

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

PRINTED: 11/07/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175159	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/01/2023
NAME OF PROVIDER OR SUPPLIER PROVIDENCE PLACE LTCU			STREET ADDRESS, CITY, STATE, ZIP CODE 8909 PARALLEL PKY KANSAS CITY, KS 66112		
(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=E	The following citations represent the findings of a Health Resurvey. The 2567 was sent electronically on 11/07/23. 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 29 residents. The sample included 13 residents. Based on record review, interviews, and observations, the facility failed to provide wheelchair foot pedals for Residents (R)15, R178, R21, and R175. This deficient practice placed the residents at risk for impaired safety and comfort. Findings Included: - On 10/30/23 at 07:34AM staff transported R15 from the main hallway to the dining room in a wheelchair. R15's wheelchair lacked foot pedals. R15 wore socks and his feet slid on the floor as he was pushed to the dining room. A review of R15's "Care Plan" revealed no documented interventions related to his foot pedals. On 10/30/23 at 11:33PM housekeeping staff pushed R178 down the main hallway in his wheelchair. R178's wheelchair did not have foot pedals in place and his feet made contact with	F 558			

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 558	Continued From page 1 the ground on several occasions. A review of R178's "Care Plan" revealed no documented interventions related to his foot pedals. On 11/01/23 at 01:16PM staff transported R21 from the dining room to his room in a wheelchair without foot pedals. R21 had non-slip socks on as his feet, and his feet slid along the floor during the transport. A review of R21's "Care Plan" revealed no documented interventions related to his foot pedals. On 11/01/23 at 01:32PM staff pushed R175 around the central hallway nurse' station with no foot pedals. His feet slid on the floor during transport. A review of R175's "Care Plan" revealed no documented interventions related to his foot pedals. On 11/01/23 at 01:30PM Certified Nurse's Aide (CNA) M stated some of the resident refused to allow foot pedals to be put on their wheelchair. She stated all the residents have foot pedals for their wheelchairs. On 11/01/2023 at 01:40PM Licensed Nurse (LN) G stated some resident wheeled themselves around the facility and the foot pedals were removed for their convenience. She stated staff would never allow a resident's feet to drag on the ground while staff propelled the resident in a wheelchair. On 11/01/2023 at 02:05PM Administrative D reported staff were expected to utilize foot pedals while transporting residents around the facility in wheelchairs. She stated foot pedals were available for use for all residents with wheelchairs. She stated staff should never allow	F 558			

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F 558	Continued From page 2 the residents feet to touch the ground while being transported in a wheelchair. A review of the facility's "Adaptive Equipment" revised 10/2023 indicated the facility will evaluate and ensure the usage of adaptive equipment as provided. The facility failed to utilize wheelchair foot pedals for R15, R178, R21, and R175. This deficient practice placed the residents at risk for impaired safety and comfort.	F 558			
F 580 SS=D	Notify of Changes (Injury/Delirium/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g) (14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2)	F 580			

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F 580	Continued From page 3 is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: The facility identified a census of 29 residents. The sample included 13 residents with one reviewed for notification of changes. Based on observation, record review, and interviews, the facility failed to notify Resident (R)127's medical provider of her weight loss or changes in meal intake. This deficient practice placed R127 at risk for complication related to weight loss and malnutrition (condition that develops when the body is deprived of vitamins, minerals and other nutrients) due to delayed physician involvement. Findings Included:	F 580			

