverse consequences, and use of unnecessary drugs (in excessive dosage; for excessive duration; without

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F 756	Continued From page 63 adequate monitoring; without adequate indications for its use; and in the presence of adverse consequences which indicate the dose should be reduced or discontinued). The report was provided by the Pharmacist or facility to the responsible physician, facility's Medical Director and the Director of Nursing withing seven working days of review. The attending physician will document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action had been taken to address it. If there had been no change in the medication, the attending physician will document his or her rationale in the resident medical record. The facility failed to ensure the CP identified and reported R16's Zyprexa lacked an appropriate indication for use, or the required physician documentation. This deficient practice placed R16 at risk of unnecessary medication administration and possible adverse side effects.	F 756		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or	F 757		

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§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 61 residents. The sample included 15 residents with five reviewed for unnecessary medications. Based on observations, record review, and interviews, the facility failed to ensure ordered parameters were followed for Resident (R) 11's antihypertensive medications (medications used to treat high blood pressure). This deficient practice had the risk for physical complications and unnecessary medication usage.

Findings included:

- The "Diagnoses" tab of R38's Electronic Medical Record (EMR) documented diagnoses of hypertension (high blood pressure), heart failure, atrial fibrillation (rapid, irregular heartbeat) and a cardiac pacemaker (implanted device to regulate the beating of the heart).

The "Quarterly Review Minimum Data Set (MDS)" dated 06/02/2023, documented R11 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. R11 required supervision of one staff member for locomotion, dressing, eating and personal hygiene. R11 required limited assistance of one staff member for toileting, bed mobility and transfers.

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The "Falls Care Area Assessment (CAA)" dated 12/11/22, documented R11 had a history of hypertension, heart failure, pacemaker and received transfer and mobility assistance from staff as needed.

The "Care Plan" revised on 02/08/21, documented that R11 had hypertension and an intervention dated 03/11/17 directed staff to give antihypertensive medications as ordered.

The "Orders" tab of R11's EMR documented an order with a start date of 01/17/22 for hydralazine (antihypertensive medication) 50 milligrams (mg) one tablet four times a day for hypertension and to hold the medication for a systolic blood pressure (SBP- top number, the force your heart exerts on the walls of your arteries each time it beats) less than 120 millimeters of mercury (mmHg). The medication had a stop date of 06/01/23.

Review of R11's "Medication Administration Record (MAR)" for 03/01/23 to 05/31/23 revealed the following days (18) when hydralazine was given outside of ordered parameters: 03/03/23, 03/07/23, 03/10/23, 03/12/23, 03/14/23, 03/24/23, 03/29/23, 03/31/23, 04/03/23, 04/11/23, 04/13/23, 04/18/23, 04/24/23, 04/25/23, 05/01/23, 05/05/23, 05/09/23, and 05/29/23.

The "Orders" tab of R11's EMR documented an order with a start date of 06/16/23 for hydralazine 50mg one and a half tablets four times a day for hypertension and to hold for SBP less than 120 mmHg.

Review of R11's "MAR" for 06/01/23 to 08/08/23 revealed the following days (6) when hydralazine

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 66	F 757		

was given outside of ordered parameters: 06/21/23, 06/28/23, 07/04/23, 07/08/23, 07/17/23, and 07/31/23.

The "Orders" tab of R11's EMR documented an order with a start date of 05/27/23 for clonidine (antihypertensive medication) 0.1mg one tablet every 12 hours as needed for SBP greater than 180 mmHg or diastolic blood pressure (minimum level of blood pressure measured between contractions of the heart; the bottom number of a blood pressure reading) greater than 100 mmHg.

Review of R11's "MAR" for 05/27/23 to 08/08/23 revealed the following days (15) where R11 had a documented SBP greater than 180 mmHg and clonidine was not administered during that day/shift: 5/30/2023, 6/2/2023, 6/3/2023, 6/7/2023, 6/8/2023, 6/15/2023, 6/16/2023, 6/17/2023, 6/18/2023, 7/11/2023, 7/17/2023, 7/19/2023, 7/24/2023, 7/31/2023, and 8/7/2023.

On 08/08/23 at 09:03 AM R11 propelled herself down the hallway in her wheelchair.

