

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

PRINTED: 10/13/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175425	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/04/2023
NAME OF PROVIDER OR SUPPLIER SPRING HILL CARE AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 251 E WILSON AVENUE SPRING HILL, KS 66083		
(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	F 000			
F 558 SS=D	The following citations represent the findings of a Health Resurvey and Complaint Investigation #KS00175482. The 2567 was sent electronically on 10/13/23. Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: The facility identified a census of 43 residents. The sample included 12 residents with two reviewed for accommodation of needs. Based on record review, interviews, and observations, the facility failed to provide Resident (R)33's care planned adaptive equipment to support his dietary needs during meal service. The facility additionally failed to provide R27 wheelchair foot pedals during transport. This deficient practice placed both residents at risk for decreased quality of care. Findings Included: - R33's Electronic Medical Record (EMR) noted diagnoses of gastro-esophageal reflux disease (GERD- backflow of stomach contents to the esophagus), dysphagia (difficulty swallowing) dementia (progressive mental disorder characterized by failing memory, confusion), anxiety disorder (mental or emotional reaction	F 558			

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

TITLE

(X6) DATE

10/13/2023

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

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F 558	Continued From page 1 characterized by apprehension, uncertainty and irrational fear), and delusional disorder (untrue persistent belief or perception held by a person although evidence shows it was untrue). R33's "Quarterly Minimum Data Set (MDS)" completed 07/21/23 noted a Brief Interview for Mental Status (BIMS) score of five indicating severe cognitive impairment. The MDS noted he required supervision and physical assistance from one staff during meals. The MDS noted no weight loss and weighed 143 pounds (lbs.). R33's "Nutritional Care Area Assessment (CAA)" completed 02/09/23 indicated he was on a mechanically altered diet related to his swallowing disorder. The CAA noted care planned interventions would be implemented. R33's "Activities of Daily Living (ADLs) CAA" completed 02/09/23 noted he required limited assistance with his ADLs. The CAA noted care planned interventions would be implemented. R33's "Care Plan" initiated 03/08/22 indicated he had impaired cognitive function and thought processes related to his dementia diagnosis. The plan noted he required reminders, prompting, and verbal cues during meals (11/16/22). The plan noted he had dysphagia and GERD that resulted hyperacidity (frequent acid reflux). The plan instructed staff to provide supervision during meals and encourage him to take small bites and to alternate drink sips with his meal. The plan instructed him to use a teaspoon for smaller bites. The plan indicated he was at risk for aspiration and choking during meals. The plan instructed staff to monitor for coughing, food pocketing, drooling, and prolonged swallowing.	F 558			

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F 558	Continued From page 2 The plan instructed staff to provide adaptive equipment (02/03/23). A "Quarterly Nutritional Evaluation" completed 07/24/23 indicated he weighed 142.5 lbs. The assessment indicated he was on a mechanically soft diet with pureed meats. The assessment instructed staff to decrease R33's intake rate with smaller drinks and bites. The assessment instructed staff to place his food in separate bowls for meals. On 10/03/23 at 12:25PM R33 sat in the recliner chair in front of the nurse's station and faced the television room. R33 ate his lunch of mashed potatoes and pureed meat. His meal was not divided into smaller bowels, and he was given regular-sized silverware. R33 had several episodes of coughing during his meal after taking bites of his food. Staff did not inspect his mouth for pocketed food after his meal. On 10/04/23 at 11:45AM R33 sat in the right-side recliner next to the nurse's station. R33 was given an oatmeal cream pie as a snack to eat before lunch service. R33 took a large bite of the snack. R33 began coughing and drooling. R33 was not monitored during the snack for food pocketing or aspiration. On 10/04/23 at 12:45PM R33 sat in the secondary dining room for lunch. R33's meal was served in three divided smaller bowels. R33 utilized a regular sized spoon to eat his pureed meal. Staff sat next to him and encourage hit to take small bites. On 10/04/23 at 11:48AM Certified Nurses Aide (CNA) M stated R33 required a mechanically soft	F 558			

