

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

PRINTED: 09/07/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175219	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/24/2023
NAME OF PROVIDER OR SUPPLIER KAW RIVER CARE AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 750 BLAKE STREET EDWARDSVILLE, KS 66111		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey.	F 000			
F 550 SS=D	The 2567 was sent electronically on 09/07/23. 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. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without	F 550			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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F 550	Continued From page 1 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 33 residents. The sample included 12 residents. Based on observation, record review, and interviews the facility failed to provide care in a respectful, dignified manner for Resident (R) 6 when staff failed to close the door to his room, to ensure privacy, while staff assisted him in changing his clothes and for R25, when staff performed personal cares without ensuring total privacy. This placed the residents at risk for impaired dignity and quality of life. Findings included: - On 08/22/23 at 07:10 AM Certified Nurse Aide (CNA) O was witnessed from the hallway as he assisted R6 with a clothing change. R6's bedroom door was open, and the privacy curtain was not pulled. CNA O was also heard from the hallway as he told R6 to take off his shirt and pants and then instructed R6 to put on clean ones. On 08/24/23 at 01:56 PM CNA M stated when staff were assisting residents with a clothing change in their rooms, the door should be closed and if the resident had a roommate, the privacy curtain should be pulled.	F 550			

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F 550	Continued From page 2 On 08/24/23 at 03:18 PM Administrative Nurse D stated when staff were assisting residents with a clothing change the privacy curtains should be pulled if residents were not the only one in the room; the door should be closed. The facility policy "Respect and Dignity; Right to Personal Property, Including Searches and Illegal Substances" revised 10/2022, documented residents have the right to be treated with respect and dignity. The facility failed to provide care in a respectful, dignified manner for R6 when staff failed to close the door to his room, to ensure privacy, while staff assisted him in changing his clothes. This placed the residents at risk for impaired dignity and quality of life. - R25's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of acute kidney failure, benign prostatic hyperplasia (BPH- non-cancerous enlargement of the prostate which can lead to interference with urine flow, urinary frequency, and urinary tract infections), dysphagia (swallowing difficulty), and atherosclerotic heart disease (hardening of the blood vessel within the heart). R25's "Quarterly Minimum Data Set" completed 07/01/23 noted a Brief Interview for Mental Status (BIMS) score of five indicating severe cognitive impairment. The MDS indicated he required extensive assistance from two staff for bed mobility and total assistance from two staff for toileting, personal hygiene, dressing, locomotion, and bathing. The MDS indicated he had an indwelling catheter (tube inserted into the bladder to drain urine) and frequently was incontinent of	F 550			

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F 550	Continued From page 3 bowel. The MDS indicated he had he had a stage three (full thickness) pressure ulcer. The MDS noted he had pressure ulcer treatments of repositioning, wound care, feet dressings, and pressure reducing devices in place. R25's "Pressure Ulcer Care Area Assessment (CAA)" completed 04/07/23 indicated he was at risk for developing skin breakdown and pressure ulcers related to his medical diagnoses, bowel incontinence, indwelling catheter, and a need for extensive to total assistance with his activities of daily living (ADLs). R25's "Care Plan" initiated 04/06/23 indicated he was totally dependent on one to two staff for bed mobility, transfers, personal hygiene, dressing, and toileting. The plan noted he required a Hoyer lift (total body mechanical lift used to transfer residents) for all transfers. The plan noted he was risk for pressure injuries related to fragile skin, incontinence, and limited mobility. The plan indicated he required a pressure reducing wheelchair cushion, low air-loss mattress, nutritional monitoring, and evaluation/treatment from wound care. The plan instructed staff to be cautious during transfers and bed mobility to prevent his body from hitting or striking hard or sharp surfaces. On 08/23/23 at 01:53PM Administrative Nurse D attempted to close the curtains during wound care for privacy but a gap in the center of the window remained visible from the main parking lot outside the window. Administrative Nurse D removed the covered and unfastened his incontinence brief. Administrative Nurse D completed catheter care but required a second staff member to assist with repositioning. R25	F 550			

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F 550	Continued From page 4 remained stripped down on is bed next to the open gap of the widow for several minutes before Licensed Nurse (LN) I entered to assist. Administrative Nurse D started cleaning R25 but ran out of peri-wipes for the cares. R25 was laid back down on his back and LN I left to find peri-wipes. Administrative Nurse D placed a pad over his groin area. Certified Nurse's Aide (CNA) N entered the room to assist with cares at 02:05PM. LN I returned to the room and staff completed peri-care. On 08/24/23 at 01:33PM CNA N stated staff were t treat the resident like they were at home. She stated the curtain show be pulled and privacy should be ensured when performing catheter and peri-care. On 08/24/23 at 01:30PM LN H reported staff were to ensure the doors were closed and the curtains pulled fully during cares for the residents. On 08/24/23 at 03:30PM Administrative Nurse D stated staff were expected to ensure the residents were given privacy and respect during personal cares. She stated staff were to close the doors, knock, and ensure the curtains were closed. The facility policy "Respect and Dignity; Right to Personal Property, Including Searches and Illegal Substances" revised 10/2022, documented residents have the right to be treated with respect and dignity. The facility failed to ensure privacy during catheter and peri-care for R25. This deficient practice placed him at risk for decreased psycho-social wellbeing.	F 550			

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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. §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	F 576			

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F 576	Continued From page 6 law. This REQUIREMENT is not met as evidenced by: The facility identified a census of 33 residents. The sample included 12 residents. Based on record review and interviews, the facility failed to provide mail services on Saturdays. Findings included: - On 08/23/23 at 01:04 PM in a private interview with Resident Council members, a member reported the facility did not always provide mail services for the residents on Saturdays. The council member reported that there was not a staff member on Saturdays that passed out mail unless the activity person worked that day. On 08/24/23 at 01:57 PM Certified Nurse Aide (CNA) M stated she did work weekends occasionally. CNA M stated mail did get delivered to the facility on Saturdays, but the mail was not always delivered to the residents unless one of the staff members had time to pass the mail out. On 08/24/23 at 02:18 PM Licensed Nurse (LN) H stated that she did work weekends and would make sure that the mail got passed out on Saturdays. LN H could not say if mail was passed out on Saturdays on the weekend that she did not work but stated that mail should be passed out to residents even on Saturdays. On 08/24/23 at 02:48 PM Administrative Nurse E stated she did work on weekends sometimes and mail should be passed out on Saturdays. On 08/24/23 at 03:19 PM Administrative Nurse D stated that staff should be making sure that mail	F 576			

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F 576	Continued From page 7 was delivered to the residents on Saturday. Administrative Nurse D had told staff that the mail needed to be delivered on Saturdays even when there was not management staff at the facility on the weekends. The facility policy "Mail F576" last approved May 2022 documented: Residents are allowed to communicate privately with individuals of their choice and may send and receive their personal mail unopened unless otherwise indicated by the Attending Physician and documented in the resident's medical record. The facility will not give mail to members of the resident's family unless the resident authorizes the facility to do so. Mail will be delivered to the resident withing 24-hours of delivery on premises or to the facility's post office box (including Saturday deliveries). The facility failed to provide mail services on Saturdays.	F 576			
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	F 623			

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F 623	Continued From page 8 (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would 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	F 623			

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F 623	Continued From page 9 completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental 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 §	F 623			

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F 623	Continued From page 10 483.70(I). This REQUIREMENT is not met as evidenced by: The facility identified a census of 33 residents. The sample included 12 residents with one resident reviewed for hospitalization. Based on observation, record review, and interviews, the facility failed to provide written notification of the reason and location for the facility-initiated transfer for Resident (R)180. This deficient practice placed the resident at risk of delayed care or uncommunicated care needs. Findings included: - R180's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of major depressive disorder (major mood disorder), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), hypertension (high blood pressure), left-sided hemiplegia (paralysis of one side of the body), and vascular dementia (progressive mental disorder characterized by failing memory, confusion). R180's EMR recorded a "Discharge Assessment-Return Anticipated" Minimum Data Set (MDS) which recorded R180 discharged to the acute hospital on 12/12/23. R180's "Entry Tracking Record" MDS documented he returned to the facility on 12/17/22. R180's "Quarterly MDS" completed 05/02/23 noted Brief Interview for Mental Status (BIMS) score of seven indicating moderate cognitive impairment. The MDS indicated he required limited assistance from one staff for most activities of daily living (ADL).	F 623			

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F 623	Continued From page 11 R180's "Care Plan" revised 02/28/23 indicated he had altered cardiovascular status related to his hypertension. The plan instructed staff to monitor his blood pressure and vital signs. The plan instructed staff to report signs/symptoms related to dizziness, fatigue, and abnormal readings of his vital signs. R180's EMR revealed a "Nursing" note completed 12/12/2022 which recorded R180 was sent out to an acute care facility for emergency treatment due to low blood pressure, dizziness, and altered mental status. The EMR revealed he returned to the facility on 12/17/23. R180's clinical record lacked evidence written notification of the facility-initiated transfer which included location and reason for transfer was provided to R180 or his representatives. The facility was unable to provide the written transfer notification for R180 as requested on 08/28/23. On 08/24/23 at 03:05PM Social Services X stated when residents admit to an acute care facility, the charge nurse will often notify the representative of the transfer, but no written notification was completed and sent to the family. She stated the nurse would complete a progress note in the EMR showing the transfer. The facility policy "Transfer or Discharge Notice" dated 08/2023 noted the facility would provide a resident and/or the resident's representative with notice of an impending transfer or discharge. Under the following circumstances, the notice would be given as soon as practicable but before	F 623			

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F 623	Continued From page 12 the transfer or discharge: The transfer is necessary for the resident's welfare and the resident's needs cannot be met in the facility.	F 623			
F 625 SS=D	The facility failed to provide written notification of the reason and location for the facility-initiated transfer to the hospital to R180 or his representative. This deficient practice placed him at risk of uncommunicated care needs. 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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F 625	Continued From page 13 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 33 residents. The sample included 12 residents with one resident reviewed for hospitalization. Based on observation, interview and record review, the facility failed to provide a copy of the facility bed hold policy to Resident (R)180 and/or their representative, with a written notice specifying the duration and cost of the bed hold policy, at the time of the resident's transfer to the hospital. This placed the resident at risk for impaired rights Findings included: - R180's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of major depressive disorder (major mood disorder), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), hypertension (high blood pressure), left-sided hemiplegia (paralysis of one side of the body), and vascular dementia (progressive mental disorder characterized by failing memory, confusion). R180's EMR recorded a "Discharge Assessment-Return Anticipated" Minimum Data Set (MDS) which recorded R180 discharged to the acute hospital on 12/12/23. R180's "Entry Tracking Record" MDS documented he returned to the facility on 12/17/22. A review of R180's "Quarterly MDS" completed 05/02/23 noted Brief Interview for Mental Status (BIMS) score of seven indicating moderate cognitive impairment. The MDS indicated he	F 625			

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F 625	Continued From page 14 required limited assistance from one staff for most activities of daily living (ADL). A review of R180's "Care Plan" revised 02/28/23 indicated he had altered cardiovascular status related to his hypertension. The plan instructed staff to monitor his blood pressure and vital signs. The plan instructed staff to report signs/symptoms related to dizziness, fatigue, and abnormal readings of his vital signs. A review of R180's EMR revealed a "Nursing" note completed 12/12/2022 which recorded R180 was sent out to an acute care facility for emergency treatment due to low blood pressure, dizziness, and altered mental status. The EMR revealed he returned to the facility on 12/17/23 R180's clinical record lacked evidence a bed-hold was provided to him or his representatives at the time of transfer. The facility was unable to provide R180's bed-hold notification as requested on 08/24/23. On 08/24/23 at 03:05PM Social Services X stated the bed hold was apart of the admission packet and provided to the family. She stated the facility provided the forms to the family but did not maintain them as part of the EMR. She stated the forms were sent out with R180 during his hospitalization. The facility policy "Bed-Hold and IN House Transfer" 05/2022 indicted a bed hold will be completed upon hospitalization or therapeutic leave depending on the state's policy. The policy indicated a copy will be provided to the legal representative and a copy maintained with the resident's medical records.	F 625			