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F 580	Continued From page 4 - The "Medical Diagnosis" section within R127s Electronic Medical Records (EMR) included diagnoses of chronic kidney disease, osteoporosis (abnormal loss of bone density and deterioration of bone tissue with an increased fracture risk), muscle weakness, history of fractures (broken bones), and history of falls. R127's "Admission Minimum Data Set (MDS)" dated 10/11/23 noted a Brief Interview for Mental Status (BIMS) score of nine indicating moderate cognitive impairment. The MDS indicated she required set-up assistance with meals. The MDS indicated she weighed 117.2 pounds (lbs.). The MDS documented the resident was not on a physician-prescribed weight loss regimen. R127's "Functional Abilities Care Area Assessment (CAA)" completed 10/31/23 was at risk for altered functional abilities related to her medical diagnoses. The CAA indicated she required assistance with her activities of daily living (ADL). R127's "Cognitive Impairment CAA" completed 10/31/23 indicated she had impaired cognition and instructed staff to cue and reorient her as needed. R127's "Care Plan" initiated 10/18/23 she had a self-care deficit related to her ADL. The plan noted she was on a regular diet with regular texture. The plan instructed staff to monitor her intake and record every meal. The plan instructed staff to monitor and report symptoms of dysphagia, malnutrition, decreased appetite, and weight loss to the medical provider.	F 580			

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F 580	Continued From page 5 An "Admission Nutrition Evaluation "completed 10/18/23 indicated R127 weight was 117.2 lbs. The evaluation indicated she was at risk due to due to acute disease in the past three months. A "Mini-Nutritional Assessment" dated 10/18/23 indicated R127 was at risk of malnutrition. A "Nutrition/Hydration Risk Evaluation" completed 10/20/23 noted R127 was at moderate risk for malnutrition. The evaluation noted she took no medications contributing to weight loss risks. R127's EMR revealed her admission weight on 10/17/23 was 117.2 lbs. The EMR recorded her weight decreased to 99.1 lbs. on 10/25/23 and 97.2 lbs. on 10/27/23. R127's EMR, between 10/25/23 through 11/01/23, lacked evidence of physician notifications related her weight loss or change in her oral intake. A review of R127's EMR under "Documentation Survey Report" from 10/17/23 to 11/01/23 indicated no meal intake monitoring occurred from 10/21/23 to 10/29/23 for breakfast, lunch, and dinner meals. On 10/30/23 at 08:11AM R127 reported she recently had issues with weigh loss but ate her meals. R127 consumed her entire breakfast without concerns in the dining room. On 11/01/2023 at 01:30PM Certified Nurses Aide (CNA) M stated direct care staff would complete scheduled weights of the resident per the physician's orders. She stated if a resident's weight was off by three pounds the resident	F 580			

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F 580	Continued From page 6 would immediately be reweighed and the nurse notified of the change. She stated meal intake monitoring would be documented in the EMR system and the physician would be notified of changes in oral intake by the nurse. She stated R127 just recently admitted to the facility and had no complaints related to her meals or eating. On 11/01/2023 at 01:40PM Licensed Nurse (LN) G stated residents with noticeable weight changes would be placed on weekly weights and monitored closely for diet, medications, and intake. She stated the resident's weight loss would be reported to the physician and dietician for review. She stated a progress note would be completed to document the notification and well as changes in care. She stated residents at risk for weight loss and malnutrition were closely monitored for oral intake. On 11/01/2023 at 02:05PM Administrative Nurse D stated staff were expected to ensure the medical provider and registered dietician were notified of suspected weight loss. She stated the facility would increase weight monitoring occurrences and provide dietary supplementation for residents at risk for malnutrition. She stated staff were expected follow each resident's care planned interventions and orders. A review of the facility's "Weight Monitoring" policy revised 10/2023 indicated the facility ensured acceptable parameters of body weight. The policy noted each resident will be provided ongoing evaluation and interventions to prevent significant weight loss. The policy indicated the physician will be notified in changes related to each resident's preferences, diet, allergies, meal consumption, and weight.	F 580			

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F 580	Continued From page 7	F 580			
F 583 SS=D	The facility failed to notify R127's medical provider of her weight loss or changes in meal intake. This deficient practice placed R127 at risk for complication related to weight loss and malnutrition due to delayed physician involvement. Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws.	F 583			