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F 558	Continued From page 3 diet with pureed meats. He stated R33 frequently put too much food in his mouth during meals and was a risk for aspiration. He stated staff would space out all R33's meals and snacks to provide smaller more frequent meals during the day. He was not sure if R33 required special adaptive equipment during meals. On 10/04/23 at 12:00PM Licensed Nurse (LN) G stated R33 utilized regular silverware but required small, separated bowls during meals to enforce smaller bites and eating slower. She stated R33 would out too much food in his mouth at one time and aspirate. She stated staff were to encourage him to take smaller bites and sip during meals. On 10/04/23 at 12:45PM Administrative Nurse D stated staff was expected to review the care plan before caring for each resident. She stated she was not familiar with R33's dietary needs but expected staff to follow each resident's interventions. A review of the facility's "Reasonable Accommodation of Needs" policy revised 11/2017 indicated each resident's individual needs shall be accommodated related to adaptive devices for performing cares related to activities of daily living, maintaining independence during daily activities, and safety within the resident's environment. The facility failed to provide R33's care planned adaptive equipment to support his dietary needs during meal service. This deficient practice placed him at risk for complications related to aspiration and weight loss.	F 558			

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F 558	Continued From page 4 - The electronic medical record (EMR) for R27 documented diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), reduced mobility, and age-related physical debility (state of general weakness or feebleness). The "Annual Minimum Data Set" (MDS) dated 02/03/23 noted R27 had a Brief Interview for Mental Status (BIMS) score of seven which indicated severe cognitive impairment. The MDS documented R27 required limited assistance of one staff member for transfers and locomotion on and off unit. The "Cognitive Loss / Dementia Care Area Assessment (CAA)" dated 02/03/23 documented R27 triggered for cognitive loss/dementia related to BIMS score of seven. The CAA further documented care plan interventions included focusing on reducing risks associated with dementia and directed staff to provide for R27's safety and to maintain a safe environment. R27's "Care Plan" dated 01/26/22 documented R27 was deconditioned, had gait/balance problems and was unaware of safety needs. On 10/02/23 at 08:34 AM an observation revealed Certified Nurse Aide (CNA) M pushed R27 through the hallway in her wheelchair. R27's wheelchair did not have foot pedals in place, and she was holding her feet slightly off the floor. On 10/02/23 an observation revealed R27 was in the hallway in her wheelchair and asked staff if she could lay down. A female staff member pushed R27 to her room in her wheelchair. R27's	F 558			

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F 558	Continued From page 5 wheelchair did not have foot pedals in place. On 10/03/23 at 11:01 AM an observation revealed CNA M pushed R27 through the hallway, toward the dining room, in her wheelchair. R27's wheelchair did not have foot pedals in place. On 10/04/23 at 11:41 AM CNA M stated from classes/education received at the facility, staff were not supposed to propel residents in their wheelchairs without having foot pedals in place. He stated that he would sometimes help propel them at a slow rate of speed for those that can usually propel themselves. On 10/04/23 at 11:55 AM Licensed Nurse G stated staff were not supposed to propel residents in their wheelchairs without having foot pedals in place. On 10/04/23 at 12:40 PM Administrative Nurse D stated if staff propelled residents in their wheelchairs, then she expected them to have foot pedals in place before doing so. She further stated that staff should not push residents in their wheelchairs unless they were using foot pedals. A review of the facility's "Reasonable Accommodation of Needs" policy revised 11/2017 indicated each resident's individual needs shall be accommodated related to adaptive devices for performing cares related to activities of daily living, maintaining independence during daily activities, and safety within the resident's environment. The facility failed to provide R27 wheelchair foot pedals during transport. This deficient practice placed R27 at risk for decreased quality of care	F 558			

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F 558	Continued From page 6 and potential injury.	F 558			
F 606 SS=E	Not Employ/Engage Staff w/ Adverse Actions CFR(s): 483.12(a)(3)(4) §483.12(a) The facility must- §483.12(a)(3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. §483.12(a)(4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. This REQUIREMENT is not met as evidenced by: The facility identified a census of 43 residents. Based on interview and record review, the facility failed to conduct a criminal background check as required for two employees. The two employees were allowed access to residents without knowing if they had been found guilty of abuse, neglect, exploitation, misappropriation of property or mistreatment by a court of law. The deficient practice placed affected residents at risk for abuse, neglect, misappropriation, or	F 606			