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F 625	Continued From page 15	F 625			
F 656 SS=D	The facility failed to provide a copy of the facility bed hold policy to R180 and/or their representative, with a written notice specifying the duration and cost of the bed hold policy, at the time of the resident's transfer to the hospital. This placed R180 at risk for impaired rights. Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the 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)-	F 656			

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F 656	Continued From page 16 (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 33 residents. The sample included 12 residents with one resident reviewed for range of motion (ROM- the full movement potential of a joint, usually its range of flexion and extension)/mobility). Based on observation, record review, and interviews, the facility failed to create a comprehensive care plan to address restorative services for Resident (R) 9, which placed him at risk of loss of ability to perform activities of daily living (ADLs) and development of contractures (abnormal fixation of a joint or muscle) due to uncommunicated care needs. Findings included: - R9's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of hemiplegia (paralysis of one side of the body), hemiparesis (muscular weakness of one half of the body), diabetes mellitus (when the body	F 656			

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F 656	Continued From page 17 cannot use glucose, not enough insulin made or the body cannot respond to the insulin), and cerebrovascular accident (CVA-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). The "Annual Minimum Data Set" (MDS) dated 01/10/23 documented a Brief Interview of Mental Status (BIMS) score of 14 which indicated intact cognition. The MDS documented that R9 required extensive assistance of one staff member for ADL. The MDS documented R9 had received insulin (medication to regulate blood sugar), diuretic (medication to promote the formation and excretion of urine), and antidepressant (class of medications used to treat mood disorders and relieve symptoms of depression) for seven days during look back period. The MDS documented R9 had received restorative services of passive ROM (PROM), bed mobility, transfer training for five days, active ROM (AROM) for six days, walking for one day, and no splint application during the look back period. The "Quarterly MDS" dated 06/07/23 documented a BIMS score of 13 which indicated intact cognition. The MDS documented that R9 required extensive assistance of two staff members assistance for ADLs. The MDS documented R9 had received insulin, antidepressant medication, and diuretic medication for seven days during look back period. The MDS documented R9 had restorative services of AROM, PROM, bed mobility, transfer training, walking for one day, and splint application during look back period. R9's "ADL Functional/Rehabilitation Potential Care Area Assessment" (CAA) dated 02/03/23	F 656			

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F 656	Continued From page 18 documented R9 was at risk for potential decline in his ADL function. R9's "Care Plan" lacked documentation or direction to staff for ROM to prevent a decline or prevention of contractures. Review of R9's clinical record lacked documentation of evaluation or documentation of a current restorative program. On 08/23/23 at 08:08 AM R9 sat in his wheelchair at the dining room table. R9 ate breakfast without assistance, using his left hand. R9 had scrambled eggs on his shirt and along the sides of his wheelchair. R9's right hand rested on the right of his lap with his fingers curled downward toward the palm of his right hand. On 08/24/23 at 10:30 AM R9 stated he refused to wear a splint on his right hand but would participate in AROM and PROM programs to help prevent his hand contracture becoming worse. On 08/24/23 at 01:57 PM Certified Nurse Aide (CNA) M stated R9 had a splint for his right hand but would refuse frequently to wear it. CNA M stated the facility did not have anyone at this time to provide restorative programs and the CNAs on the floor did not provide ROM to the residents. On 08/24/23 at 02:19 PM Licensed Nurse (LN) H stated there was no staff at this time at the facility that provided ROM to the residents. On 08/24/23 at 03:19 PM Administrative Nurse D stated the restorative programs should be on the plan of care and on the Kardex (a medical information system used by nursing staff as a	F 656			

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F 656	Continued From page 19 way to communicate important information on their patients. It is a quick summary of individual patient needs that is updated at every shift change). The facility did not provide a comprehensive care plan policy. The facility failed to create a comprehensive care plan to address restorative services for R9, which placed him at risk of loss of ability to perform ADL and development of contractures due to uncommunicated care needs.	F 656			
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 and interaction in the community. This REQUIREMENT is not met as evidenced by: The facility identified a census of 33 residents. The sample included 12 residents. Based on observation, record review, and interviews, the facility failed to consistently provide facility directed weekend activities to the cognitively impaired residents unable to self direct. This deficient practice had the risk for a decline in psychosocial well-being.	F 679			

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F 679	Continued From page 20 Findings included: - The facility had nine residents that had a "Brief Interview for Mental Status" (BIMS) score of eight or less (indicating severely impaired cognition). Review of the monthly activity calendar for June 2023 revealed weekend activity on Saturday and Sunday of: Resident Choice Movie and Music. On Sunday 06/04/23 and 06/18/23 included the 06:00 PM Church service. Review of the monthly activity calendar for July 2023 revealed weekend activity on Saturday and Sunday of: Resident Choice Movie and Music. On Sunday 07/02/23 and 07/16/23 activities included the 06:30 PM Church service. Review of the monthly activity calendar for August 2023 revealed weekend activity on Saturday and Sunday of: Resident Choice Movie and Music. The weekend activities included self-directed activities but lacked evidence of structured activity offerings for residents with impaired cognition unable to self-direct. On 08/24/23 at 01:57 PM Certified Nurse Aide (CNA) M stated usually on the weekends residents would watch movies or listen to music. CNA M stated the residents usually would start the movie themselves. CNA M stated the facility did have a few activity boards or blankets for the residents with cognitive impairment. On 08/24/23 at 02:18 PM Licensed Nurse (LN) H stated the facility currently did not have an activity director, so weekend activities were basically whatever the residents wanted to do like watch tv,	F 679			

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F 679	Continued From page 21 play cards, or games. LN H stated the facility had a blanket or something like that with little activity things on it to let the cognitively impaired residents use. LN H stated there was no staff-initiated activities on the weekend. On 08/24/23 at 03:17 PM Administrative Nurse D stated that weekend activities were resident's choice which was generally movies or games that the residents would initiate themselves. Administrative Nurse D stated the facility's activity director left at the beginning of the month but when she was here, she would come in on some weekends to do activities with the residents. Administrative Nurse D stated she was not certain what activities staff provided on weekends for the residents that were cognitively impaired. The facility policy "Activities and Social Events" last approved May 2022 documented: Residents had the right to choose the types of activities and social events in which they wish to participate. When developing the resident's activity and social care plan, the resident should be given an opportunity to choose when, where, and how he or she would participate in activities and social events. Activities, social events, and schedules were developed in conjunction with the resident's interests, assessment, and plan of care. Staff would evaluate a resident's physical and mental capacity to participate in various levels of activities. Staff would note any significant physical and cognitive limitations or behavior issues that would influence the level of a resident's participation or type of activity that were relevant to that individual. The facility would provide activities on most days, including weekends and holidays, as well as scheduled religious and social activities. However, residents were free to	F 679			

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F 679	Continued From page 22 decide whether to attend any activity or other scheduled event. The facility failed to consistently provide structured weekend activities for cognitively impaired residents. This deficient practice had the risk for a decline in physical, mental, and psychosocial well-being.	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 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 33 residents. The sample included 12 residents with two reviewed for pressure ulcer (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) care. Based on observations, record reviews, and interviews, the facility failed to ensure appropriate application of Resident (R)25 pressure relieving boots, failed to ensure repositioning which included ensuring feet were not pressed into the	F 686			

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F 686	Continued From page 23 footboard, and failed to provide wound care per standards of practice. This deficient practice placed R25 at risk for complication related to skin breakdown and pressure ulcers. Findings included: - R25's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of acute kidney failure, benign prostatic hyperplasia (BPH- non-cancerous enlargement of the prostate which can lead to interference with urine flow, urinary frequency, and urinary tract infections), dysphagia (swallowing difficulty), and atherosclerotic heart disease (hardening of the blood vessel within the heart). R25's "Quarterly Minimum Data Set" completed 07/01/23 noted a Brief Interview for Mental Status (BIMS) score of five indicating severe cognitive impairment. The MDS indicated he required extensive assistance from two staff for bed mobility and total assistance from two staff for toileting, personal hygiene, dressing, locomotion, and bathing. The MDS indicated he had an indwelling catheter (tube inserted into the bladder to drain urine) and frequently was incontinent of bowel. The MDS indicated he had he had a stage three (full thickness) pressure ulcer. The MDS noted he had pressure ulcer treatments of repositioning, wound care, feet dressings, and pressure reducing devices in place. R25's "Pressure Ulcer Care Area Assessment (CAA)" completed 04/07/23 indicated he was at risk for developing skin breakdown and pressure ulcers related to his medical diagnoses, bowel incontinence, indwelling catheter, and a need for extensive to total assistance with his activities of	F 686			

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F 686	Continued From page 24 daily living (ADLs). R25's "Care Plan" initiated 04/06/23 indicated he was totally dependent on one to two staff for bed mobility, transfers, personal hygiene, dressing, and toileting. The plan noted he required a Hoyer lift (total body mechanical lift used to transfer residents) for all transfers. The plan noted he was risk for pressure injuries related to fragile skin, incontinence, and limited mobility. The plan indicated he required a pressure reducing wheelchair cushion, low air-loss mattress, nutritional monitoring, and evaluation/treatment from wound care. The plan instructed staff to be cautious during transfers and bed mobility to prevent his body from hitting or striking hard or sharp surfaces. R25's EMR under "Physician's Orders" revealed an order dated 04/18/23 for him to wear heel protector boots while in bed every shift for skin protection. On 08/22/23 at 08:14AM R25 slept in his bed. R25's bed was a low air-loss mattress and air pump was set at 180 to 220 pounds (lbs.) per his weight requirement. R25 had protective boots on both feet. though R25's right boot was loose with his right foot was partially sideways in the boot. On 08/23/23 at 07:10AM R25 sat upward in his bed with his bedside table over his lap and prepared to eat his breakfast. R25's body was positioned lower towards the foot of the bed. R25 had his protective boots on but feet were pressed up against the foot board of the bed. On 08/23/23 at 10:30AM R25 was asleep but remained in the same upright position in his bed.			F 686			

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F 686	Continued From page 25 R25's feet remained against the footboard of his bed. On 08/23/23 at 01:53PM Administrative Nurse D collected supplies to complete catheter and wound care for R25. Upon entry of the room R25 was awake in the same upright position as earlier documented. His legs and feet were low in the bed and his footboard and air pump were knocked off the bed frame with the right side of the footrest dangling against the floor. Administrative Nurse D commented "What's wrong with your bed?" and she reattached the footboard to the bedframe. Administrative Nurse D placed a clean towel barrier down of the bedside table. At 02:10PM Licensed Nurse (LN) I and Certified nurse aide (CNA)N had to pull R25 upward in bed to complete wound care on his feet due to his positioning being too low in the bed. All staff completed hand hygiene and re-donned gloves. Administrative Nurse D removed R25's protective boots and the gauze wraps on both his feet. She removed the calcium alginate (wound barrier that promotes healing) from inside the right heel wound. No protective barrier was placed between R25's heel wounds and his soiled mattress. R25's left heel and wound rested on the mattress as CNA N held onto his right leg up above his left leg. Administrative Nurse D had to get supplies prepped for the wound care and left the area. CNA N then rested R25's exposed right heel on top of his left leg. R25's right leg touched the soiled mattress several times during the observation. Administrative Nurse D returned and completed wound care on both heels. On 08/24/23 at 01:30PM CNA M stated staff should be checking and repositioning R25 twice each shift. She stated R25 was very stiff and	F 686			