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F 583	Continued From page 8 (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: The facility identified a census of 29 residents. The sample included 13 residents. Based on observation, record review, and interviews, the facility failed to secure protected health information (PHI) for Resident (R)125. This deficient practice placed R125 at risk for decreased psychosocial wellbeing due to lack of privacy. Findings Included: - The "Medical Diagnosis" section within R125's Electronic Medical Records (EMR) included diagnoses of fracture of right femur (broken bone), aphasia (difficulty speaking), dementia (progressive mental disorder characterized by failing memory, confusion), and a cerebral infarction (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). R125's "Admission Minimum Data Set (MDS)" dated 10/11/23 noted a Brief Interview for Mental Status (BIMS) score of three indicating severe cognitive impairment. The MDS indicated he was independent with ambulation and utilized a manual wheelchair and dependent for staff assistance for mobility over 50 feet. R125's "Communication CAA" completed 10/21/23 indicated he was at risk for altered	F 583			

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F 583	Continued From page 9 communication related to his aphasia. The CAA instructed staff to give him extra time to form words and assist him with functional abilities. The CAA noted care planning would address his risks. R125's "Care Plan" initiated 10/13/23 indicated he was at risk for impaired cognitive function or impaired thought process. The plan instructed social services to provide psycho-social support as needed. The plan noted he took medication with black box warnings (BBW- highest safety-related warning that medications can have assigned by the Food and Drug Administration) On 10/20/23 at 07:05AM a walkthrough of the facility's Prairie View hallway revealed the medication storage room door was propped fully open and unattended by nursing staff. A laptop on top of the medication cart was left unlocked with R125's "Medication Administration Report (MAR)" displayed facing towards the door and visible from doorway. At 07:21AM Licensed Nurse (LN) G entered the hallway and reported the medication room should not have been left open. She stated patient information should not be left displayed in view. She stated the monitor should be shut off when not in use. On 11/02/23 at 02:05PM Administrative Nurse D stated staff were expected to securely close the medication room doors when not in use. She stated PHI should be kept out of view from other residents or those who did not need the PHI. She stated staff were expected to ensure PHI was protected for the resident's privacy. A review of the facility's "Resident Rights" revised 10/2023 indicated the facility will ensure each resident's privacy and ensure all residents were	F 583			

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F 583	Continued From page 10 educated and informed of their rights.	F 583			
F 677 SS=D	The facility failed to secure PHI out of view for R125. This deficient practice placed the R125 at risk for decreased psychosocial wellbeing due to impaired privacy. ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: The facility identified a census of 29 residents. The sample included 13 residents. Based on observations, record review, and interviews, the facility failed to provide the necessary care and services for activities of daily living (ADL) for Resident (R)5 when staff pulled on R5 under her arms instead of using available equipment to assist in repositioning her. This deficient practice placed R5 at risk for injury. Findings included: - R5's Electronic Medical Record (EMR) documented diagnoses age related osteoporosis (abnormal loss of bone density and deterioration of bone tissue with an increased fracture risk), unsteadiness on feet, and hemiplegia (paralysis of one side of the body) and hemiparesis (muscular weakness of one half of the body) following cerebral infarction (stroke- sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain) affecting left	F 677			

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F 677	Continued From page 11 side. The "Annual Minimum Data Set (MDS)" dated 04/25/23, documented a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS documented R5 was dependent and required staff for all effort for transition from laying to seated position, seated to standing, and chair/bed/toilet transfers. The "ADL Functional/Rehabilitation Potential Care Area Assessment (CAA)" dated 04/25/23, documented R5's ADL functional rehabilitation potential would be addressed in R5's "Care Plan." R5's "Care Plan" with an initiated date of 10/30/23, documented R5 was at risk for falls/injury related to left hemiplegia and osteoporosis. R5's "Care Plan" with an initiated date of 10/30/23, documented R5 had an alteration in functional abilities related to left-side hemiplegia. An intervention initiated 10/30/23 documented R5 was dependent on staff for rolling left and right, transferring from sitting to lying, and lying to sitting. An intervention with an initiated date of 10/30/23, documented R5 was dependent for chair, bed and shower transfers and required use of a Hoyer Lift (total body mechanical lift). An observation on 10/30/23 at 11:18 AM revealed R5's representative propelled R5 in her wheelchair in a common area. R5 had a Hoyer lift sling under her in the wheelchair. R5's representative asked staff for assistance in repositioning R5 in the wheelchair. Administrative Nurse D came over and attempted to reposition R5. Administrative Nurse D stood behind R5 and	F 677			