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F 606	Continued From page 7 mistreatment. Findings included: - Employee review of Certified Nurse Aide (CNA) M revealed a hire date of 04/06/20. The facility was unable to produce the results of CNA M's background check upon request. Employee review of Licensed Nurse (LN) H revealed a hire date of 03/12/19. The facility was unable to produce the results of LN H's background check upon request. On 10/03/23 at 03:52 PM Administrative Staff B stated that the facility did not have the background checks for CNA M or LN H. She stated that they ran the background check for CNA M but do not have the results. She further stated LN H was hired during receivership and they do not have the results of her background check. On 10/04/23 at 01:25 PM Administrative Staff A stated Administrative Staff B initiates the process for obtaining background checks. He stated LN H was hired during receivership and they were not able to obtain the results from the company that was previously used to process LN H's background check. The Facility provided "Abuse Prevention Program" policy revised 08/2022, documented background checks are completed per state guidelines. This community will not knowingly employ any individual who has been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law.	F 606			

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F 606	Continued From page 8 The facility failed to perform criminal background checks on two employees with direct access to the residents who resided in the facility. This deficient practice placed affected residents in the facility at risk for abuse, neglect and/or exploitation.	F 606			
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would	F 623			

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F 623	Continued From page 9 be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental	F 623			

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F 623	Continued From page 10 disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: The facility identified a census of 43 residents. The sample included 12 residents with two residents reviewed for hospitalization. Based on observation, record review, and interviews, the facility failed to provide written notification of the reason and location for the facility-initiated transfer for Resident (R)35. This deficient practice placed the resident at risk of delayed care or uncommunicated care needs. Findings Included: - R35's Electronic Medical Record (EMR) noted	F 623			

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F 623	Continued From page 11 diagnoses of morbid obesity (severely overweight), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), type two diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), heart failure, and chronic kidney disease. R35's EMR recorded a "Discharge Assessment-Return Anticipated" Minimum Data Set (MDS) which recorded R35 discharged to the acute hospital on 06/21/23. R35's "Entry Tracking Record" MDS documented R35 returned to the facility on 06/28/23. Another "Discharge Assessment-Return Anticipated" dated 07/13/23 recorded R35 discharged to the acute hospital and the "Entry Tracker Record" recorded she returned to the facility on 07/17/23. R35's "Annual MDS" completed 07/04/23 noted a Brief Interview for Mental Status (BIMS) score of 13 indicating mild cognitive impairment. The MDS indicated she required extensive staff assistance from one staff for her activities of daily living (ADLs). The MDS indicated she had frequent urinary incontinence episodes. R35's "Care Plan" initiated 12/12/22 indicated she required extensive staff assistance from staff for bathing, toileting, transfers, bed mobility, and personal hygiene. The plan indicated she had bladder incontinence and required timed toileting to prevent episodes. The plan instructed staff to monitor R35 for signs of urinary infections related to her bladder dysfunction. R35's EMR under "Progress Notes" tab documented a "Nursing Note" on 06/21/23	F 623			

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F 623	Continued From page 12 indicated she had increased confusion and difficulty responding to staff. The note indicated R33 was sent out for emergency treatment to an acute care facility. The note indicated she was admitted for evaluation of vascular stenosis (narrowing of the blood vessels in the neck) and a urinary tract infection (UTI). R35's EMR indicated she returned to the facility on 06/28/23. R35's EMR under "Progress Notes" tab documented a "Nursing Note" on 07/13/23 indicated she was readmitted to the acute care facility for complications related to her chronic kidney disease. R35's EMR indicated she returned to the facility on 07/17/23. R35's clinical record lacked evidence of written notification of the facility-initiated transfer which included location and reason for transfer was provided to R35 or her representatives. The facility was unable to provide this documentation as requested on 10/03/23. On 10/03/23 at 07:40AM R35 sat in wheelchair and prepared for breakfast. She stated she recently had increased health issues related to her kidneys that led to her going to the hospital. On 10/03/23 at 01:30PM Administrative Staff A reported that the facility did not issue bed holds or written notification of transfers to residents sent out. He stated they assumed the residents sent out would be returning to their rooms. The facility policy "Transfer or Discharge Notice"	F 623			

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

PRINTED: 10/13/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175425	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/04/2023
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F 623	Continued From page 13 dated 10/2022 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 the transfer or discharge: The transfer is necessary for the resident's welfare and the resident's needs cannot be met in the facility. The facility failed to provide written notification of the reason and location for the facility-initiated transfer to the hospital to R35 or her representative. This deficient practice placed R35 at risk of delayed care.	F 623			
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section.	F 625			