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F 686	Continued From page 26 could not reposition himself. She stated he was tall and to ensure he was pulled upward in bed to prevent his feet from contacting the footboards. On 08/24/23 at 02:44PM Administrative Nurse E indicated clean barriers should be placed to reduce the risk of wound infections. She stated staff should check each resident every two hours and reposition them during each interaction. She stated R25 required two staff to reposition due to his difficulty assisting staff during bed mobility. On 08/24/23 at 02:18PM Administrative Nurse D stated staff were expected to check R25's positioning during each interaction. She stated R25 had a history of refusing cares and staff assistance. She stated staff were expected to ensure R25's were boots were placed each shift, empty his catheter, and provide cares as needed. A review of the facility's "Repositioning" policy revised 08/2023 indicated the facility will ensure each resident was properly assessed and provided interventions to prevent skin breakdown and pressure relief. The policy noted that residents that had difficulty repositioning would closely be monitored and reposition within every two hours. The facility failed to ensure appropriate application of R25's pressure relieving boots, failed to ensure repositioning which included ensuring feet were not pressed into the footboard, and failed to provide wound care per standards of practice. This deficient practice placed R25 at risk for complication related to skin breakdown and pressure ulcers.	F 686			

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F 686	Continued From page 27 - The "Diagnoses" tab of R27's Electronic Medical Record (EMR) documented diagnoses of 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), hemiplegia affecting left side (paralysis of one side of the body). The "Admission Minimum Data Set (MDS)" dated 05/17/23, documented R27 had a Brief Interview for Mental Status (BIMS) score of 14 which indicated intact cognition. The MDS documented R27 required extensive assistance with one staff physical assistance for eating and personal hygiene and two staff physical assistance for dressing, and bed mobility. R27 was totally dependent with assistance of one staff member for locomotion on and off the unit, and he required two staff assistance with transfers, and toileting. The "Functional / Rehabilitation Potential Care Area Assessment (CAA)" dated 05/17/23, documented R27 was extensive to total assist with activities of daily living and required a Hoyer lift (total body mechanical lift used to transfer residents) for transfers. The "Care Plan" dated 06/18/23, documented R27 had potential/actual impairment to skin integrity related to lack of independent bed mobility. The "Care Plan" with an intervention dated 07/19/23 directed staff to keep R27's heel protector boots on at all times when he was in bed. An "Order" dated 07/19/23, documented heel protector boot was to be on left heel at all times, every shift, for wound on left heel.	F 686			

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F 686	Continued From page 28 R27's EMR from 8/22/23 to 08/24/23 lacked documentation of refusal to wear the heel protector boot. On 08/23/23 at 10:37 AM R27 laid in his bed in his room, no heel protector boot noted to either foot. R27 was wearing nonskid socks at the time and his heels rested on his mattress. He stated that he hadn't had the boot on all night. R27 stated if he wore the boot, then staff had to put it on him as he was unable to do it himself. He stated that he doesn't refuse to wear the protector boot as he needed to wear it because of the sore on his heel. He stated that he doesn't tell staff not to put it on him. On 08/24/23 at 07:26 AM R27 laid in his bed and slept. No heel protector boot was on either foot, and his heels rested on his mattress. On 08/24/23 at 11:30 AM observation revealed a small, scabbed area to R27's left heel. On 08/24/23 at 01:56 PM Certified Nurse Aide (CNA) M stated she believed R27 was supposed to wear his heel protector boot during the day and that he could have it off at night. She further stated that she believed he had two boots and was supposed to wear both of them. On 08/24/23 at 02:18 PM Licensed Nurse (LN) H stated R27 was supposed to have a heel protector boot on his left heel at all times. She stated R27 does refuse to wear it occasionally, but that the refusal would have been charted in a progress note. She further stated that it didn't happen very often, but sometimes he would not wear them.	F 686			

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F 686	Continued From page 29 On 08/24/23 at 03:18 PM Administrative Nurse D stated R27 had a splint on his left foot and ended up with a wound to his heel. She stated that staff were monitoring his wound and tried to keep his pressure reducing boots on. She further stated if R27 didn't refuse to wear the boot then staff should have it on him at all times. The facility policy "Repositioning" revised on 10/2010, documented positioning the resident on an existing pressure ulcer should be avoided since it puts additional pressure on the tissue that is already compromised and may impede healing. The facility failed to implement/ensure pressure reducing measures were in place for R27, who was at risk for pressure injuries. This placed R27 at increased risk for pressure/skin injuries.	F 686			
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with	F 688			

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F 688	Continued From page 30 the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: The facility identified a census of 33 residents. The sample included 12 residents with one resident reviewed for range of motion (ROM- the full movement potential of a joint, usually its range of flexion and extension)/mobility. Based on observation, record review, and interviews, the facility failed to provide services to prevent a potential decrease in ROM/mobility and/or worsening of contractures (abnormal fixation of a joint or muscle) for Resident (R) 9, which placed him at risk of loss of ability to perform activities of daily living (ADLs) and development of contractures. Findings included: - R9's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of hemiplegia (paralysis of one side of the body), hemiparesis (muscular weakness of one half of the body), diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), and cerebrovascular accident (CVA-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). The "Annual Minimum Data Set" (MDS) dated 01/10/23 documented a Brief Interview of Mental Status (BIMS) score of 14 which indicated intact cognition. The MDS documented that R9 required extensive assistance of one staff member for ADL. The MDS documented R9 had received insulin (medication to regulate blood sugar),	F 688			

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F 688	Continued From page 31 diuretic (medication to promote the formation and excretion of urine), and antidepressant (class of medications used to treat mood disorders and relieve symptoms of depression) for seven days during look back period. The MDS documented R9 had received restorative services of passive ROM (PROM), bed mobility, transfer training for five days, active ROM (AROM) for six days, walking for one day, and no splint application during the look back period. The "Quarterly MDS" dated 06/07/23 documented a BIMS score of 13 which indicated intact cognition. The MDS documented that R9 required extensive assistance of two staff members assistance for ADLs. The MDS documented R9 had received insulin, antidepressant medication, and diuretic medication for seven days during look back period. The MDS documented R9 had restorative services of AROM, PROM, bed mobility, transfer training, walking for one day, and splint application during look back period. R9's "ADL Functional/Rehabilitation Potential Care Area Assessment" (CAA) dated 02/03/23 documented R9 was at risk for potential decline in his ADL function. R9's "Care Plan" lacked documentation or direction to staff for ROM to prevent a decline or prevention of contractures. Review of R9's clinical record lacked documentation of evaluation or documentation of a current restorative program. On 08/23/23 at 08:08 AM R9 sat in his wheelchair at the dining room table. R9 ate breakfast without assistance, using his left hand. R9 had scrambled	F 688			

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F 688	Continued From page 32 eggs on his shirt and along the sides of his wheelchair. R9's right hand rested on the right of his lab with his fingers curled downward toward the palm of his right hand. On 08/24/23 at 10:30 AM R9 stated he refused to wear a splint on his right hand but would participate in AROM and PROM programs to help prevent his hand contracture becoming worse. On 08/24/23 at 01:57 PM Certified Nurse Aide (CNA) M stated R9 had a splint for his right hand but would refuse frequently to wear it. CNA M stated the facility did not have anyone at this time to provide restorative programs and the CNAs on the floor did not provide ROM to the residents. On 08/24/23 at 02:19 PM Licensed Nurse (LN) H stated there was no staff at this time at the facility that provided ROM to the residents. On 08/24/23 at 03:19 PM Administrative Nurse D stated R9 had thrown his right-hand splint into the trash two times. Administrative Nurse D stated ROM was provided during dressing and other ADLs. Administrative Nurse D stated the restorative programs should be on the plan of care and on 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). The facility's "Goals and Objectives, Restorative Services" policy last revised 12/2007 documented specialized rehabilitative service goals and objectives shall be developed for problems identified through resident assessments.	F 688			

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F 688	Continued From page 33 Rehabilitative goals and objectives are developed for each resident and are outlined in his/her plan of care relative to therapy services. Goals may include but are not limited to assisting the resident in adjusting to his/her abilities; assisting the resident in developing and strengthening his/her physiological and psychological resources; encouraging the resident to maintain his/her independence and self-esteem; encouraging the resident to participate in the development and implement at ion of his/ her plan of care; and other information as may become necessary or appropriate. The facility failed to access R9 to prevent a loss or decrease in ROM /mobility, which placed him at risk of worsening ROM, development of contractures, ability to participate with his ADLs and maintain his independence.	F 688			
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility had a census of 33 residents. The sample included 12 residents with five residents reviewed for accidents and/or hazards. Based on observation, record review, and interview the facility failed to secure rooms containing hazardous materials to keep out of reach of 12	F 689			

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F 689	Continued From page 34 cognitively impaired /independently mobile residents. This deficient practice placed the 12 residents at risk for preventable injuries and accidents. Findings Included: - On 08/22/23 at 07:04AM an initial walkthrough of the facility was completed. An inspection of the supplemental oxygen storage room revealed no lock or mechanism to secure the room's contents from opening the door. The room contained 20 full cylindrical oxygen cannisters stored in the rack with the room. Licensed Nurse (LN) G stated the door should be locked but she was not sure if it could be. LN G stated she would notify Administrative Nurse D. The lockable doorknob was placed at 09:00AM. An inspection the "East Hall" revealed an unsecured utility closet with an open and unlocked electrical switch panel. The panel contained the label warning "High Voltage, Keep Locked". An inspection the "West Hall" revealed an unsecured utility closet with an open and unlocked electrical switch panel. The panel contained the label warning "High Voltage, Keep Locked". On 08/24/23 at 01:30PM, Certified Nurse Aide (CNA) M stated rooms that contained potential hazards should be always locked to prevent accidental injuries for the residents. She stated the janitor's closet were usually kept locked but not sure why the oxygen storage room did not have a lock on the door.	F 689			

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F 689	Continued From page 35 On 08/24/23 at 01:45PM, Administrative Nurse D stated the oxygen room recently was moved and a lock had been installed to prevent the residents from opening it. She stated all staff were expected to make sure the cleaning closet and shower rooms remained locked after being used. A review of the facility's "Environment" policy revised 08/2023 indicated the facility will provide a safe, functional, sanitary, and comfortable environment for the residents. A review of the facility's "Oxygen" policy revised 08/2023 indicated oxygen cylinders will be stored in a locked well-ventilated room separated from electrical appliances. The facility failed to secure rooms containing hazardous materials to keep out of reach of 12 cognitively impaired independently mobile residents. This deficient practice placed 12 residents at risk for preventable injuries and accidents.	F 689			
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2) For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-	F 690			

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F 690	Continued From page 36 (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: The facility identified a census of 33 residents. The sample included 12 residents with three reviewed for incontinence care. Based on observations, record reviews, and interviews, the facility failed to provide appropriate indwelling urinary catheter (tube inserted into the bladder to drain urine into a collection bag) care and placement per standards of practice for Resident (R)25. This deficient practice placed R25 at risk for complication related complications. Findings included: - R25's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of	F 690			

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F 690	Continued From page 37 acute kidney failure, benign prostatic hyperplasia (BPH- non-cancerous enlargement of the prostate which can lead to interference with urine flow, urinary frequency, and urinary tract infections), dysphagia (swallowing difficulty), and atherosclerotic heart disease (hardening of the blood vessel within the heart). R25's "Quarterly Minimum Data Set (MDS)" completed 07/01/23 noted a Brief Interview for Mental Status (BIMS) score of five indicating severe cognitive impairment. The MDS indicated he required extensive assistance from two staff for bed mobility and total assistance from two staff for toileting, personal hygiene, dressing, locomotion, and bathing. The MDS indicated he had an indwelling catheter and frequently was incontinent of bowel. R25's "Pressure Ulcer Care Area Assessment (CAA)" completed 04/07/23 indicated he was at risk for developing skin breakdown and pressure ulcers related to his medical diagnoses, bowel incontinence, indwelling catheter, and a need for extensive to total assistance with his activities of daily living (ADLs). R25's "Urinary Incontinence CAA" completed 04/07/23 indicated he was at risk for skin breakdown related to his bowel incontinence. The CAA indicated he had an indwelling urinary catheter and required extensive to total assistance from staff for his ADLs. R25's "Care Plan" initiated 07/13/23 indicated he was totally dependent on one to two staff for bed mobility, transfers, personal hygiene, dressing, and toileting. The plan noted he required a Hoyer lift (total body mechanical lift used to transfer	F 690			