On 08/09/23 at 02:50 PM Licensed Nurse (LN) J stated if a resident had an order for a blood pressure medication that had hold parameters on it, and the resident was outside of those parameters, she would hold that medication. LN J further stated that she would let the director of nursing (DON) know (and the doctor if she held the medication. She stated that if a blood pressure medication was held, that she would go back and recheck the resident's blood pressure to see if it came back up or to see if she needed to notify their provider. LN J stated that if a resident had an order to administer an as needed blood pressure medication for a SBP over 180

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F 757	Continued From page 67 mmHg and found the resident's SBP blood pressure was above 180 mmHg, she would administer the as needed blood pressure medication per the order. On 08/09/23 at 03:48 PM Administrative Nurse D stated that if staff were to administer a blood pressure medication, he expected staff would check the resident's blood pressure and pulse and if their blood pressure or pulse was outside of the ordered parameters for those medications, staff were to hold the medications. He further stated that if a resident had an as needed blood pressure medication with a parameter to give for a SBP over 180 mmHg and staff found that the resident's blood pressure was over 180 mmHg , he expected staff to administer that medication. The facility's "Medication Administration General Guidelines" policy revised on August 2014; documented medications are administered in accordance with written orders of the prescriber. The facility failed to ensure ordered parameters were followed for R11's antihypertensive medications. This deficient practice had the risk for physical complications and unnecessary medication usage.	F 757		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic;	F 758		

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F 758	Continued From page 68 (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for	F 758		

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the appropriateness of that medication.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 61 residents. The sample included 15 residents with five sampled for unnecessary medications. Based on observation, record review and interview, the facility failed to ensure Resident (R)16's Zyprexa (antipsychotic -a class of medications used to treat psychosis and other mental emotional conditions) medication had an appropriate indication for use, or the required physician documentation. This deficient practice placed R16 at risk of unnecessary psychotropic (alters mood or thought) medication administration and possible adverse side effects.

Findings included:

- The "Diagnoses" tab of R16's Electronic Medical Record (EMR) documented diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), anxiety disorder (mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), and major depressive disorder (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness and hopelessness).

The "Annual Minimum Data Set (MDS)" dated 09/30/22 documented R16's Brief Interview for Mental Status (BIMS) score was not assessed and the staff assessment for mental status was not completed. R16 showed no signs or symptoms of delirium (sudden severe confusion, disorientation, and restlessness). R16 was independent to supervision for her activities of

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daily living (ADLs). R16 required the administration of an antipsychotic medication on seven of seven days during the lookback period.

The "Quarterly MDS" dated 05/31/23 documented R16 had a BIMS score of 11 which indicated moderately impaired cognition. R16 required supervision to limited assistance of one staff for her ADLs. R16 required the administration of an antipsychotic medication seven of seven days during the lookback period. A gradual dose reduction (GDR) was last attempted on 05/20/23.

Thee "Psychotropic Drug Use Care Area Assessment (CAA)" dated 10/13/22, documented R16 triggered due to daily antidepressant, antianxiety and antipsychotic medications. R16 received Zyprexa for anxiety and dementia. Her mood was stable, and she did not report nor exhibit any adverse side effects. Medications were reviewed by pharmacy routinely with recommendations for GDR shared with the physician as indicated.

The "Psychotropic Care Plan" for R16 revised 03/01/22 directed staff to monitor episodes of psychotic behavior. Staff was directed to speak in a calm manner, ensure to explain what staff was doing when R16 displayed episodes of agitation. Staff was directed to provide non-pharmacological interventions.

Under the "Orders" tab for R16 was an order dated 07/15/22 for Zyprexa 2.5 milligram (mg) tablet by mouth in the evening for anxiety with psychosis.

R16's EMR lacked evidence of the physician rationale which included unsuccessful attempts

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for nonpharmacological symptom management and risk versus benefit for the medication use of Zyprexa.

On 08/08/23 at 09:44 AM R16 sat in her wheelchair in her room visiting with the social worker.

On 08/09/23 at 02:50 PM Licensed Nurse (LN) G stated that she was not positive what an appropriate use for an antipsychotic medication was, so she did not want to state the wrong answer.

On 08/09/23 at 03:54PM Administrative Nurse D stated he was not aware that R16 did not have an appropriate indication for use for her Zyprexa but did know that antipsychotics should only be used for certain diagnoses. Administrative Nurse D stated that the physicians did do the risk versus benefit when a GDR was made but could not state if one had been completed for R16's Zyprexa.