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

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F 625	Continued From page 14 §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: The facility identified a census of 43 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)35 and/or their representative, with a written notice specifying the duration and cost of the bed hold, at the time of the resident's two transfers to the hospital. This placed the resident at risk for impaired rights. Findings Included: - R35's Electronic Medical Record (EMR) noted diagnoses of morbid obesity (severely overweight), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), type two diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), heart failure, and chronic kidney disease. R35's EMR recorded a "Discharge Assessment-Return Anticipated" Minimum Data Set (MDS) which recorded R35 discharged to the acute hospital on 06/21/23. R35's "Entry Tracking Record" MDS documented R35 returned to the facility on 06/28/23. Another "Discharge Assessment-Return Anticipated" dated 07/13/23	F 625			

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

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F 625	Continued From page 15 recorded R35 discharged to the acute hospital and the "Entry Tracker Record" recorded she returned to the facility on 07/17/23. R35's "Annual MDS" completed 07/04/23 noted a Brief Interview for Mental Status (BIMS) score of 13 indicating mild cognitive impairment. The MDS indicated she required extensive staff assistance from one staff for her activities of daily living (ADLs). The MDS indicated she had frequent urinary incontinence episodes. R35's "Care Plan" initiated 12/12/22 indicated she required extensive staff assistance from staff for bathing, toileting, transfers, bed mobility, and personal hygiene. The plan indicated she had bladder incontinence and required timed toileting to prevent episodes. The plan instructed staff to monitor R35 for signs of urinary infections related to her bladder dysfunction. R35's EMR under "Progress Notes" tab documented a "Nursing Note" on 06/21/23 indicated she had increased confusion and difficulty responding to staff. The note indicated R33 was sent out for emergency treatment to an acute care facility. The note indicated she was admitted for evaluation of vascular stenosis (narrowing of the blood vessels in the neck) and a urinary tract infection (UTI). R35's EMR indicated she returned to the facility on 06/28/23. R35's EMR under "Progress Notes" tab documented a "Nursing Note" on 07/13/23 indicated she was readmitted to the acute care facility for complications related to her chronic kidney disease.	F 625			

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

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F 625	Continued From page 16 R35's EMR indicated she returned to the facility on 07/17/23. R35's clinical record lacked evidence a bed-hold was provided to him or his representatives at the time of transfer. On 10/03/23 at 01:30PM Administrative Staff A reported that the facility did not issue bed holds or written notification of transfers to residents sent out. He stated they assumed the residents sent out would be returning to their rooms. The facility policy "Discharge/Transfer" policy revised 10/2022 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. The facility failed to provide a copy of the facility bed hold policy to R35 and/or their representative, with a written notice specifying the duration and cost of the bed hold policy, at the time of the resident's two transfers to the hospital. This placed the resident at risk for impaired rights.	F 625			
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to--	F 657			

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

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F 657	Continued From page 17 (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: The facility identified a census of 43 residents. The sample included 12 residents. Based on observation, record review, and interviews, The facility failed to update/revise Residents (R)9 care plans to reflect post-fall interventions and changes in assistive care requirements. This deficient practice placed the resident at risk for preventable injuries and ineffective treatment due to uncommunicated care needs. Findings Included: - R9's Electronic Medical Record (EMR) noted a diagnose of overactive bladder, major depressive disorder (major mood disorder), abnormalities of gait and mobility, fracture of left femur (broken large bone), obesity (overweight), and history of	F 657			

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

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F 657	Continued From page 18 falls. R9's "Annual Minimum Data Set (MDS)" completed 06/01/23 noted a Brief Interview for Mental Status (BIMS) score of nine indicating moderate cognitive impairment. The MDS indicated she required limited assistance from one staff for transfers, bed mobility, locomotion, and walking. The MDS indicated no previous falls. The MDS noted she used a walker for mobility. R9's "Quarterly MDS" completed 08/08/23 indicated her functional assistance increased to extensive assistance from two staff for bed mobility, transfers, locomotion, dressing, toileting, personal hygiene, and bathing after her major injury fall. The MDS noted she switched a wheelchair for mobility. R9's "Fall Care Area Assessment (CAA)" completed 07/15/23 indicated she was at risk for falls related to her medical diagnoses. The CAA noted she required staff assistance for her activities of daily living (ADLs) and had incontinence episodes. The CAA noted she used an assistive walker for mobility. The CAA indicated R9's "Care Plan" will address her ADL needs and fall prevention. R9's "Care Plan" initiated 08/04/21 indicated she required limited assistance from one staff for bed mobility, ambulation, and transfers. The plan noted she required extensive assistance from one staff for toileting, personal hygiene, dressing, and bathing. R9's plan indicated she was a high risk for falls. The plan instructed staff to use contact assist	F 657			