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F 690	Continued From page 38 residents) for all transfers. The plan noted he had a Foley catheter and was incontinent of bowel. The plan instructed staff to inspect the catheter tubing two times each shift for kinks. The plan noted the catheter tubing and urine collection bag were to be positioned below the resident's bladder. On 08/22/23 at 07:22AM R25 slept in his bed. His catheter bag hung from the frame of the bed below him. An inspection of the catheter tubing revealed pooled urine in tubing next to his groin and in the tubing hanging off the bed due to long length of the tubing that ran sideways and up to his headrest frame instead of downward to gravity. The catheter collection bag had no privacy bag, and a small amount of dark yellow urine was visible. On 08/22/23 at 09:34AM R25 slept in the same position with urine pooled in his catheter next to his groin. On 08/23/23 at 02:05PM, Administrative Nurse D and Licensed Nurse (LN) I completed catheter care on R25 and prepped him for peri-care by turning him onto his left side. The urinary collection bag was removed from the right-side bed frame and held over him to be placed on the left side on him. This resulted in pooled urine in the catheter tubing getting flushed back into body. On 08/24/23 at 01:30PM, Certified Nurse's Aide (CNA) M stated R25's urinary collection bag and tubing were to be positioned below his bladder. She stated staff were to check and empty the collection bag twice a shift. She stated urine should flow downward into the bag and not remain in the tubing.	F 690			

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F 690	Continued From page 39 On 08/24/23 at 01:44PM, LN H reported staff were to ensure the catheter bag was stored below the bladder, with a privacy bag, and away from the door to the room. She stated urine should not be pooled in the tubing due to the risk of back-flow and infections. She stated if pooled urine was in the tubing staff could flush the catheter to ensure contaminants were pushed down in the bag. On 08/24/23 at 02:44PM Administrative Nurse E reported the facility holds frequent in-service training on proper catheter care, hand hygiene, and infection prevention. She stated the urinary collection bag should be maintained below the bladder to prevent urine from reentering the body and being an infection risk. On 08/24/23 at 03:19PM Administrator Nurse D reported staff were to inspect R25's indwelling catheter and collection bag every two hours. She stated the collection bag should be a privacy cover and be stored below the bladder of the resident. A review of the facility's "Indwelling Urinary Catheter" policy revised 08/2023 instructed that catheter care must be provided every shift and as needed every day. The policy indicated that the administration of a catheter may be applied by the facility to assist with wound healing for residents that may have sacral or perineal wounds. The facility failed to provide appropriate urinary catheter care and placement to prevent back flow and to promote dignity for R25. This deficient practice placed R25 at risk for catheter related complications.	F 690			

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F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: The facility identified a census of 33 residents. The sample included 12 residents with one resident reviewed for dialysis (blood purifying treatment given when kidney function is not optimum). Based on observation, interview, and record review, the facility failed to assess and document arteriovenous (AV-a surgically created connection between artery and a vein used for hemodialysis) fistula for infection or bleeding every day and failed to obtain communication from the dialysis center and assess post dialysis for Resident (R) 81. This deficient practice placed R81 at risk for complications related to dialysis. Findings included: - R81's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of chronic kidney disease (CKD - damaged kidneys and unable to filter blood the way they should), diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), and major depressive disorder (major mood disorder). The "Admission Minimum Data Set" (MDS) was in progress for R81. R81's "Care Area Assessment" (CAA) was not	F 698			

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F 698	Continued From page 41 completed. R81's "Baseline Care Plan" dated 08/07/23 documented and directed staff to monitor/document shunt (fistula) site for abnormal bleeding or signs/symptoms of infection. Review of the EMR under "Orders" tab revealed a physician order: Resident was to go to hemodialysis Monday, Wednesday, and Friday dated 08/15/23. Review of the EMR for R81's dialysis communication sheets from 08/05/23 to 08/23/23 revealed one dialysis communication sheet scanned under "Misc" tab dated 08/18/23. The facility provided dialysis communication sheets dated 08/16/23, 08/21/23, and 08/23/23 which lacked a signature from the dialysis center. The facility was unable to provide dialysis communication sheets for the four following dates: 08/07/23, 08/09/23, 08/11/23, and 08/14/23. The clinical record lacked documentation of verbal or writing communication was obtained from the dialysis center. R81's clinical record lacked evidence staff routinely assessed R81's fistula site. On 08/23/23 at 08:06 AM R81 sat dressed in her wheelchair next to her bed. On 08/24/23 at 01:57 PM Certified Nurse Aide (CNA) M stated the nurse usually obtained R81's vital signs and completed her assessment prior to dialysis. On 08/24/23 at 02:19 PM Licensed Nurse (LN) H	F 698			

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F 698	Continued From page 42 stated nursing would fill out R81's dialysis communication sheet and send it with her to the dialysis center. LN H stated the nurse would review the dialysis communication upon return to the facility. LN H stated the nurse should call if R81 returned without the communication sheet or if the communication sheet was blank for a verbal report from the dialysis center and document that report in the clinical record. LN H stated the assessment of the fistula site should be documented in the progress notes daily. On 08/24/23 at 03:19 PM Administrative Nurse D stated a communication sheet should be sent with R81 when she was sent to the dialysis center and reviewed upon her return from dialysis. Administrative Nurse D stated she would except the nurse to call the dialysis center if the communication was returned unfilled out or not returned to get a verbal report from the dialysis center and document that conversation in the clinical record. The facility's "Care for a Resident with dialysis" policy last revised 05/2021 documented Residents with end-stage renal disease (ESRD) will be cared for according to currently recognized standards of care. The type of assessment data that is to be gathered about the resident's condition on a daily or per shift basis, the care of grafts and fistulas. Communication between the community and the dialysis facility shall contain: Information of medication was administered not according to orders or plan of care; new orders and results of labs; current vital signs and weights; nutritional and fluid management, including residents compliance with diet, during and /or after dialysis; response to dialysis and any behaviors which may impede the treatment;	F 698			

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F 698	Continued From page 43 changes or declines in condition unrelated to dialysis and recommendations for monitoring; concerns for vascular access site; and concerns and risks regarding transport to dialysis. The facility's "End-Stage Renal Disease, Documentation Pre and Post Dialysis" policy last revised 07/2017 documented documentation of residents with end-stage renal disease (ESRD), receiving dialysis would be standard. The facility failed to obtain communication from the dialysis center regarding health status with each procedure and further failed to document daily assessment of R81's dialysis access site. This deficient practice placed R81 at risk for complication related to dialysis.	F 698			
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:	F 725			

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F 725	Continued From page 44 (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: The facility identified a census of 33 residents. The sample included 12 residents. Based on observations, record reviews, and interviews, the facility failed to ensure there was a sufficient number of nursing staff to provide care and to respond to each resident's basic needs and individual needs. This deficient practice had the potential for physical or psychosocial harm. Findings included: - The "Payroll Based Journal" (PBJ) report provided by the Centers for Medicare and Medicaid Services (CMS) for FY 2023 Quarter one documented the facility had one star staffing. The facility had posted scheduled smoking times for residents at 09:30 AM, 01:30 PM, 05:30 PM, and 07:30 PM. On 08/22/23 at 10:11 AM R 24 stated that staff were slow when offering smoke breaks and she always had to wait on a staff member to be available to take residents out to smoke. On 08/23/23 at 01:04 PM R24 voiced during an interview with Resident Council members that the facility a lot of times did not have an aide assigned for the scheduled smoking times so the	F 725			

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F 725	Continued From page 45 residents would often have to wait for a staff member or sometimes would not get their scheduled smoke break. An observation on 08/23/23 at 11:41 AM of R5's call light revealed her call light was on for 24 minutes before staff entered her room to assist the resident to get out of bed to be taken to the bathroom. An observation on 08/23/23 at 01:04 PM R5's call light had been on for 16 minutes when Certified Medication Aide (CMA) R entered R5's room to give medications and exited room and told resident an aide would be there soon to assist her. At 01:25 PM an unidentified staff member entered R5's room to assist the resident after her call light had been on for over 35 minutes. On 08/23/23 at 01:04 PM in a private interview with Resident Council members, a member reported the facility did not always provide mail services for the residents on Saturdays. The council member reported that there was not a staff member on Saturdays that passed out mail unless the activity person worked that day. On 08/24/23 at 01:57 PM Certified Nurse Aide (CNA) M stated she did work weekends occasionally. CNA M stated mail did get delivered to the facility on Saturdays, but the mail was not always delivered to the residents unless one of the staff members had time to pass the mail out. On 08/24/23 at 01:57 PM Certified Nurse Aide (CNA) M stated the aides would take turns during the day to take the residents that smoked outside for the scheduled smoke breaks. CNA M stated that at times yes the residents might have to wait	F 725			

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F 725	Continued From page 46 a while for an available person to take them outside. CNA M stated call lights should be answered within five minutes but should never take more than 15 minutes to be answered. CNA M stated usually on the weekends residents would watch movies or listen to music. CNA M stated the residents usually would start the movie themselves. CNA M stated the facility did have a few activity boards or blankets for the residents with cognitive impairment. On 08/24/23 at 02:18 PM Licensed Nurse (LN) H stated there was scheduled times for the smoke breaks and usually an aide would take the residents outside for those times. LN H stated it should take no more than 10 to 15 minutes to answer a residents call light. LN H stated she would expect staff to answer a call light promptly. LN H stated the facility currently did not have an activity director, so weekend activities were basically whatever the residents wanted to do like watch tv, play cards, or games. LN H stated the facility had a blanket or something like that with little activity things on it to let the cognitively impaired residents use. LN H stated there was no staff-initiated activities on the weekend. On 08/24/23 at 03:19 PM Administrative Nurse D stated either an aide or a nurse could take the residents outside for their scheduled smoke breaks. Administrative Nurse D stated at times the residents would have to wait until a staff member was available to be taken outside. Administrative Nurse D stated she would not expect a resident to have to wait more than 15 minutes for a residents call light to be answered. Administrative Nurse D stated that weekend activities were resident's choice which was generally movies or games that the residents	F 725			

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F 725	Continued From page 47 would initiate themselves. Administrative Nurse D stated the facility's activity director left at the beginning of the month but when she was here, she would come in on some weekends to do activities with the residents. Administrative Nurse D stated she was not certain what activities staff provided on weekends for the residents that were cognitively impaired. The facility policy "Nursing Services" last revised October 2022 documented: The community provided adequate staffing with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. The facility failed to ensure there was a sufficient number of nursing staff to provide care and to respond to each resident's individual needs. This deficient practice had the potential for physical or psychosocial harm.	F 725			
F 727 SS=F	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve	F 727			