The facility policy "Psychotropic Drug Use" revised August 2017 documented: residents who used psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Psychotropic medications shall not be administered for the purpose of discipline or convenience. They are to be administered only when required to treat the resident's medical symptoms and will be considered only after non-pharmacological interventions have been attempted and failed. The attending physician will review the resident's treatment plan, in collaboration with the consultant pharmacist, to re-evaluate the use of

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F 758	Continued From page 72 the psychotropic medication and consider whether or not medication can be reduced or discontinued upon admission or soon after admission, during initial physician admission visit. The facility failed to ensure R16's Zyprexa had an appropriate indication for use, or the required physician documentation. This deficient practice placed R16 at risk of unnecessary medication administration and possible adverse side effects.	F 758		
F 760 SS=D	. Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: The facility identified a census of 61 residents. The sample included 15 residents. Based on observation, record review, and interviews, the facility failed to ensure Resident (R) 104 was free from medication errors when twelve medications were crushed and mixed together then administered via percutaneous endoscope gastrostomy (PEG-a tube inserted through the wall of the abdomen directly into the stomach) without a physician order. This deficient practice placed R104 at risk for increased complications and adverse side effects related medication	F 760		

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interaction.

Findings included:

- R104's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness), pneumonia (inflammation of the lungs), muscle weakness, and need for care with personal care.

The "Admission Minimum Data Set" (MDS) dated 07/27/23 documented cognition was not assessed. The MDS documented that R104 was dependent on two staff members assistance for activities of daily living (ADLs). The MDS documented the activity of bathing had occurred during the look back period for R104.

R104's "Feeding Tube Care Area Assessment" (CAA) dated 08/02/23 documented R104's had aspiration pneumonia and staff would keep the head of her bed elevated.

R104's "Care Plan" dated 07/17/23 documented staff would elevate R104's head of her bed 45 degrees during and thirty minutes after administration of her tube feeding.

Review of the EMR under "Orders" tab revealed physician orders:
Ascorbic acid oral tablet (vitamin C supplement) 500 milligrams (mg) give one tablet via PEG-tube in the morning for supplement dated 07/24/23.

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Aspirin 81mg oral tablet chewable (anti-inflammatory-class of medication used to reduce inflammation), give one tablet via PEG-tube in the morning for blood thinner dated 07/24/23.

Cholecalciferol oral tablet (vitamin D supplement) give 25 micrograms (mcg) via PEG-tube in the morning for supplement dated 07/24/23.

Clopidogrel bisulfate oral tablet (an antiplatelet medicine that prevents blood clots) 75mg give one tablet via PEG-tube in the morning for blood thinner dated 07/24/23.

Cyanocobalamin oral tablet (vitamin B12 supplement) 1000mcg give one tablet via PEG-tube in the morning for supplement dated 07/24/23.

Fluoxetine HCl oral tablet antidepressant -class of medications used to treat mood disorders and relieve symptoms of depression) 20mg give one tablet via PEG-tube one time a day for depression dated 07/24/23.

Magnesium oxide oral tablet (magnesium supplement) 400mg give one tablet via PEG-tube in the morning for supplement dated 07/24/23.

Metamucil oral (bulk forming fiber supplement) packet 28 percent (%) give one packet via PEG-tube one time a day for bowel management dated 07/27/23.

Cefpodoxime proxetil (antibiotic that treats bacterial infections) tablet 200mg give one tablet via PEG-tube every 12 hours for pneumonia for 10 Days dated 07/31/23.

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Lactobacillus capsule (probiotic used to help grow healthy bacteria in the stomach) give one capsule via PEG-tube two times a day for supplement for three days dated 08/07/23.

Metformin HCl (anti-diabetic medication) oral tablet 500mg give one tablet via PEG-tube two times a day for diabetes mellitus dated 07/24/23.

Methenamine Hippurate (urinary antibacterial agent) oral tablet one mg give one tablet via PEG-tube two times a day for urinary tract antiseptic dated 07/24/23.

R104's clinical record lacked a physician order to crush and combine medication prior to administration via PEG-tube. The EMR also lacked instruction for water for flush between each medication and the amount of water each medication was to be dissolved with.

On 08/08/23 at 07:16 AM R104 laid on her right side on the bed, her hair was uncombed and had an oily appearance.