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F 677	Continued From page 12 placed her arms under R5's arms and attempted to lift R5 up and back into the chair, two times, causing R5's shoulders and arms to raise upward before being assisted by another staff member. Once the other staff member arrived to assist, Administrative Nurse D and the staff member moved to each side of R5 and repositioned R5 in her wheelchair manually without the aid of the lift. On 11/01/23 at 02:10 PM Certified Nurse Aide (CNA) M stated if a resident required repositioning in a wheelchair, and required a Hoyer lift for transfers, that she would use the Hoyer lift to reposition them in the wheelchair. She stated that she would refrain from pulling on the resident under their arms as she was afraid it may hurt them. On 11/01/23 at 02:24 PM Licensed Nurse (LN) H stated if a resident required repositioning in a wheelchair and the resident was unable to do it on their own, she would have them lock the chair and have another staff assist her in reposition them. She stated they would reposition the resident with two people going under the resident's arms, she further stated if the resident already had a Hoyer sling under them then she would use the sling to reposition them and not pull on the resident. On 11/01/23 at 02:39 PM Administrative Nurse D stated she expected staff to safely reposition a resident in a wheelchair, so the resident did not fall on the floor. She stated that she repositioned R5 in the common area due to R5 was tilted in the wheelchair and she was concerned R5 may fall out of the chair onto the floor. She stated if a resident had a Hoyer sling in their chair, then staff could use that to help reposition the resident and	F 677			

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F 677	Continued From page 13 not pull on the residents extremities. The undated "Quality of Care" policy documented It is the policy of this facility that residents are given the appropriate treatment and services to maintain or improve his/her abilities. The facility failed to provide the necessary care and services needed to reposition R5 in her wheelchair when staff pulled on R5 under her arms instead of using available equipment to assist in repositioning her. This placed R5 at risk for injury.	F 677			
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 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 29 residents. The sample included 13 residents. Based on	F 688			

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F 688	Continued From page 14 observation, record review, and interview, the facility failed to ensure Resident (R) 1 had the physician-ordered ankle foot orthotics (AFO-brace that supports the ankle and foot) and services to prevent reduction of range of motion [ROM] and/or mobility. This deficient practice left R1 at risk for further decline and decreased ROM or mobility. Findings included: - R1's Electronic Medical Record (EMR) documented a diagnosis of generalized muscle weakness, contracture (abnormal permanent fixation of a joint or muscle) of the left and right elbow, wrist, and shoulders, hemiplegia (paralysis of one side of the body) and hemiparesis (muscular weakness of one half of the body) following cerebral infarction (stroke- sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain) affecting left side. The "Annual Minimum Data Set (MDS)" dated 09/02/23, documented a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS documented R1 was dependent on staff for activities of daily living (ADL) and transfers. The "ADL Functional/Rehabilitation Potential Care Area Assessment (CAA)" dated 09/02/23, documented R1's ADL functional rehabilitation potential would be addressed in R1's "Care Plan." R1's "Care Plan" with an initiated date of 05/20/16, documented R1 had a self care deficit related to decreased mobility secondary to	F 688			

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F 688	Continued From page 15 hemiplegia and contracture of her hands. Intervention with an initiated date of 11/29/21 documented a foot board was added to R1's wheelchair pedals to help keep her feet from sliding off. A "Written Order" dated 11/29/21 documented therapy to evaluate and treat for positioning foot drop (inability or difficulty in moving the ankle and toes upward). A "Physician's Order" dated 10/18/23 documented bilateral AFO for contracture management. An observation on 10/31/23 at 03:50 PM revealed R1 sat in a recliner in her room with her feet elevated on the footrest and her feet/toes were pointed down, toward the wall across from her. R1's representative was in the room with her. R1 stated that she did not have a brace for her feet/ankles and that she had never received one. R1's representative stated that R1 was supposed to have a brace to help keep her feet straight; however, the facility never got the braces for her. He further stated that he had asked about getting something to help with her feet before the facility changed ownership and was told staff would check into it. He stated that he was recently told that the facility was checking into getting the AFO braces for R1, but she had still not received them yet. On 11/01/23 08:02 at AM Consultant HH stated her therapy team started therapy services for the facility in October of 2023. She stated that she was not aware if R1 admitted to the facility with the foot drop issue; however, she stated that her team identified the issue and were in the process	F 688			