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F 727	Continued From page 48 as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: The facility identified a census of 33 residents. The sample included 12 residents. Based on observation, record review and interview, the facility failed to ensure that there was a registered nurse (RN) on staff for at least eight consecutive hours, seven days a week. This deficiency had the potential for poor quality of care and negative outcomes for the residents. Findings included: - Review of the facility daily staffing sheets and actual working schedule from 04/01/22 to 12/31/22 and 04/01/23 to 08/24/23 revealed the facility did not provide proof of having eight consecutive hours of RN coverage on 48 days during that period. The facility failed to provide proof of eight consecutive RN hours on the following weekend dates from 04/01/22 to 06/30/22: (04/24/22, 05/01/22, 05/07/23, 05/21/22, 05/22/22, 06/05/22, 06/25, and 06/26/22). The facility failed to provide proof of eight consecutive RN hours on the following weekend dates from 07/01/22 to 09/30/22: (07/09/22, 07/10/22, 07/16/22/22, 07/30/22, 08/13/22, 08/14/22, 08/27/22, 09/05/22, 09/24/22, and 09/25/22). The facility failed to provide proof of eight consecutive RN hours on the following weekend dates from 10/01/22 to 12/31/22: (10/15/22, 11/13/22, 11/24/22, 12/03/22, 12/04/22, 12/24/22,	F 727			

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F 727	Continued From page 49 and 12/25/22). The facility failed to provide proof of eight consecutive RN hours on the following dates from 04/01/23 to 08/23/23: (4/9/23, 5/6/23, 5/7/23, 5/20/23, 6/21/23, 6/3/23, 6/4/23, and 6/17/23). On 08/23/23 at 11:30 AM, Administrative Staff A stated that on most days listed above the facility did not have any RN coverage until Administrative Nurse D started about a year ago. Administrative Staff A stated after Administrative Nurse D started, she would cover the RN hours on the weekend or one of the as needed RN staff nurse would work. Administrative Staff A stated she had no proof Administrative Nurse D hours that she had worked due to the fact that she was a salaried employee and had no clock times logged anywhere. Administrative Staff A stated she would have to speak with the corporate office to figure out a way that Administrative Nurse D's hours could be logged. On 08/24/23 at 03:11PM Administrative Nurse D stated when she first started about a year ago there had been some days where there was no RN coverage. Administrative Nurse D stated on some of the weekends she has had to cover but had not clock in/clock out times for those days because she was a salary employee. Administrative Nurse D stated during the week an as needed RN staff member would work to cover RN hours. The facility policy "Registered Nurse, Director of Nursing Services" last revised 09/22 documented: Except when waived, the community will staff an RN, for at least eight consecutive hours, seven days a week, unless	F 727			

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F 727	Continued From page 50 during the establishment and review of the Facility Assessment, it is deemed that the community requires additional hours based upon acuity. The director of nursing may serve as the charge nurse only when the facility had an average daily occupancy of 60 or fewer residents. The facility failed to ensure there was an RN on staff for at least eight consecutive hours, seven days a week. This deficient practice had the potential for poor quality of care and negative outcomes for the residents.	F 727			
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist 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	F 756			

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F 756	Continued From page 51 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 33 residents. The sample included 12 residents with five residents reviewed for unnecessary medications. Based on observation, record review, and interviews, the facility failed to ensure the Consultant Pharmacist (CP) identified and reported irregularities regarding lack of dosing instructions for Voltaren (topical pain reliever medication) gel for Resident (R) 80, no duration for as-needed psychotropic (alters mood or thought) medication for R80 and R81. The CP also did not identify medication administered outside the physician ordered parameters for antihypertensive (class of medication used to treat hypertension (high blood pressure) medications for R9. This deficient practice had the risk for unnecessary medication use and physical complications for the affected residents. Findings included: - R80's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of	F 756			

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F 756	Continued From page 52 anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear) disorder, bipolar disorder (major mental illness that caused people to have episodes of severe high and low moods), and major depressive disorder (major mood disorder). The "Admission Minimum Data Set" (MDS) was in progress for R80. R80's "Care Area Assessment" (CAA) was not completed. R80's "Baseline Care Plan" dated 07/26/23 documented staff would administer medications as ordered and directed to monitor/document for side effects and effectiveness. Review of the EMR under "Orders" tab revealed the following physician orders: Benadryl (antihistamine with sedative effects) allergy oral tablet 25 milligrams (mg) give 25 mg by mouth every eight hours as needed for itching dated 07/25/23. The order lacked a stop date. Lorazepam (antianxiety medication) oral tablet 0.5mg give 0.5 mg by mouth every eight hours as needed for increased anxiety related to anxiety disorder dated 07/31/23. The order lacked a stop date. Diclofenac sodium external gel (Voltaren) one percent (%) (topical) apply to back topically two times a day for pain dated 07/31/23. The order lacked a dose. Review of the "Monthly Medication Review" (MMR) for August 2023 that were scanned into the EMR lacked evidence of notification of as needed psychotropic medication duration and for a lack of dosing instructions for Voltaren.	F 756			

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F 756	Continued From page 53 On 08/23/23at 02:15 PM R80 laid on the bed with her eyes closed. The blankets were pulled up to chest height and the TV was on in the room. On 08/24/23 at 02:19 PM Licensed Nurse (LN) H stated every medication should have dosage for administration. LN H stated Voltaren had a paper dosing sheet that came with the medication to administer the medication. LN H stated she did not work with the MMRs from the pharmacy; the director of nursing took care of that monthly. LN H stated every as needed medication was discontinued every 60 or 90 days if not used, so any as needed psychotropic medications would be discontinued at that time. On 08/24/23 at 03:19 PM Administrative Nurse D stated as needed psychotropic medication should have a 14-day duration unless ordered by the physician. Administrative Nurse D stated some of the physicians would order "no stop date," but not a specific duration for any residents who are receiving hospice per her request. Administrative Nurse D stated the physician had not documented the rationale for the "no stop date" and that did not meet the regulation for the use of as needed psychotropic medication. Administrative Nurse D stated the pharmacy would email her the MMR every month and she printed the reports and had the physician review them and she made any changes to the orders. Administrative Nurse D stated all medication should have dosage for administration. Administrative Nurse D stated Voltren should have the amount of gel that was to be applied. The facility's "Medication Regimen Reviews" policy last revised November/2016 documented	F 756			

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F 756	Continued From page 54 the CP would review the medication regimen per state and federal guidelines. Reporting of "irregularities" to the attending physician, the facility medical director and the director of nursing. Rationale for no change based upon the reported irregularities. 4. A review of the resident 's with as needed (PRN) psychotropic medications for a documented diagnoses specific condition, and that they are limited to 14 days and if greater than 14 days the rationale for such listed in the medical record. A review of the residents with PRN (as needed) psychotropic medications for a documented diagnoses specific condition, and that they are limited to 14 days and if greater than 14 days the rationale for such listed in the medical record. Unnecessary drugs, as defined by CMS, are medications given: 1. In excessive dose (including duplicate therapy); or 2. In excessive duration; or 3. Without adequate monitoring; or 4. Without adequate indications for use; or 5. In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or 6. Any combination of the above. The facility failed to ensure the CP identified and reposted irregularities for a lack of dosing instructions for Voltaren gel and no duration for as needed psychotropic medication for R80. This deficient practice placed R80 at risk for unnecessary medication use, side effects and physical complications. - R81's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of chronic kidney disease (CKD - damaged kidneys and unable to filter blood the way they should), diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body	F 756			

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F 756	Continued From page 55 cannot respond to the insulin), and major depressive disorder (major mood disorder). The "Admission Minimum Data Set" (MDS) was in progress for R81. R81's "Care Area Assessment" (CAA) was not completed. R81's "Baseline Care Plan" dated 08/07/23 documented staff would administer medications as ordered and directed to monitor/document for side effects and effectiveness. Review of the EMR under "Orders" tab revealed physician orders: Trazodone hci oral tablet 50 milligrams (mg) give 50mg by mouth every 24 hours as needed for insomnia, may give at bedtime dated 08/04/23. The order lacked a stop date. Review of the "Monthly Medication Review" (MMR) for August 2023 that were scanned into the EMR lacked evidence of notification of as needed psychotropic medication with no stop date for R81. On 08/23/23 at 08:06 AM R81 sat dressed in her wheelchair next to her bed. On 08/24/23 at 02:19 PM Licensed Nurse (LN) H stated she did not work with the MMRs from the pharmacy; the director of nursing took care of that monthly. LN H stated every as needed medication was discontinued every 60 or 90 days if not used, so any as needed psychotropic medications would be discontinued at that time. On 08/24/23 at 03:19 PM Administrative Nurse D	F 756			

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F 756	Continued From page 56 stated as needed psychotropic medication should have a 14-day duration unless ordered by the physician. Administrative Nurse D stated some of the physicians would order "no stop date," but not a specific duration for any residents who are receiving hospice per her request. Administrative Nurse D stated the physician had not documented the rationale for the "no stop date" and that did not meet the regulation for the use of as needed psychotropic medication. Administrative Nurse D stated the pharmacy would email her the MMR every month and she printed the reports and had the physician review them and she made any changes to the orders. The facility's "Medication Regimen Reviews" policy last revised November/2016 documented the CP would review the medication regimen per state and federal guidelines. Reporting of "irregularities" to the attending physician, the facility medical director and the director of nursing. Rationale for no change based upon the reported irregularities. 4. A review of the resident 's with as needed (PRN) psychotropic medications for a documented diagnoses specific condition, and that they are limited to 14 days and if greater than 14 days the rationale for such listed in the medical record. A review of the residents with PRN (as needed) psychotropic medications for a documented diagnoses specific condition, and that they are limited to 14 days and if greater than 14 days the rationale for such listed in the medical record. Unnecessary drugs, as defined by CMS, are medications given: 1. In excessive dose (including duplicate therapy); or 2. In excessive duration; or 3. Without adequate monitoring; or 4. Without adequate indications for use; or 5. In the presence of adverse consequences which indicate the dose should be	F 756			

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F 756	Continued From page 57 reduced or discontinued; or 6. Any combination of the above. The facility failed to ensure the CP identified and reposted irregularities for no duration/stop date for as needed psychotropic medication for R81. This deficient practice placed R80 at risk for unnecessary medication use, side effects and physical complications. - R9's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of hemiplegia (paralysis of one side of the body), hemiparesis (muscular weakness of one half of the body), diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), hypertension (elevated blood pressure) and cerebrovascular accident (CVA-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). The "Annual Minimum Data Set" (MDS) dated 01/10/23 documented a Brief Interview of Mental Status (BIMS) score of 14 which indicated intact cognition. The MDS documented that R9 required extensive assistance of one staff member for activities of daily living (ADL). The MDS documented R9 received insulin (medication to regulate blood sugar), diuretic (medication to promote the formation and excretion of urine), and antidepressant (class of medications used to treat mood disorders and relieve symptoms of depression) for seven days during look back period. The "Quarterly MDS" dated 06/07/23 documented a BIMS score of 13 which indicated intact	F 756			

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F 756	Continued From page 58 cognition. The MDS documented that R9 required extensive assistance of two staff members assistance for ADL. The MDS documented R9 received insulin, antidepressant medication, and diuretic medication for seven days during look back period. R9's "Psychotropic Drug Use Care Area Assessment" (CAA) dated 02/03/23 documented R9 was at risk for potential injuries/complications related to the use of his psychoactive medications. R9's "Care Plan" dated 03/22/18 documented staff would educate R9 to adhere with current treatment regimen/medications and therapy. Review of the EMR under "Orders" tab revealed the following physician orders: Hemoglobin A1c (HbA1c-blood test used to evaluate the level of glucose control over the past 90 days) in March and September every year dated 07/13/20. Hydralazine hci tablet (antihypertensive) 50 milligrams (mg) give one tablet by mouth three times a day for uncontrolled hypertension. Hold if systolic blood pressure (SBP-relating to the phase of the heartbeat when the heart muscle contracts and pumps blood from the chambers into the arteries) was less than (<) 110mmHg. Notify physician if SBP greater than (>) 160mmHg or pulse < 60 heart beats dated 06/19/23. Review of the EMR under the "Reports" tab "Medication Administration Record" (MAR) from 05/01/23 thru 06/30/23 (61 days). Hydralazine was given outside physician ordered parameters	F 756			