On 08/08/23 at 09:22 AM an observation of Licensed Nurse (LN) G had a paper towel on the bedside table next R104 bed with a glass of medication mixed in water. LN G stated she administered R104 medication by gravity after crushing and mixing them together.

On 08/08/23 at 02:50 PM Licensed Nurse (LN) J stated physician order was needed to crush medications, mix the medication together and dissolve in water prior to administration via PEG-tube.

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On 08/09/23 at 03:53 PM Administrative Nurse D stated a physician order was needed to crush and combine medication prior to administration via PEG-tube. Administrative Nurse D stated the medication order should include the amount of water the medication was to be dissolved in and amount of water flushed between each medication.

The facility's "Medication Administration via Feeding Tube" policy dated 01/2022 documented a physician's order was required for the administration of any medication via feeding tube. Liquid dosage forms should be ordered if available. Tablets that must be crushed prior to administration via feeding tube require a specific order. The order must specify the medication, dose route (tube), frequency, and volume of water to be administered with the medication. The amount of water used to flush, mix, and administer the medication must be considered when calculating the total free water prescribed by the physician. Many medications require special consideration and care when administered via feeding tube. Examples include antibiotics, bulk-forming agents. Different medications should not be mixed for administration. If administering several medications, administer each one separately. The tube should be flushed with at least five milliliters (ml) of water between medications. Flush tube with at least 30ml of water or prescribed flush to clear tube and decrease chance of clogging.

The facility failed to ensure R104 was free from medication errors when her 12 medications were crushed and mixed and administered via PEG-tube without a physician order. This placed R104 at risk for potential adverse side effects

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F 760	Continued From page 77 related medication interactions.	F 760		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: The facility identified a census of 61 residents with one kitchen. Based on observation, record review, and interviews, the facility failed to maintain sanitary dietary standards related to storage of food. This deficient practice placed the residents at risk related to food borne illnesses and food safety concerns. Findings included: - On 08/07/23 at 07:30 AM an observation in the kitchen's dry food storage room revealed two opened packages of cream soup base. The	F 812		

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packages were undated.

On 08/07/23 at 07:32 AM an observation in the kitchen's dry food storage room revealed one opened package of spaghetti noodles. The package was undated.

On 08/07/23 at 07:35 AM an observation in the kitchen's walk-in refrigerator revealed one sealable plastic container of mixed fruit. The container was not labeled or dated.

On 08/07/23 at 07:37 AM an observation in the kitchen's walk-in refrigerator revealed one opened roll of raw hamburger meat. The meat was in plastic packaging and wrapped in plastic wrap. The packaging/wrapping was undated.

On 08/07/23 at 07:38 AM an observation in the kitchen's walk-in freezer revealed one opened plastic bag of frozen biscuits. The plastic bag was undated.

On 08/09/23 at 12:12 PM Dietary BB stated that when a box of food comes in it should be dated when it arrived. If staff take packages out of a box and open them, then those packages need to be dated with the date they were opened. He stated that meat is pulled from the freezer and stored in the refrigerator on trays and that he typically pulls enough meat to make a scheduled meal. He stated that staff may have decided to use some of the hamburger that was being thawed for a meal and didn't put a date on it. He stated that if someone opens a package of meat that any left-over should be dated and anything that isn't dated should be thrown out. Dietary BB further stated that any food items that have been opened require a date. Dietary BB stated that it was

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F 812	Continued From page 79 everyone's reasonability to date food that they open. He stated that he does rounds in the morning to look for undated food items and discards them. The facility's undated "General Food Handling/Storage/Preparation" policy directed staff to cover, label and date refrigerated items and indicate an expiration date for all items. The facility failed to maintain sanitary dietary standards related to food storage. This deficient practice placed the residents at risk related to food borne illnesses and food safety concerns.	F 812		
F 849 SS=D	Hospice Services CFR(s): 483.70(o)(1)-(4) §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and	F 849		

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to the timeliness of the services.
(ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following:
(A) The services the hospice will provide.
(B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter.
(C) The services the LTC facility will continue to provide based on each resident's plan of care.
(D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day.
(E) A provision that the LTC facility immediately notifies the hospice about the following:
(1) A significant change in the resident's physical, mental, social, or emotional status.
(2) Clinical complications that suggest a need to alter the plan of care.
(3) A need to transfer the resident from the facility for any condition.
(4) The resident's death.
(F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided.
(G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual

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resident's needs.
(H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions.
(I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility.
(J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation.
(K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.