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F 688	Continued From page 16 of having the AFOs ordered for R1. She stated that documentation had to be sent to an outside facility to be reviewed and that the braces would be ordered through this outside facility and sent to R1. She stated that R1 was not receiving therapy services at the facility previously as there was no in house therapy under the previous ownership. On 11/01/23 at 02:24 PM Licensed Nurse (LN) H stated she believed R1 had braces for her feet/ankle a long time ago and that R1 thought they were uncomfortable. She stated that R1's representative bought a new wheelchair for R1, and staff used the footboard on her new wheelchair instead. She stated that she was unsure if anything further had been done to address R1's foot/ankle issues. On 11/01/23 at 02:39 PM Administrative Nurse D stated R1's representative had come to staff with concerns about R1's foot drop and was worried it had gotten worse. Administrative Nurse D stated that staff had spoken with the previous provider about having her sent to an outside clinic to see if something could be done to address the issues with her feet before the facility had therapy services. Administrative Nurse D further stated the facility has inhouse therapy services that were looking into finding something that will work for R1. She stated that the believed R1's representative mentioned his concerns about R1's foot drop at the beginning of September 2023 and that staff had told him they were looking into finding something for R1 to help with the issue. Administrative Nurse D stated they had tried to use different things in the past to help with R1's foot drop and nothing had worked. The undated facility provided "Range of Motion"	F 688			

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F 688	Continued From page 17 policy documented It is the policy of this facility to prevent a resident's loss of range of motion and appropriate treatment and services will be administered to increase range of motion and/or prevent further decrease in range of motion. The facility failed to ensure R1 had the physician-ordered AFO and services to prevent reduction of ROM and/or mobility. This deficient practice left R1 at risk for further decline and decreased ROM or mobility.	F 688			
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- (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	F 690			

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F 690	Continued From page 18 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 29 residents. The sample included 13 residents with three reviewed for bowel and bladder management. Based on observation, record review, and interviews, the facility failed to implement individualized interventions to improve/maintain Resident (R)15's bowel and bladder incontinence. This deficient practice placed R15 at risk for complications related to incontinence. Findings Included: - The "Medical Diagnosis" section within R15s Electronic Medical Records (EMR) included diagnoses of chronic kidney disease, acute kidney failure, history of falls, weakness, and a need for assistance with personal care. R15's "Admission Minimum Data Set (MDS)" dated 10/14/23 noted a Brief Interview for Mental Status (BIMS) score of 11 indicating mild cognitive impairment. The MDS indicated he required partial to moderate assistance with toileting care and transferring. The MDS noted he was frequently incontinent of bowel and bladder with no toileting program.	F 690			

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F 690	Continued From page 19 R15's "Urinary Incontinence Care area Assessment (CAA)" completed 10/21/23 indicated he had an alteration in continence related to his recent fall and hospitalization. The CAA noted he had bowel and bladder incontinence and was toileted upon request. The CAA noted his care plan would address his care needs. R15's "Care Plan" initiated 10/11/23 indicated he had an alteration in self-care related to his hospitalization prior to his admission. The plan indicated his fall resulted from syncope (fainting) during toileting. The plan indicated he required assistance of one staff for bathing, bed mobility, dressing, and personal hygiene. The plan lacked individualized interventions to maintain and promote R15's highest level of functioning related to incontinence. R15's "Admission Bowel and Bladder" assessment completed 10/11/23 indicated he was incontinent of bowel and bladder. The assessment indicated he was alert and oriented. The assessment indicated he had initiative and willingness to participate in the toileting program. The assessment noted he was a likely candidate for bowel and bladder re-training. On 11/01/23 at 01:30PM Certified Nurse's Aide (CNA) M stated R15 was checked on ever two hours and provided incontinence products. She stated he had both bowel and bladder incontinence. She stated some residents were toileted more frequently due to their heavy incontinence patterns. She stated most resident were check and change every few hours. On 11/01/2023 at 01:40PM Licensed Nurse (LN)	F 690			