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F 756	Continued From page 59 11 times on the following dates: 05/06/23, 05/12/23, 05/17/23, 05/27/23, 05/31/23, 06/03/23, 06/07/23, 06/14/23, 06/22/23, 06/26/23, and 06/28/23. The clinical record lacked documentation the physician was notified of SBP > 160mmHg. Review of the "Monthly Medication Review" (MMR) for August 2022 to August 2023 that were scanned into the EMR lacked evidence of notification of Hydralazine given outside the physician ordered parameters. MRR for May 2023 noted irregularity of HbA1c was not updated in R9's clinical record. The facility disregarded the recommendation and reported HbA1c would be obtained in September. Review of the clinical revealed last HbA1c scanned into EMR under "Misc" tab was dated September/2022. On 08/23/23 at 08:08 AM R9 sat in his wheelchair at the dining room table. R9 ate breakfast without assistance, using his left hand. R9 had scrambled eggs on his shirt and along the sides of his wheelchair. R9's right hand rested on the right of his lap with his fingers curled downward toward the palm of his right hand. On 08/24/23 at 02:18 PM Licensed Nurse (LN) H stated some antihypertensive medication had physician ordered specific parameters. LN H stated she would notify the physician as ordered. LN H stated that notification would be documented in the clinical record. LN H stated she did not work with the MMRs from the pharmacy; the director of nursing took care of that monthly.	F 756			

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F 756	Continued From page 60 On 08/24/23 at 03:19 PM Administrative Nurse D stated the pharmacy would email her the MMR every month and she printed the reports and had the physician review them and she made any changes to the orders. Administrative Nurse D stated she expected the nurses to follow the physician ordered parameters. Administrative Nurse D stated that would be documented in the clinical record. The facility's "Medication Regimen Reviews" policy last revised November/2016 documented the CP would review the medication regimen per state and federal guidelines. Reporting of "irregularities" to the attending physician, the facility medical director and the director of nursing. Rationale for no change based upon the reported irregularities. 4. A review of the resident 's with as needed (PRN) psychotropic medications for a documented diagnoses specific condition, and that they are limited to 14 days and if greater than 14 days the rationale for such listed in the medical record. A review of the residents with PRN (as needed) psychotropic medications for a documented diagnoses specific condition, and that they are limited to 14 days and if greater than 14 days the rationale for such listed in the medical record. Unnecessary drugs, as defined by CMS, are medications given: 1. In excessive dose (including duplicate therapy); or 2. In excessive duration; or 3. Without adequate monitoring; or 4. Without adequate indications for use; or 5. In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or 6. Any combination of the above. The facility failed to ensure the CP identified and reposted irregularities for medications given	F 756			

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F 756	Continued From page 61 outside the physician ordered parameter. The facility also failed to follow the CP recommendation related to physician ordered laboratory test for R9. This deficient practice placed R9 at risk for unnecessary medication use, side effects and physical complications.	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 §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 33 residents. The sample included 12 residents with five residents reviewed for unnecessary medications. Based on observation, record review, and interviews, the facility failed to ensure dosing	F 757			

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F 757	Continued From page 62 instructions for Voltaren (topical pain reliever medication) gel for Resident (R) 80. The facility also failed to identify medication administered outside the physician ordered parameters for antihypertensive (class of medication used to treat hypertension (high blood pressure) medications for R9 and the lack of monitoring antihypertensive medication as physician ordered for R2. This deficient practice had the risk for unnecessary medication use and physical complications for the affected residents. Findings included: - R80's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear) disorder, bipolar disorder (major mental illness that caused people to have episodes of severe high and low moods), and major depressive disorder (major mood disorder). The "Admission Minimum Data Set" (MDS) was in progress for R80. R80's "Care Area Assessment" (CAA) was not completed. R80's "Baseline Care Plan" dated 07/26/23 documented staff would administer medications as ordered and directed to monitor/document for side effects and effectiveness. Review of the EMR under "Orders" tab revealed the following physician orders: Diclofenac sodium external gel (Voltaren) one percent (%) (topical) apply to back topically two times a day for pain dated 07/31/23. The order	F 757			

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F 757	Continued From page 63 lacked a dose. On 08/23/23at 02:15 PM R80 laid on the bed with her eyes closed. The blankets were pulled up to chest height and the TV was on in the room. On 08/24/23 at 02:19 PM Licensed Nurse (LN) H stated every medication should have dosage for administration. LN H stated Voltaren had a paper dosing sheet that came with the medication to administer the medication. On 08/24/23 at 03:19 PM Administrative Nurse D stated all medication should have dosage for administration. Administrative Nurse D stated Voltren should have the amount of gel that was to be applied. The facility's "Psychotropic Drug Use F757 F758" policy last revised October/2022 documented an unnecessary drug was any drug used in an excessive dose, including duplicative therapy or for excessive duration, or without adequate monitoring or without adequate indications for its use or in the presence of adverse consequences which indicated the dose should be reduced or discontinued or any combination of the reasons above. Physician orders would include diagnosis; condition or symptoms for what is being ordered; and dose. The facility failed to ensure dosing instructions for Voltaren gel for R80. This deficient practice placed R80 at risk for unnecessary medication use, side effects and physical complications. - R9's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of	F 757			

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F 757	Continued From page 64 hemiplegia (paralysis of one side of the body), hemiparesis (muscular weakness of one half of the body), diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), hypertension (elevated blood pressure) and cerebrovascular accident (CVA-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). The "Annual Minimum Data Set" (MDS) dated 01/10/23 documented a Brief Interview of Mental Status (BIMS) score of 14 which indicated intact cognition. The MDS documented that R9 required extensive assistance of one staff member for activities of daily living (ADL). The MDS documented R9 received insulin (medication to regulate blood sugar), diuretic (medication to promote the formation and excretion of urine), and antidepressant (class of medications used to treat mood disorders and relieve symptoms of depression) for seven days during look back period. The "Quarterly MDS" dated 06/07/23 documented a BIMS score of 13 which indicated intact cognition. The MDS documented that R9 required extensive assistance of two staff members assistance for ADL. The MDS documented R9 received insulin, antidepressant medication, and diuretic medication for seven days during look back period. R9's "Psychotropic Drug Use Care Area Assessment" (CAA) dated 02/03/23 documented R9 was at risk for potential injuries/complications related to the use of his psychoactive medications.	F 757			

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F 757	Continued From page 65 R9's "Care Plan" dated 03/22/18 documented staff would educate R9 to adhere with current treatment regimen/medications and therapy. Review of the EMR under "Orders" tab revealed the following physician orders: Hemoglobin A1c (HbA1c-blood test used to evaluate the level of glucose control over the past 90 days) in March and September every year dated 07/13/20. Hydralazine hci tablet (antihypertensive) 50 milligrams (mg) give one tablet by mouth three times a day for uncontrolled hypertension. Hold if systolic blood pressure (SBP-relating to the phase of the heartbeat when the heart muscle contracts and pumps blood from the chambers into the arteries) was less than (<) 110mmHg. Notify physician if SBP greater than (>) 160mmHg or pulse < 60 heart beats dated 06/19/23. Review of the EMR under the "Reports" tab "Medication Administration Record" (MAR) from 05/01/23 thru 06/30/23 (61 days). Hydralazine was given outside physician ordered parameters 11 times on the following dates: 05/06/23, 05/12/23, 05/17/23, 05/27/23, 05/31/23, 06/03/23, 06/07/23, 06/14/23, 06/22/23, 06/26/23, and 06/28/23. The clinical record lacked documentation the physician was notified of SBP > 160mmHg. The facility failed obtain HbA1c as ordered in March. Review of the clinical revealed last HbA1c scanned into EMR under "Misc" tab was dated September/2022. On 08/23/23 at 08:08 AM R9 sat in his wheelchair	F 757			

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F 757	Continued From page 66 at the dining room table. R9 ate breakfast without assistance, using his left hand. R9 had scrambled eggs on his shirt and along the sides of his wheelchair. R9's right hand rested on the right of his lab with his fingers curled downward toward the palm of his right hand. On 08/24/23 at 02:18 PM Licensed Nurse (LN) H stated some antihypertensive medication had physician ordered specific parameters. LN H stated she would notify the physician as ordered. LN H stated that notification would be documented in the clinical record. LN H stated she did not work with the MMRs from the pharmacy; the director of nursing took care of that monthly. On 08/24/23 at 03:19 PM Administrative Nurse D stated the pharmacy would email her the MMR every month and she printed the reports and had the physician review them and she made any changes to the orders. Administrative Nurse D stated she expected the nurses to follow the physician ordered parameters. Administrative Nurse D stated that would be documented in the clinical record. The facility's "Psychotropic Drug Use F757 F758" policy last revised October/2022 documented residents would only receive antipsychotic and psychotropic medications when necessary to treat specific conditions for which they are indicated and effective and would not be used for discipline or convenience of the staff. An unnecessary drug was any drug used in an excessive dose, including duplicative therapy or for excessive duration, or without adequate monitoring or without adequate indications for its use or in the presence of adverse consequences	F 757			

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F 757	Continued From page 67 which indicated the dose should be reduced or discontinued or any combination of the reasons above. Physician orders would include diagnosis; condition or symptoms for what is being ordered; and dose. Review of the medication regime for all types of medications and apply appropriate clinical indications, monitoring and documentation, if being used as a substitution for another psychotropic medication rather than for the original approved indication. The facility failed to ensure the physician was notified of out parameter SBP as ordered by the physician. The facility also failed to follow the physician ordered laboratory test for R9. This deficient practice placed R9 at risk for unnecessary medication use, side effects and physical complications. - The "Diagnoses" tab of R2's Electronic Medical Record (EMR) documented diagnoses of congestive heart failure (CHF - a condition with low heart output and the body becomes congested with fluid), and essential hypertension (elevated blood pressure). The "Admission Minimum Data Set (MDS)" dated 03/01/23, documented R2 had a Brief Interview for Mental Status (BIMS) score of two which indicated severe cognitive impairment. The MDS further documented R2 required limited assistance of one staff member for bed mobility, transfers, locomotion on and off the unit, and dressing. He required extensive assistance of one staff member for eating, toileting, and personal hygiene. The "Cognitive Loss / Dementia Care Area Assessment (CAA)" dated 03/01/23, documented	F 757			

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F 757	Continued From page 68 R2 had a diagnosis of mild intellectual disability. The "Care Plan" with an intervention dated 03/06/23, directed staff to give anti-hypertensive medications as ordered, monitor for side effects such as orthostatic hypotension (blood pressure dropping with change of position), increased heart rate and effectiveness. The "Orders" tab of R2's EMR documented an order with a start date of 06/27/23 for metoprolol succinate (antihypertensive medication) 25 milligrams (mg) one time a day for hypertension. The order directed staff 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 110 millimeters of mercury (mmHg), or a pulse less than 60 beats per minute (BPM) and to notify the doctor if the dose was held. Review of R2's "Medication Administration Record (MAR)" for 06/27/23 to 08/23/23 lacked documentation that a blood pressure or pulse were taken prior to administration of metoprolol. Review of R2's EMR under the "Vitals" tab for 06/27/23 to 08/23/23 lacked evidence that a blood pressure and pulse was monitored prior to the administration of metoprolol on the following days (35): 06/27/23, 06/28/23, 06/30/23, 07/01/23, 07/02/23, 07/03/23, 07/05/23, 07/07/23, 07/09/23, 07/10/23, 07/12/23, 07/14/23, 07/16/23, 07/17/23, 07/19/23, 07/21/23, 07/27/23, 07/30/23, 07/31/23, 08/02/23, 08/03/23, 08/04/23, 08/05/23, 08/06/23, 08/07/23, 08/09/23, 08/10/23, 08/11/23, 08/12/23, 08/13/23, 08/14/23, 08/16/23, 08/17/23, 08/18/23, and 08/21/23.	F 757			