§483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the

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LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident.

The designated interdisciplinary team member is responsible for the following:

(i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services.

(ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family.

(iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians.

(iv) Obtaining the following information from the hospice:

(A) The most recent hospice plan of care specific to each patient.

(B) Hospice election form.

(C) Physician certification and recertification of the terminal illness specific to each patient.

(D) Names and contact information for hospice personnel involved in hospice care of each patient.

(E) Instructions on how to access the hospice's 24-hour on-call system.

(F) Hospice medication information specific to each patient.

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F 849	Continued From page 83 (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by: The facility identified a census of 61 residents. The sample included 15 residents with two residents reviewed for hospice and end of life care. Based on observation, record review, and interviews, the facility failed to collaborate with hospice to determine and direct the services, medication, and equipment provided to Resident (R)34 by hospice services. This deficient practice created a risk for missed opportunities for services and delayed treatment. Findings included: - The "Diagnoses" tab of R34's Electronic Medical Record (EMR) documented diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily), depression (abnormal emotional state	F 849		

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characterized by exaggerated feelings of sadness, worthlessness and emptiness), 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 07/08/23 for R34 documented R34's cognition, mood, and behavior was not assessed. R34 required limited to extensive assistance of one to two staff of for activities of daily living (ADLs). R34 utilized the use of a walker and wheelchair for mobility. R34 used hospice services.

The "Urinary Care Area Assessment (CAA)" dated 07/14/23 documented she needed assist for toilet use and transfers. Contributing factors included dementia, retention of urine (the inability to urinate and the bladder to fully empty), and Parkinson's. Risk factors included potential for urinary incontinence as well as potential for further skin breakdown and recurrent urinary tract infections (UTI- an infection involving organs of the urinary tract). Nursing provided toileting assistance and toilet transfers, skin cleansing and inspection, incontinent care as needed and application of moisture barrier product after each incontinent episode.

The "Hospice Care Plan" initiated 07/10/23 and revised 07/14/23 for R34 directed staff to adjust provisions of ADLs to compensate for R34s changing abilities. Staff was to encourage participation to the extent the resident wished to participate. Staff was to encourage resident to express feelings, listen with non-judgmental acceptance, compassion. Staff was to encourage a support system of family and friends. Staff was

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to observe R34 closely for signs of pain, administer pain medications as ordered, and notify physician immediately if there was breakthrough pain. Staff was to work cooperatively with the hospice team to ensure the resident's spiritual, emotional, and intellectual, physical, and social needs were met. Staff was to work together to provide maximum comfort for the resident.

The "Hospice Care Plan" lacked identification of the contact information for the Hospice provider. The care plan lacked information related to the services provided by hospice including the nursing, spiritual nd social services provided and frequency. The plan lacked information regarding which medications were provided by hospice and what equipment and supplies were provided by hospice.

On 08/07/23 at 10:00 AM R34 propelled herself in her wheelchair down the hallway and entered another resident's room, a staff member noted R34 in the other resident's room and wheeled her out of the room and back to her own room.

On 08/09/23 at 02:11 PM Certified Nurse Aide (CNA) N stated he knew that R34 was on hospice and knew hospice provided the briefs, beds and "things like that" for the resident.

On 08/09/23 at 02:50 PM Licensed Nurse (LN) J stated the hospice care plan should list the hospice service the resident was using and typically listed the supplies that hospice provide and things like that. LN J stated she could not say without looking at R34's care plan to know if R34's care plan included that information.

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F 849	Continued From page 86 On 08/09/23 at 03:54 PM Administrative Nurse D stated the care plan for residents on hospice should let staff know what services and such was provided by hospice. Administrative Nurse D stated R34's care plan should have been updated to reflect what was provided for the resident by hospice. The "End of Life Care; Hospice and/or Palliative Care" facility policy revised January 2023 documented hospice services would be offered as appropriate and as ordered by the physician. These services would be integrated into the overall individualized, interdisciplinary care plan. Collaboration with hospice would include the processes for orientating staff to facility policies and procedures which may include: resident rights, documentation and record keeping requirements. The facility would continue to update and implement and individualized, interdisciplinary plan of care. The facility failed to collaborate with hospice in order to provide a description of the services, medication, and equipment provided to R34 by hospice. This deficient practice created a risk for missed opportunities for services and delayed treatment.	F 849		
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.	F 880		

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F 880	Continued From page 87 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (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	F 880		

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disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 51 residents. The sample included 15 residents. Based on record review, observations, and interviews, the facility failed to maintain sanitary infection control practices related to the storage of oxygen therapy equipment, performing hand hygiene during cares, and sanitization of shared equipment. This deficient practice placed the residents at risk for complications related to infectious diseases.