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

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F 657	Continued From page 19 during ambulation (03/19/22), educate her on safety (08/04/21), ensure appropriate footwear (08/04/21), anticipate her needs (08/04/21), and keep her call light within reach (08/04/23). The plan indicated she still used her wheeled walker for mobility (07/05/22). The plan lacked revisions related to her fall intervention on 08/01/23 or changes in her care requirements reflected on her "Quarterly MDS" dated 08/08/23. The care plan lacked direction that R9 no longer used her walker. A "Fall Investigation" completed 08/01/23 indicated she was assisted to the dining room by staff for breakfast service. The investigation indicated R9 attempted to stand and fell to the ground on her left side and sustained a femur fracture of the left leg. The investigation indicated the facility would attach a sign to her walker to remind her to call her assistance. On 10/03/23 at 08:11AM R9 attended breakfast in the dining room. She stated she recently broke her hip when she fell. She stated she was working with therapy to help her walk again. R9's wheeled walker was stored in her room next to her bed. On 10/04/23 at 11:48AM Certified Nurse's Aide (CNA) M stated R9's care requirements increased after her hip fracture. He stated she required two staff, and a gait belt transfers. He stated all direct care staff had access to the care plan and were expected to follow them. On 10/04/23 at 12:00PM Licensed Nurse (LN) G stated staff were responsible for reviewing and following the care plan interventions. She stated the interdisciplinary team (IDT) would meet and	F 657			

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

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F 657	Continued From page 20 discuss changes to the plans. She stated it wouldn't take more than 24 hours to update interventions to the plans. She stated Administrative Nurse D would be notified if changes needed to be made to the plans. She stated R9 was a high fall risk and required extensive assistance from two staff for most cares due to her hip injury. On 10/03/23 at 01:30PM Administrative Staff A stated that IDT team met weekly to discuss the care plan, but change could be made at any time to reflect the care needs. She stated she had not worked with R9 much since starting in August, but the care plans should all be revised at least quarterly with the MDS assessment. A review of the facility's "Care Plan" policy revised 10/2022 indicated care plans will be reviewed and updated by the interdisciplinary team to reflect goals, treatments, and changes to the resident's care with appropriate revision reviewed. The facility failed to revise R9's care plan to reflect her increased care needs after a major injury fall. This deficient practice placed the residents at risk for preventable injuries and ineffective treatment.	F 657			
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	F 727			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 727	Continued From page 21 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 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 43 residents. Based on record review and interviews, the facility failed to provide a Registered Nurse (RN) for at least eight consecutive hours, seven days a week. This placed all residents in the facility at risk for decreased quality of care. Findings included: - RN coverage documentation for 04/22/23 - 04/23/23 and 06/17/23 - 06/20/23 was requested from the facility. The facility provided documents "Direct Care Staffing for Spring Hill Care and Rehab" recorded the name of the nurse who provided RN coverage each day. The documents listed the following dates where RN coverage was recorded as provided by Administrative Nurse E (the former Director of Nursing): 04/23/23 and 06/19/23. Upon request, the facility was unable to provide verifiable times which demonstrated the eight consecutive hours as required for Administrative Nurse E on the above dates. On 10/03/23 at 11:08 AM Administrative Nurse D stated that Administrative Nurse F clocked in for work and her hours would be logged; however, she did not clock in as she worked in a salary position. She stated that she was unsure how her	F 727			