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F 757	Continued From page 69 On 08/23/23 at 10:36 AM R2 sat in his wheelchair in front of the nurse's station. On 08/24/23 at 02:18 PM Licensed Nurse (LN) H stated before administering a medication like metoprolol, staff would be directed to enter the resident's vitals and that documentation could be found on the MAR/Treatment Administration Record (TAR) and it would automatically be pulled into the vital sign section. She stated that staff must enter the blood pressure and pulse for that medication. On 08/24/23 at 03:18 PM Administrative Nurse D stated pulse and blood pressure documentation could be found on the MAR/TAR during administration and that blood pressure and pulse would show up along with the staff members initials. The facility's "Psychotropic Drug Use F757 F758" policy last revised October/2022 documented an unnecessary drug was any drug used in an excessive dose, including duplicative therapy or for excessive duration, or without adequate monitoring or without adequate indications for its use or in the presence of adverse consequences which indicated the dose should be reduced or discontinued or any combination of the reasons above. Physician orders would include diagnosis; condition or symptoms for what is being ordered; and dose. The facility failed to ensure ordered parameters were followed for R2's antihypertensive medication. This deficient practice had the risk for physical complications and unnecessary medication usage.	F 757			

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F 758	Continued From page 70	F 758			
F 758	Free from Unnec Psychotropic Meds/PRN Use	F 758			
SS=D	CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented 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				

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F 758	Continued From page 71 prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. \$483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: The facility identified a census of 33 residents. The sample included 12 residents with five residents reviewed unnecessary medications. Based on observation, record review, and interviews, the facility failed to provide a 14-day stop date, intended duration of therapy, and rationale for extended use related to Resident (R)24 and R80's PRN (given as needed) lorazepam (antianxiety medication that calms and relaxes people with excessive anxiety, nervousness, or tension) medication and R81's PRN trazodone (antidepressant medications used to treat mood disorders and relieve symptoms of depression) medication. This deficient practice placed the residents at risk for ineffective treatment and unnecessary side effects. Findings included: - R24's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of respiratory failure, heart failure, type two diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), chronic obstructive pulmonary disorder (progressive and irreversible condition	F 758			

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F 758	Continued From page 72 characterized by diminished lung capacity and difficulty or discomfort in breathing), muscle weakness, major depressive disorder (major mood disorder), anxiety disorder (progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), and diabetic neuropathy (pain due to nerve damage caused by diabetes). R24's "Quarterly Minimum Data Set" completed 05/10/23 noted a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. The MDS indicated she was independent with all her activities of daily living (ADLs) except bathing and required limited assistance from one staff. The MDS indicated she was on hospice services. The MDS noted she was taking an antianxiety medication. R24's "Psychotropic Medication Care Area Assessment (CAA)" completed 02/06/23 indicated she was at risk for potential complication related to her medications. The CAA noted she received hospice services and was at risk for depression and anxiety. The CAA noted she was at risk for potential side effects and encouraged staff to monitor for physical and behavioral changes. The CAA instructed staff to cooperate with hospice service to ensure continuity of care. R24's "Care Plan" initiated 08/03/23 indicated she was at risk for adverse reactions related to black box warnings associated with her medications. The plan noted she was taking lorazepam and at risk for physical dependance, withdraw, sedation with other medications, coma, and death. R24's EMR under "Physician's Orders" revealed	F 758			

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F 758	Continued From page 73 an active order dated 05/03/23 for staff to administer one milligram (mg) of lorazepam oral concentrated every four hours as needed for restlessness and anxiety. The order lacked a 14-day stop date or duration of use. R24's EMR revealed another active order dated 07/27/23 for staff to administer 0.5mg of lorazepam (one tablet) every for hours as needed for restlessness and anxiety. The order lacked a 14-day stop date or duration of use. A "Consultation Report" completed 05/12/23 indicated the Consulting Pharmacist (CP) noted R24's lorazepam PRN medication required a stop or intended duration of therapy, condition being treated, and rationale for the extended time of the medication. The medical provider responded to the recommendation on 05/30/34 and stated R24 was on hospice services and required the medication for end-of-life care but failed to document a specified duration as required. The facility could not provide documentation for R24's PRN lorazepam medication indicating the intended duration of therapy, or a 14-day stop date as requested on 08/24/23. On 08/24/23 at 02:18PM Administrative Nurse E stated PRN psychotropic medications usually required a 14-day period to stop but she was not sure if R24 being on hospice would be different from normal orders. She stated hospice worked with the facility to ensure the medication and orders were provided for her care. She stated hospice would often send the orders to the pharmacy before the facility had a chance to review them.	F 758			

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F 758	Continued From page 74 On 08/24/23 at 08/24/23 Administrative Nurse D stated she reviewed the pharmacy reports and worked with the medical provider to make the changes as necessary. She reported R24 was on hospice and her lorazepam order should be covered by her hospice therapy but not sure about the duration requirements. A review of the facility's "Psychotropic Drug Use" policy dated revised 10/2022 indicated PRN antianxiety medications should be limited to 14 days. The policy indicated the medications would not be continued unless the medical provider evaluates the appropriateness of the medication. The facility failed to provide a 14-day stop date, intended duration of therapy, and rationale for extended use for R24's PRN lorazepam medication. This deficient practice placed the residents at risk for unnecessary side effects. - R80's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear) disorder, bipolar disorder (major mental illness that caused people to have episodes of severe high and low moods), and major depressive disorder (major mood disorder). The "Admission Minimum Data Set" (MDS) was in progress for R80. R80's "Care Area Assessment" (CAA) was not completed. R80's "Baseline Care Plan" dated 07/26/23 documented staff would administer medications as ordered and directed to monitor/document for	F 758			

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F 758	Continued From page 75 side effects and effectiveness. Review of the EMR under "Orders" tab revealed the following physician orders: Benadryl (antihistamine with sedative effects) allergy oral tablet 25 milligrams (mg) give 25 mg by mouth every eight hours as needed for itching dated 07/25/23. The order lacked a stop date. Lorazepam (antianxiety medication) oral tablet 0.5mg give 0.5 mg by mouth every eight hours as needed for increased anxiety related to anxiety disorder dated 07/31/23. The order lacked a stop date. On 08/23/23at 02:15 PM R80 laid on the bed with her eyes closed. The blankets were pulled up to chest height and the TV was on in the room. On 08/24/23 at 02:19 PM Licensed Nurse (LN) H stated every as needed medication was discontinued every 60 or 90 days if not used, so any as needed psychotropic medications would be discontinued at that time. On 08/24/23 at 03:19 PM Administrative Nurse D stated as needed psychotropic medication should have a 14-day duration unless ordered by the physician. Administrative Nurse D stated some of the physicians would order "no stop date," but not a specific duration for any residents who are receiving hospice per her request. Administrative Nurse D stated the physician had not documented the rationale for the "no stop date" and that did not meet the regulation for the use of as needed psychotropic medication. The facility's "Psychotropic Drug Use F757 F758" policy last revised October/2022 documented	F 758			

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F 758	Continued From page 76 residents would only receive antipsychotic and psychotropic medications when necessary to treat specific conditions for which they are indicated and effective and would not be used for discipline or convenience of the staff. An unnecessary drug was any drug used in an excessive dose, including duplicative therapy or for excessive duration, or without adequate monitoring or without adequate indications for its use or in the presence of adverse consequences which indicated the dose should be reduced or discontinued or any combination of the reasons above. Physician orders would include diagnosis; condition or symptoms for what is being ordered; and dose. Review of the medication regime for all types of medications and apply appropriate clinical indications, monitoring and documentation, if being used as a substitution for another psychotropic medication rather than for the original approved indication. The facility failed to ensure as needed psychotropic medication for R80 had an indicated duration of use/stop date. This deficient practice placed R80 at risk for unnecessary medication use, side effects and physical complications. - R81's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of chronic kidney disease (CKD - damaged kidneys and unable to filter blood the way they should), diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), and major depressive disorder (major mood disorder). The "Admission Minimum Data Set" (MDS) was in progress for R81.	F 758			

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F 758	Continued From page 77 R81's "Care Area Assessment" (CAA) was not completed. R81's "Baseline Care Plan" dated 08/07/23 documented staff would administer medications as ordered and directed to monitor/document for side effects and effectiveness. Review of the EMR under "Orders" tab revealed physician orders: Trazodone hci oral tablet 50 milligrams (mg) give 50mg by mouth every 24 hours as needed for insomnia, may give at bedtime dated 08/04/23. The order lacked a stop date. On 08/23/23 at 08:06 AM R81 sat dressed in her wheelchair next to her bed. On 08/24/23 at 02:19 PM Licensed Nurse (LN) H stated every as needed medication was discontinued every 60 or 90 days if not used, so any as needed psychotropic medications would be discontinued at that time. On 08/24/23 at 03:19 PM Administrative Nurse D stated as needed psychotropic medication should have a 14-day duration unless ordered by the physician. Administrative Nurse D stated some of the physicians would order "no stop date," but not a specific duration for any residents who are receiving hospice per her request. Administrative Nurse D stated the physician had not documented the rationale for the "no stop date" and that did not meet the regulation for the use of as needed psychotropic medication. The facility's "Psychotropic Drug Use F757 F758" policy last revised October/2022 documented residents would only receive antipsychotic and	F 758			

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F 758	Continued From page 78 psychotropic medications when necessary to treat specific conditions for which they are indicated and effective and would not be used for discipline or convenience of the staff. An unnecessary drug was any drug used in an excessive dose, including duplicative therapy or for excessive duration, or without adequate monitoring or without adequate indications for its use or in the presence of adverse consequences which indicated the dose should be reduced or discontinued or any combination of the reasons above. Physician orders would include diagnosis; condition or symptoms for what is being ordered; and dose. Review of the medication regime for all types of medications and apply appropriate clinical indications, monitoring and documentation, if being used as a substitution for another psychotropic medication rather than for the original approved indication. The facility failed to ensure as needed psychotropic medication for R81 had an indicated duration of use/stop date. This deficient practice placed R81 at risk for unnecessary medication use, side effects and physical complications.	F 758			
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent	F 812			

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F 812	Continued From page 79 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 32 residents with one kitchen. Based on observation, record review, and interviews, the facility failed to maintain sanitary dietary standards related to storage of food and kitchenware. This deficient practice placed the residents at risk related to food borne illnesses and food safety concerns. Findings included: - On 08/22/23 at 07:21 AM an observation in the kitchen's dry food storage area revealed one opened bag of wheat bread. The bag was undated. On 08/22/23 at 07:22 AM an observation in the kitchen's dry food storage area revealed one opened bag of hamburger buns. The bag had a large hole torn in it exposing the hamburger buns to air and the bag was undated. On 08/22/23 at 07:23 AM an observation in the kitchen's dry food storage area revealed one opened bag of hotdog buns. The bag had a large hole torn in it exposing the hotdog buns to air and the bag was undated. On 08/22/23 at 07:24 AM an observation in the	F 812			

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F 812	Continued From page 80 kitchen's dry food storage area revealed one opened bag of tortilla chips. The bag was undated. On 08/22/23 at 07:33 AM an observation in the kitchen's dry food storage area revealed four plastic storage containers of noodles. The containers were not labeled or dated. On 08/22/23 at 07:36 AM an observation in the kitchen's refrigerator revealed one resealable bag with ham inside. The bag was not labeled or dated. On 08/22/23 at 07:37 AM an observation in the kitchen's refrigerator revealed one opened bag of sausage patties. The bag was not labeled or dated. On 08/22/23 at 07:37 AM an observation in the kitchen's refrigerator revealed one opened bag of country fried steaks. The bag was not labeled or dated. On 08/22/23 at 07:39 AM an observation in the kitchen's freezer revealed one resealable bag of French/Texas toast. The bag was not labeled or dated. On 08/22/23 at 07:40 AM an observation in the kitchen's freezer revealed one cup, with a plastic lid, of what Dietary BB stated was frozen puree strawberries. The cup was not labeled or dated. On 08/22/23 at 07:42 AM an observation in the kitchen's freezer revealed one box of frozen hamburger patties. The box was open to air and the meat was exposed.	F 812			