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F 690	Continued From page 20 G stated direct care staff would encourage bathroom use before laying him down for bed. She was not sure if individualized interventions were implemented but most residents were checked on at least every two hours. On 11/01/2023 at 02:05PM Administrative D stated each resident was screened upon admission for incontinence and a care plan implemented to maintain or improve the resident's incontinence status. She stated each resident's incontinence status was monitored and documented. She stated the interdisciplinary team would meet to discuss interventions to improve incontinence and prevent infections. The facility's "Incontinence Management" policy revised 10/2023 stated that resident will be evaluated for bowel and bladder incontinence management. The policy noted that pattern evaluations will be provided to residents for individualized continence management programs. The assessment The facility failed to implement individualized toileting interventions related to bowel and bladder incontinence for R15, who was a candidate for bowel and bladder retraining. This deficient practice placed R15 at risk for complications related to incontinence.	F 690			
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's	F 692			

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F 692	Continued From page 21 comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: The facility identified a census of 29 residents. The sample included 13 residents with one reviewed for nutrition. Based on observation, record review, and interviews, the facility failed to monitor Resident (R)127's weight loss or changes in dietary intake. This deficient practice placed R127 at risk for complication related to weight loss and malnutrition (condition that develops when the body is deprived of vitamins, minerals and other nutrients). Findings Included: - The "Medical Diagnosis" section within R127s Electronic Medical Records (EMR) included diagnoses of chronic kidney disease, osteoporosis (abnormal loss of bone density and deterioration of bone tissue with an increased fracture risk), muscle weakness, history of fractures (broken bones), and history of falls.	F 692			

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F 692	Continued From page 22 R127's "Admission Minimum Data Set (MDS)" dated 10/11/23 noted a Brief Interview for Mental Status (BIMS) score of nine indicating moderate cognitive impairment. The MDS indicated she required set-up assistance with meals. The MDS indicated she weighed 117.2 pounds (lbs.). The MDS documented the resident was not on a physician-prescribed weight loss regimen. R127's "Functional Abilities Care Area Assessment (CAA)" completed 10/31/23 was at risk for altered functional abilities related to her medical diagnoses. The CAA indicated she required assistance with her activities of daily living (ADL). R127's "Cognitive Impairment CAA" completed 10/31/23 indicated she had impaired cognition and instructed staff to cue and reorient her as needed. R127's "Care Plan" initiated 10/18/23 she had a self-care deficit related to her ADL. The plan noted she was on a regular diet with regular texture. The plan instructed staff to monitor her intake and record every meal. The plan instructed staff to monitor and report symptoms of dysphagia, malnutrition, decreased appetite, and weight loss to the medical provider. An "Admission Nutrition Evaluation" completed 10/18/23 indicated R127 weight was 117.2 lbs. The evaluation indicated she was at risk due to due to acute disease in the past three months. A "Mini-Nutritional Assessment" dated 10/18/23 indicated R127 was at risk of malnutrition. A "Nutrition/Hydration Risk Evaluation" completed	F 692			

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F 692	Continued From page 23 10/20/23 noted R127 was at moderate risk for malnutrition. The evaluation noted she took no medications contributing to weight loss risks. R127's EMR revealed her admission weight on 10/17/23 was 117.2 lbs. The EMR recorded her weight decreased to 99.1 lbs. on 10/25/23 and 97.2 lbs. on 10/27/23. R127's EMR, between 10/25/23 through 11/01/23, lacked evidence of physician notifications related her weight loss or change in her oral intake. A review of R127's EMR under "Documentation Survey Report" from 10/17/23 to 11/01/23 indicated no meal intake monitoring occurred from 10/21/23 to 10/29/23 for breakfast, lunch, and dinner meals. On 10/30/23 at 08:11AM R127 reported she recently had issues with weigh loss but ate her meals. R127 consumed her entire breakfast without concerns in the dining room. On 11/01/2023 at 01:30PM Certified Nurse's Aide (CNA) M stated direct care staff would complete scheduled weights of the resident per the physician's orders. She stated if a resident's weight was off by three pounds the resident would immediately be reweighed and the nurse notified of the change. She stated meal intake monitoring would be documented in the EMR system and the physician would be notified of changes in oral intake by the nurse. She stated R127 just recently admitted to the facility and had no complaints related to her meals or eating. On 11/01/2023 at 01:40PM Licensed Nurse (LN)	F 692			