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

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F 727	Continued From page 22 hours could be logged/tracked since she did not clock in for work. On 10/04/23 at 11:18 AM Administrative Staff B stated that she manually entered the eight hours for Administrative Nurse E has they hold a salary position and do not clock in or out. On 10/04/23 at 01:25 PM Administrative Staff A stated the facility had no way to show consecutive hours for their administrative nurses that worked in a salary position as they did not clock in. Administrative Staff A stated they planned to have Administrative Nurses use their clocking system in order to track logged hours going forward. The facility provided "Nursing Services" policy revised on 10/2022, documented under guidelines to complete the Facility Assessment annually, review quarterly, as needed to address appropriate numbers of licensed nursing staff to provide direct services to residents as well as to assist and monitor the aides that they have on their shift. The facility failed to provide RN services for at least eight consecutive hours, seven days a week. This placed all residents in the facility at risk for decreased quality of care.	F 727			
F 730 SS=F	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the	F 730			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 730	Continued From page 23 requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: The facility had a census of 43 residents. The sample included 12 residents and five Certified Nurse Aide's (CNA) reviewed for performance evaluations and required in-service training. Based on record review and interview, the facility failed to ensure four of the five CNA staff reviewed had the required yearly performance evaluations completed. This placed the residents at risk for inadequate care. Findings included: - Review of the facility's performance evaluation records revealed the following: CNA N, hired 11/09/18, last annual performance evaluation provided by the facility was dated for a review period of January 2019 to December 2019. No further yearly performance evaluations were provided by the facility for CNA N after 2019. - CNA O, hired 07/08/22, no yearly performance evaluations were provided upon request. - CNA P, hired 04/06/22, no yearly performance evaluations were provided upon request. - CNA Q, hired 08/23/21, no yearly performance evaluations were provided upon request. On 10/04/23 at 01:44 PM Administrative Staff A stated Administrative Staff B would have provided the yearly staffing evaluations. He stated that the facility provided what they had available. He stated that he received a notification from Administrative Staff B when a staff member was due for a yearly performance evaluation, and he then turned that information over to the Director of Nursing (DON) and other department heads to	F 730			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 730	Continued From page 24 be completed. He further stated that once completed, the documents were scanned into the employees' files. He said that he believed the evaluations were completed by the prior DON, but the facility was unable to locate them. On 10/04/23 at 02:25 PM Administrative Nurse D stated all of the yearly employee evaluations were likely done by the previous DON and stated that she would check with Administrative Staff B about the missing evaluations. Upon return, she stated that the facility did not have the yearly evaluations for the requested CNAs. The facility provided "Nursing Services" policy revised 10/2022, documented the community provides 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 four of the five CNA staff reviewed had the required yearly performance evaluations completed. This placed the residents at risk for inadequate care.	F 730			
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant;	F 758			

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

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F 758	Continued From page 25 (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.	F 758			

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F 758	Continued From page 26 This REQUIREMENT is not met as evidenced by: The facility identified a census of 43. The sample included 12 residents with five residents reviewed for unnecessary medications. Based on observation, record review, and interview the facility failed to ensure Resident (R)33 had an appropriate indication for use, or a documented physician rationale which included the multiple unsuccessful attempts for nonpharmacological symptom management and risk versus benefits for the continued use of Zyprexa (antipsychotic-class of medications used to treat major mental conditions which cause a break from reality). This deficient practice placed R33 at risk of unnecessary medication administration and possible adverse side effects. Findings Included: - R33's Electronic Medical Record (EMR) noted a diagnose of dementia (progressive mental disorder characterized by failing memory, confusion), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), and delusional disorder (untrue persistent belief or perception held by a person although evidence shows it was untrue). R33's "Quarterly Minimum Data Set (MDS)" completed 07/21/23 noted a Brief Interview for Mental Status (BIMS) score of five indicating severe cognitive impairment. The MDS noted he required supervision and physical assistance from one staff during meals. The MDS noted no weight loss. The MDS indicated he received antipsychotic medication on a routine basis. The MDS noted a gradual dose reduction had not	F 758			