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F 812	Continued From page 81 On 08/22/23 at 07:43 AM an observation in the kitchen's freezer revealed one opened bag of frozen breakfast sandwiches. The bag was not labeled or dated. On 08/22/23 at 07:47 AM an observation in the kitchen's main area revealed two pans stored under a table not covered or inverted. On 08/22/23 at 07:48 AM an observation in the kitchen's main area revealed a stack of metal bowls and a stack of metal pots stored under a table. The pots and bowls were not covered or inverted. On 08/23/23 at 11:26 AM Dietary BB stated all opened food items, including those stored in plastic storage bins, should be labeled, and dated. She stated that she checks each day for items that have not been labeled or dated. She further stated she checks the menu for leftovers that were served and if they are older than three days, she throws them in the trash. Dietary BB stated all pots, pans, and dishes should be stored inverted. The facility's "Food Safety Requirements" policy revised on 10/2022, documented dry foods that are stored in bins will be removed from original packaging, labeled, and dated. The policy further documented all foods stored in the refrigerator or freezer will be covered, labeled, and dated. The facility failed to maintain sanitary dietary standards related to storage of food and kitchenware. This deficient practice placed the residents at risk related to food borne illnesses and food safety concerns.	F 812			

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F 849 F 849 SS=D	Continued From page 82 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 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	F 849 F 849			

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F 849	Continued From page 83 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 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	F 849			

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F 849	Continued From page 84 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 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	F 849			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175219	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/24/2023
NAME OF PROVIDER OR SUPPLIER KAW RIVER CARE AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 750 BLAKE STREET EDWARDSVILLE, KS 66111		
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F 849	Continued From page 85 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. (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	F 849			

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F 849	Continued From page 86 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 33 residents. The sample included 12 residents with two residents reviewed for hospice services. Based on observation, record review, and interviews, the facility failed to ensure necessary information regarding Resident (R)24's care between the nursing home and hospice was available and known to all staff 24-hours a day, seven days a week including documentation of a description of the services, medication, and equipment provided to R24 by hospice. This deficient practice created a risk for missed opportunities for services and delayed physical, mental, and psychosocial needs for R24. Findings Included: - R24's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of respiratory failure, heart failure, type two diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), chronic obstructive pulmonary disorder (progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), muscle weakness, major depressive disorder (major mood disorder), anxiety disorder (progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), and diabetic neuropathy (pain due to nerve damage caused by diabetes). R24's "Quarterly Minimum Data Set" completed 05/10/23 noted a Brief Interview for Mental Status	F 849			

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F 849	Continued From page 87 (BIMS) score of 15 indicating intact cognition. The MDS indicated she was independent with all her activities of daily living (ADLs) except bathing and required limited assistance from one staff. The MDS indicated she was on hospice services. The MDS noted she was taking an antianxiety medication (class of medications that calm and relax people with excessive anxiety, nervousness, or tension). R24's "Psychotropic Medication Care Area Assessment (CAA)" completed 02/06/23 indicated she was at risk for potential complication related to her medications. The CAA noted she received hospice services and was at risk for depression and anxiety. The CAA noted she was at risk for potential side effects and encouraged staff to monitor for physical and behavioral changes. The CAA instructed staff to cooperate with hospice service to ensure continuity of care. R24's "Care Plan" initiated 01/23/23 indicated she required hospice care due to end of processes. The plan instructed staff to provide activity as tolerated, expect weight changes related to her terminal diagnoses, aid related her to fatigue/weakness, and keep her comfortable to the extent possible. R24's "Care Plan" lacked documentation related to the services, medication covered by hospice and any medical equipment provided by hospice. R24's EMR under "Physician's Orders" revealed she admitted on hospice 01/20/23 for terminal diagnosis of congestive heart failure (a condition with low heart output and the body becomes congested with fluid).	F 849			

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F 849	Continued From page 88 On 08/23/23 at 08:23AM R24 reported she chose to start hospice due to increased health issues related to her heart. She stated hospice comes to provide comfort care. R24's hair was washed and combed. She reported hospice provided bathing on top of her baths with the facility. She reported no concerns with her hospice cares. On 08/24/23 at 01:56PM Certified Nurse's Aide (CNA) M stated the services hospice provided should be listed in R24's care plan. She was not sure if it was the care plan listed what equipment was provided but thought her low air-loss mattress may have been provided by them. She stated hospice would have stickers on the equipment they own. On 08/24/23 at 02:18PM Licensed Nurse (LN) H reported hospice usually will let the nurses and staff know what they are doing for the week. She stated hospice will fax over orders and instructions for treatments, but she was not sure if the care plans listed the services or equipment managed by hospice. On 08/24/23 at 03:19PM Administrative Nurse D stated staff will often look at the hospice binder for instructions related to treatments and services for the residents. She stated the care plans stated what hospice provider the resident chose and how to contact them if they need anything. A review of the facility's "Hospice" policy revised 06/2021 indicated the facility will coordinate with hospice services to ensure treatments and services provided to care for the needs of the resident. The policy indicated the person-centered care plan will identify the services hospice will provide. The facility and	F 849			

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F 849	Continued From page 89 hospice will collaborate to provide a coordinate care plan with measurable goals, resident choices, and identification of services/treatments the facility and hospice services have been agreed upon. The facility failed to ensure necessary information regarding R24's care between the nursing home and hospice was available and known to all staff 24-hours a day, seven days a week including documentation of a description of the services, medication, and equipment provided to R24 by hospice. which had the potential for negative outcomes for R24.	F 849			
F 851 SS=C	Payroll Based Journal CFR(s): 483.70(q)(1)-(5) §483.70(q) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(q)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping).	F 851			

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F 851	Continued From page 90 §483.70(q)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(q)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(q)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(q)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is not met as evidenced by: The facility identified a census of 33 residents.	F 851			

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F 851	Continued From page 91 Based on interview and record review, the facility failed to submit complete and accurate staffing information to the federal regulatory agency through Payroll Based Journaling (PBJ), when the facility failed to submit accurate staffing hour data for all licensed nursing personnel. Findings included: - The PBJ report provided by the Centers for Medicare and Medicaid Services (CMS) for FY 2023 Quarter one documented the facility failed to have Licensed Nursing Coverage 24 hours/day on four instances (11/12/22, 11/13/22, 11/24/22, and 12/25/22). The facility was able to provide clock in/clock out times for Licensed Nursing staff for those dates. On 08/23/23 at 11:30 AM Administrative Staff A stated that she submitted all the nursing staff hours to the corporate office and then they were who submitted the information to CMS. The facility policy "Payroll Based Journal" approved 05/2022 documented: Our community would submit payroll data in a uniform format to CMS, including staffing information for community, agency, and contract staff. Submit data electronically based upon specifications determine by CMS, which include the following: the category of work for each person on direct care staff (including, but not limited to, whether the individual was a RN, Licensed Practical Nurse [LPN], licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); resident census data; and information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day	F 851			

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F 851	Continued From page 92 (including but not limited to, start date, end date, and hours worked for each individual). The facility failed to submit complete and accurate staffing information to the federal regulatory agency through PBJ when the facility failed to submit/provide accurate data for all nursing personnel.	F 851			
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify	F 880			

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F 880	Continued From page 93 possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: The facility identified a census of 33 residents.	F 880			

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F 880	Continued From page 94 The sample included 12 residents. Based on record review, observations, and interviews, the facility failed to maintain sanitary infection control practices related to indwelling catheters (tube inserted into the bladder to drain urine into a collection bag), wound care, laundry services, and medication administration. This deficient practice placed the residents at risk for complications related to infectious diseases. Findings Included: - On 08/22/23 at 07:05AM an inspection of the "Main Hall" revealed the soiled utility room was unsecured. On 08/22/23 at 07:10AM an inspection of the unsecured "West Hall" shower room revealed an overfilled trashcan next to the toilet with soiled incontinence products. On 08/22/23 at 07:59AM observation revealed soiled linen on the floor of Resident (R)6's room. On 08/22/23 at 09:18AM staff transported a clean linen cart down the "East Hall" without a cover or protective barrier. The cart contained clean bed linen. Housekeeping Staff U stated the soiled linen room usually was locked and laundry should always be covered when transported. On 08/23/23 at 02:05PM, Administrative Nurse D and Licensed Nurse (LN) I completed indwelling catheter care on R25 and prepped his for peri-care by turning him onto his left side. The urinary collection bag was removed from the right-side bed frame and held over him to be placed on the left side on him. This resulted in pooled urine in the catheter tubing getting flushed			F 880			

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F 880	Continued From page 95 back into body. On 08/23/23 at 02:10PM, wound care was completed for R25. Administrative Nurse D removed R25's protective boots and the gauze wraps on both his feet. She removed the calcium alginate (wound barrier that promotes healing) from inside the right heel wound. No protective barrier was placed between R25's two heel wounds and his soiled mattress. R25's left heel and wound rested on the mattress as Certified Nurse's Aide (CNA) N held his right leg above his left leg. Administrative Nurse D had to get supplies prepped for the wound care and left the area. CNA N then rested R25's exposed right heel on top of his left leg. R25's right leg touched the soiled mattress several times during the observation. Administrative Nurse D returned and completed wound care on both heels. On 08/23/23 at 03:01AM, LN I failed to complete hand hygiene while administering R27's medications through his gastrostomy tube (G-tube- surgical creation of an artificial opening into the stomach thru the abdominal wall). On 08/24/23 at 01:30PM, CNA M stated R25's urinary collection bag and tubing were to be positioned below his bladder. She stated urine should flow downward into the bag and not remain in the tubing. She stated soiled linen should be transported directly to the soiled linen closet with a sealed bag or container. She stated laundry should be transported using the covered cart. On 08/24/23 at 02:02PM LN H reported staff were expected to place soiled linen in a bag or container and not the floor. She stated catheter	F 880			

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F 880	Continued From page 96 collection bags should never be held above to bladder due to the risk of old urine re-entering the body. She stated wounds should never be placed directly on contaminated surfaces and a clean barrier should be placed below the wound to prevent infections. On 08/24/23 at 02:44PM Administrative Nurse E reported the facility holds frequent in-service training on proper catheter care, hand hygiene, and infection prevention. She stated the urinary collection bag should be maintained below the bladder to prevent urine from reentering the body and being an infection risk. The facility's "Medication Administration" policy revised 05/2022 indicated hand hygiene must be completed before and after medication pass to the residents. The facility's "Laundry Policy" revised 05/2022 indicated contaminated laundry must be transported in a sealed bag or container to the soiled linen room. The policy indicated clean and soiled laundry should never be placed on contaminated surfaces or the floor. A review of the facility's "Indwelling Urinary Catheter" policy revised 03/2023 instructed that catheter care must be provided every shift and as needed every day. The policy indicated staff will ensure the urinary catheter, tubing, and collection bag are stored in a manner complaint with infection control standards. A review of the facility's "Wound Care" policy revised 04/2023 instructed staff to place a clean disposable cloth under the wound to act as a barrier to prevent wounds from contacting bed	F 880			

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F 880	Continued From page 97 linens and other body parts. The facility failed to maintain sanitary infection control practices related to indwelling catheters, wound care, laundry services, and medication administration. This deficient practice placed the residents at risk for complications related to infectious diseases.	F 880			