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F 692	Continued From page 24 G stated residents with noticeable weight changes would be placed on weekly weights and monitored closely for diet, medications, and intake. She stated the resident's weight loss would be reported to the physician and dietician for review. She stated a progress note would be completed to document the notification and well as changes in care. She stated residents at risk for weight loss and malnutrition were closely monitored for oral intake. On 11/01/2023 at 02:05PM Administrative Nurse D stated staff were expected to ensure the medical provider and registered dietician were notified of suspected weight loss. She stated the facility would increase weight monitoring occurrences and provide dietary supplementation for residents at risk for malnutrition. She stated staff were expected follow each resident's care planned interventions and orders to prevent or avoid unnecessary weight loss for the residents. A review of the facility's "Weight Monitoring" policy revised 10/2023 indicated the facility ensured acceptable parameters of body weight. The policy noted each resident will be provided ongoing evaluation and interventions to prevent significant weight loss. The policy indicated the physician will be notified in changes related to each resident's preferences, diet, allergies, meal consumption, and weight. The facility failed to monitor R127's weight loss or changes in dietary intake. This deficient practice placed R127 at risk for complication related to weight loss and malnutrition.	F 692			
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6)	F 757			

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F 757	Continued From page 25 §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 29 residents. The sample included 13 residents with five residents reviewed for unnecessary medication. Based on observation, record review, and interviews, the facility failed to provide adequate pulse monitoring for Resident (R)125's anti-hypertensive beta-blocker (class of medication used to treat high blood pressure). This deficient practice placed R125 at risk for unnecessary medications and adverse medication effects. Findings Included:	F 757			

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F 757	Continued From page 26 - The "Medical Diagnosis" section within R125's Electronic Medical Records (EMR) included diagnoses of fracture of right femur (broken bone), aphasia (difficulty speaking), dementia (progressive mental disorder characterized by failing memory, confusion), cerebral infarction (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), and congestive heart failure (a condition with low heart output and the body becomes congested with fluid). R125's "Admission Minimum Data Set (MDS)" dated 10/11/23 noted a Brief Interview for Mental Status (BIMS) score of three indicating severe cognitive impairment. The MDS indicated he admitted on 10/06/23. The MDS noted he had hypertension (high blood pressure) and heart failure. R125's "Communication Care Area Assessment (CAA)" completed 10/21/23 indicated he was at risk for altered communication related to his aphasia. The CAA instructed staff to give him extra time to form words and assist him with functional abilities. The CAA noted care planning would address his risks. R125's "Psychotropic Medication CAA" completed 10/21/23 indicated he was at risk for adverse medication affects. The CAA noted care planning would address his risks. R125's "Care Plan" initiated 10/13/23 indicated he had congestive heart failure. The plan instructed staff to administer his antihypertensive medication as ordered and observe him for adverse effects. The plan indicated he took	F 757			