Findings Included:

- On 08/07/23 at 09:31AM, Licensed Nurse (LN) J did not sanitize a shared blood pressure cuff before using it on different residents.

On 08/07/23 at 10:44AM, R37's continuous positive airway pressure (CPAP- mask used to treat sleep disturbances) mask was on the floor in

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his room with the face side down touching the floor. R37 reported he was not sure why the mask was on the floor. No storage bag was in the room.

On 08/07/23 at 01:26 PM, R28's CPAP mask sat out on his dresser bedside his bed with no storage bag present.

On 08/08/23 at 03:33 PM Licensed Nurse (LN) G and LN H entered R103's room. LN G explained the procedure to R103 and he agreed to allow staff to change his wound dressings. LN G and LN H washed hands and donned gloves. LN G removed R103's teeth from the bedside table and placed them into a denture cup. LN G doffed gloves then donned new gloves without performing hand hygiene. LN G placed a clean barrier onto the bedside table, then placed her wound care supplies onto the clean barrier. LN H removed pressure relieving boots from R103's lower extremities, LN H doffed gloves and washed hands. LN H left the room and returned to room with a chux donned new gloves and placed chux under R103's lower extremities. LN G removed ace wraps, dry kerlix gauze and soiled dressing from left heel pressure wound. LN H supported R103's left leg. LN G doffed soiled gloves, then doffed new gloves with no hand hygiene preformed.

On 08/08/23 at 10:12 AM, R1 sat in her recliner watching television. R1's bilevel positive airway pressure (BiPAP- mask used to treat sleep disturbances) mask sat on top on her bedside table with no storage bag present.

On 08/09/23 at 07:32 AM, R104 sat in a reclined Broda chair (specialized wheelchair with the ability to tilt and recline) chair without a pressure

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reducing cushion next to her bed. R104's nebulizer mouthpiece sat uncovered and undated on the bedside table next to the bed.

On 08/09/23 at 01:28 PM, R104 sat reclined in a Broda chair without a pressure reducing cushion. R104's nebulizer mouthpiece was uncovered and undated on her bedside table.

On 08/09/23 at 01:45PM Administrative Nurse E stated the facility held frequent in-service training related to infection control. She stated the facility monitored trends in infection control monitoring and provided training in the specific areas identified by the quality assurance team. She stated all oxygen therapy equipment should be cleaned and stored in the provided bags when not in use to prevent contamination. She stated all shared equipment should be sanitized in between residents with the provided sanitary cleaning wipes. She stated staff were to take soiled linens to the sela containers. She stated hand hygiene needed to be completed in between changing gloves and when hands were visibly soiled.

On 08/09/23 at 02:30PM Certified Nurse's Aide (CNA) N stated hand hygiene needed to be completed before, during, and after cares. She stated hands should be washed when visibly soiled and after glove removal. She sated oxygen equipment should be stored in a protective bag when not in use.

On 08/09/23 at 02:53PM LN H stated staff were expected to complete hand hygiene in in between glove changes and when in direct contact with the resident or environment. He stated shared equipment should be sanitized in between use and when soiled or dirty.

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F 880	Continued From page 91 A review of the facility's "Hand Hygiene" policy revised 10/2022 indicated staff were expected to complete hand hygiene before, during, and after cares provided to the residents. The policy noted staff were to complete hand hygiene in between changing gloves. A review of the facility's "Infection Control" policy revised 10/2022 noted staff were to ensure soiled equipment, waste, linens, and medical products be transported in a manner that minimizes the risk of contamination of the environment. The policy indicated shared equipment must be properly sanitized in between uses by trained staff. A review of the facility's "Oxygen Equipment" policy revised 01/2022 indicated oxygen therapy equipment must be covered and stored properly when not in use to prevent contamination. The facility failed to maintain sanitary infection control practices related to the storage of oxygen therapy equipment, hand hygiene during cares and sanitizations of shared equipment. This deficient practice placed the residents at risk for complications related to infectious diseases.	F 880		