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F 758	Continued From page 27 been attempted or documented as contraindicated by a physician. R33's "Dementia Care Area Assessment (CAA)" completed 02/09/23 indicated he had severe cognitive impairment with a BIMS score of five. The CAA noted he was easily distractable. The CAA indicated care planned interventions were implemented to maintain a safe environment. R33's "Behaviors CAA" completed 02/09/23 indicated he was triggered for behaviors due to aimless wandering. The CAA indicated a care planned interventions were implemented to maintain a safe environment. R33's "Psychotropic Medication CAA" completed 02/09/23 indicated he took antipsychotic medications. The CAA instructed staff to monitor him for side effects and adverse reactions reduce the risks associated with the medication. R33's "Care Plan" initiated 11/16/22 indicated his olanzapine (Zyprexa) medication had a black box warning (BBW- highest safety-related warning that medications can have assigned by the Food and Drug Administration) related to an increased mortality rate (higher rate of death) associated with elderly patients with dementia related psychosis taking antipsychotic medications. The plan indicated olanzapine was not an approved treatment for patients with dementia related psychosis (11/16/22). R33's EMR revealed an order noted under "Physician's Orders" dated 03/08/22 for staff to administer five milligrams (mg) of Zyprexa (antipsychotic medication) at bedtime related to anxiety disorder.	F 758			

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F 758	Continued From page 28 A "Pharmacy Consultation Report" dated 03/23/22 noted R33 received olanzapine without documentation of a diagnosis and adequate indication of use in his medical record. The medical provider responded to the review on 05/06/23 indicating R33 had occasional paranoia, delusions, and psychosis. R33's EMR indicated delusional disorders was added to his diagnoses on 05/06/23. R33's EMR revealed an order noted under "Physician's Orders" dated 05/08/22 indicated his indicated diagnosis for his Zyprexa was changed to psychosis, delusions, and paranoia. A review of R33's "Periodic Psychiatric Evaluation" dated 09/10/23 indicated R33 was calm with occasional behavioral disturbances. The note indicated his confusion had improved. The note indicated R33 had advanced dementia and could not fully participate in the evaluation. The note indicated he was taking the olanzapine medication for delusional disorders. On 10/04/23 at 12:00PM Licensed Nurse (LN) G stated R33 had behaviors but was easily redirected by staff. She stated she was not sure if a diagnosis delusional disorder was an appropriate indication for antipsychotic medication use. On 10/04/23 at 12:45PM Administrative Nurse D stated the goal was to lower R33's olanzapine medication and eventually have it discontinued due to it being an antipsychotic. She stated she believed R33's behaviors were more associated with his advanced dementia and not psychotic	F 758			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 758	Continued From page 29 related. She stated R33 admitted to the facility on the antipsychotic medication. A review of the facility's "Psychotropic Medication" policy dated 06/2023 indicated all psychotropic medications will be evaluated for accurate indicated use and will be used per professional guidelines. The policy noted antipsychotic medication will be monitored for behavioral changes and side effects. The facility failed to ensure an appropriate indication for use, or the required physician documentation, for the antipsychotic medication Zyprexa for R33. This deficient practice placed this resident at risk of unnecessary medication administration and possible adverse side effects.	F 758			
F 882 SS=F	Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4) §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP) (s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control.	F 882			

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F 882	Continued From page 30 This REQUIREMENT is not met as evidenced by: The facility identified a census of 43 residents. Based on record review, and interviews, the facility failed to provide a certified infection preventionist to oversee the facility's "Infection Prevention and Control Program (IPCP)." This deficient practice placed all residents at increased risk for infections related to lack of identification, tracking/trending, and treatment of infections. Findings included: - A review of the facility's infection control log indicated the facility infection control log for July, August, and September 2023 indicated the facility had 16 urinary tract infections and 15 upper respiratory infections. On 10/02/23 at 09:30AM, Administrative Nurse D reported that she assumed the responsibilities of infection preventionist (IP) after the previous IP nurse quit the facility. She stated that she was currently working on becoming certified. She reported the last IP quit in July of 2023. On 10/03/23 at 10:20AM, Administrative Staff A reported the facility recently had lost two IP's within the last year. He reported Administrative Nurse D was completing the required course to become certified but said the facility had not had a certified IP since 07/17/23. A review of the facility's "Infection Prevention and Control Program" policy revised 10/2022 indicated the facility will maintain a certified IP to ensure professional standards and protocols	F 882			

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F 882	Continued From page 31 were maintained related to staff training/education, infection prevention and monitoring, antibiotic stewardship program, and immunizations. The facility failed to provide a certified infection preventionist to oversee the facility's IPCP program. This deficient practice placed all residents at increased risk for infections related to lack of identification, tracking/trending, and treatment of infections.	F 882			