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F 757	Continued From page 27 metoprolol (antihypertensive beta-blocker medication) related to his heart failure. R125's EMR under "Physician's Orders" dated 10/06/23 revealed an order to administer 25 milligrams (mg) of metoprolol tartrate by mouth once daily for hypertension. The "Medication Administration Record" (MAR) indicated the medication was scheduled to be given at 07:00AM. The orders lacked instruction to monitor R125's pulse before administration. A review of R125's EMR revealed no consistent pulse monitoring to correspond with the administration of R125's daily metoprolol. On 10/30/23 at 08:00AM, R125 sat in his wheelchair in his room. He was clean and well groomed. On 11/01/2023 at 01:40PM, Licensed Nurse (LN) G reported the facility currently had no standing orders to monitor antihypertensive medications due to the recent ownership change. She stated the nurses were expected to use their nursing judgement when administering medications. On 11/01/2023 at 02:05PM Administrative Nurse D stated that many of the orders have not been updated in the new system since the ownership change. She stated staff were expected to administer medications based on the physician's order and call if they had questions. A review of the "Medication Administration" policy 10/2023 indicated medications will be prepared, monitored, and administered per the physician's order.	F 757			

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F 757	Continued From page 28	F 757			
F 761 SS=E	The facility failed to provide adequate pulse monitoring for R125's anti-hypertensive beta-blocker medication. This deficient practice placed R125 at risk for complications related to unnecessary medications and adverse medication effects. Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: The facility reported a census of 29 residents.	F 761			

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F 761	Continued From page 29 Based of observations, record review, and interviews, the facility failed to ensure safe storage of medications for one of three medication rooms. This deficient practice placed the residents at risk for unnecessary medication and administration errors and/or diversion. Findings Included: - On 10/20/23 at 07:05AM a walkthrough of the facility's Prairie View hallway revealed the medication storage room door was propped fully open and unattended by nursing staff. The medication storage cart within the room was left unlocked and contained medications for all five residents on the Prairie View hallway, Resident (R)8, R11, R13, R19 and R125. At 07:21AM Licensed Nurse (LN) G entered the hallway and reported the medication room should not have been left open. She stated she was not sure why the room was propped open, or the cart left unlocked. She stated staff were to ensure they secured the door as the left the room. On 11/02/23 at 02:05PM Administrative Nurse D stated staff were expected to securely close the medication room doors when not in use. She stated the medication carts within the rooms should be locked for added security of the medications. The facility's "Medication Access and Storage" policy revised 10/2023 indicated that all drugs and biologicals were to be stored in locked compartments accessible only by licensed personnel. The policy indicated all medication rooms, carts, and supplies remain locked when not attended.	F 761			

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F 761	Continued From page 30 The facility failed to ensure safe storage of medications for one of three medication rooms. This deficient practice placed the residents at risk for unnecessary medication and administration errors or diversion.	F 761			
F 851 SS=F	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). §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,	F 851			

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F 851	Continued From page 31 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 had a census of 29 residents. Based on observation, interview, and record review, the facility failed to submit complete and accurate staffing information through Payroll Based Journaling (PBJ) as required. This deficient practice placed the residents at risk for unidentified and ongoing inadequate nurse staffing. Findings included:	F 851			

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F 851	Continued From page 32 - The PBJ report provided by the Centers for Medicare & Medicaid Services (CMS) for Fiscal year (FY) 2023 Quarter 2 and Quarter 3 indicated the facility did not have licensed nurse coverage 24 hours a day, seven days a week on multiple (10) dates. Review of the facility licensed nurse timeclock data for the dates listed on the PBJ revealed a licensed nurse was on duty for 24 hours a day seven days a week. On 11/01/23 at 02:24 PM, an observation revealed a licensed nurse on duty in the facility. On 11/01/23 at 12:05 PM Administrative Staff A stated staff reporting to CMS was done through the hospital/previous owners and would be until the end of November 2023. He stated the facility would take over staff reporting in December 2023. Administrative Staff A stated that he was not aware of any staffing issue reported on the PBJ and that the facility did not have any days where there were no nurses on duty to cover every shift. The undated facility provided "Payroll-Based Journal" policy documented It is the policy of this facility to submit information on a quarterly basis to CMS as required that details the hours facility staff works in specific job titles. Data reported includes, for every direct care worker, the dates they worked, and the number of hours worked on that day. The facility failed to submit complete and accurate staffing information through PBJ as required. This deficient practice placed the	F 851			

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F 851	Continued From page 33 residents at risk for unidentified and ongoing inadequate nurse staffing.	F 851			