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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey and Complaints #KS00183643, #KS00183986, #KS00183203, #KS00183173, and #KS00182306. The 2567 was sent electronically on 12/08/23.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.	F 550		

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

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

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

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 77 residents. The sample included 19 residents, with three reviewed for dignity. Based on observation, record review, and interview, the facility failed to promote dignity for Resident (R) 31, who was observed by a resident of the opposite sex while in the shower, and for R3 and R56 who did not have dignity bags over their urine collection bags. This placed the residents at risk for undignified care and services.

Findings included:

- R31's Electronic Medical Record (EMR) documented diagnoses of diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), hypertension (high blood pressure), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and chronic respiratory failure (occurs when the blood has too much carbon dioxide or not enough oxygen).

The "Quarterly Minimum Data Set" (MDS), dated 07/14/23, documented R31 had intact cognition,

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and required extensive assistance with bed mobility, transfers, dressing, and toileting. The MDS documented that bathing did not occur during the observation period. The MDS further documented R31 required setup and supervision with personal hygiene.

R31's "Care Plan," dated 08/28/23, initiated on 01/11/22, documented R31 could be independent with personal hygiene, toileting, and showers with the use of a reacher but she often asked for assistance.

On 11/27/23 at 09:30 AM, R31 stated she was in the shower and a Certified Nurse Aide (CNA) opened the door to the shower room and started to bring R34, a male resident, through the door. R31 said R34 saw her nude. R31 stated the CNA with her in the shower yelled at them to leave but it was too late, R34 already saw her. R31 said she was "mortified."

On 11/28/23 at 01:03 PM, Licensed Nurse (LN) I stated he heard something regarding the incident in the shower room with R31 but did not know all the facts.

On 11/29/23 at 04:00 PM, CNA OO stated she gave R31 a shower and CNA Q opened the door and started to bring R34 into the shower room. CNA OO stated she yelled for CNA Q to leave the room but said she knew that the male resident had already saw R31 nude. CNA OO further stated she told CNA Q that she was going to give R31 a shower so that CNA Q would know that she was unavailable to assist with other cares.

On 11/30/23 at 02:30 PM, CNA Q stated she was holding R34 by the hand to take him along with

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her so he would not go into other resident rooms. CNA Q said she put the shower room code in and opened the door to the shower room. CNA Q further stated CNA OO had stated "I'm giving [R31] a shower." CNA Q stated she did not think R34 saw R31 nude, but she was unsure. Observation of the shower room, with CNA Q, revealed the shower stall was highly visible from the shower room door. CNA Q then said, "well yes, he probably could have seen her, but he is so demented, he probably wouldn't notice." CNA Q stated that it took over an hour to give R31 a shower, so she went to see what was took so long because R34 needed a shower also.

On 11/30/23 at 11:45 AM, Administrative Nurse E stated she was unaware of the incident and was very surprised R31 had not told administration staff about it as they talked with her almost daily.

On 11/30/23 at 12:40 PM, Administrative Staff A stated an investigation would be completed regarding the incident with R31. Administrative Staff A said she wanted to make sure that the incident truly happened and was not just misinformation from R31.

The facility's "Quality of Life - Dignity" policy, dated 12/2021, documented each resident shall be cared for in a manner that promoted and enhanced quality of life, dignity, respect and individuality. Associates shall promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures.

The facility failed to promote dignity for R31 when staff failed to prevent a resident of the opposite sex from viewing R31 in the shower. This placed

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the resident at risk for an undignified experience.

- The "Medical Diagnosis" section of R3's Electronic Medical Record (EMR) included diagnoses of congested heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), chronic respiratory failure with hypoxia (inadequate supply of oxygen), urinary tract infection (UTI-an infection in any part of the urinary system), chronic kidney disease, retention of urine, and major depressive disorder (major mood disorder which causes persistent feelings of sadness).

The "Comprehensive Minimum Data Set" (MDS), dated 07/28/23, documented R3 had moderately impaired cognition, was dependent on staff for oral hygiene, toileting hygiene, and dressing. R3 had an indwelling urinary catheter (tube placed in the bladder to drain urine into a collection bag) and was always incontinent of bowel. The MDS further documented R3 had pain and received scheduled and as needed pain medication. R3 took an anticoagulant (a group of medication that decreases blood ability to clot), antibiotic (medication used to treat infection) and diuretic (medication to promote the formation and excretion of urine) daily.

The "Urinary Incontinent/Indwelling Catheter Care Area Assessment" (CAA), dated 10/10/23, documented R3 had a catheter due to urine retention. R3 took a diuretic for CHF and required maximum assistance with activities of daily living (ADL).

R3's "Care Plan", dated 02/10/23, documented R3 had altered elimination related to use of an

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indwelling catheter. The care plan directed staff to monitor for signs/symptoms of urinary tract infections, maintain a closed drainage system, and catheter care per facility policy. The care plan lacked instruction for the use of a privacy bag, to maintain dignity of the resident.

The "Physician Order", dated 07/29/22, directed staff to provide catheter care every shift.

The "Physician Order", dated 07/15/23, directed staff to change indwelling catheter every month for urinary retention.

The "Physician Order", dated 06/20/23, directed staff to administer nitrofurantoin 100 milligrams (mg) daily for prophylaxis (preventative in nature).

On 11/27/23 at 11:57 AM, observation revealed R3 sat in the dining room, in a wheelchair, with the catheter drainage bag attached to the underside of the wheelchair. The bag touched the floor and was not covered with a privacy bag.

On 11/28/23 at 07:49 AM, observation revealed R3 sat in the dining room with a privacy bag attached to the underside of the wheelchair.

On 11/29/23 at 09:28 AM, observation revealed R3 remained in bed. The catheter drainage bag was hooked to the bed frame at the foot of the bed, did not have a privacy bag, and touched the floor. It was visible from the hallway.

On 11/29/23 at 10:03 AM, observation revealed Certified Nurse Aide (CNA) M assisted R3 with ADLs. Licensed Nurse (LN) G assisted with R3's mechanical lift transfer from R3's bed to recliner. Once R3 was placed in the recliner, staff

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unhooked the catheter drainage bag and placed it on the floor. Once the mechanical lift was removed, staff hooked the catheter drainage bag onto the trash can next to the recliner. It remained in contact with the floor, lacked a a privacy bag, and was visible from the hallway door.

On 11/27/23 at 12:41 PM, CNA O stated the catheter bag should not touch the ground. CNA O said she unsure of the facility's policy regarding privacy bags, but stated there was another resident on the unit who had one. CNA O reported she was not sure where to obtain a privacy bag for catheters.

On 11/27/23 at 12:41, LN H verified catheter bags should not touch the floor. LN H stated he thought it was the resident's family that provided privacy bags and said he would have to find out if the facility had privacy bags.

On 11/29/23 at 01:58 PM CNA M stated R3 should have a privacy bag covering the drainage bag but was not sure if R3 had one.

On 11/30/23 at 11:37 AM Administrative Nurse E verified R3 should have a privacy cover for the catheter.

The facility's "Quality of Life-Dignity", dated 12/2021, documented each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality. Associates shall maintain an environment in which confidential clinical information is protected. Demeaning practices and standards of care that compromise dignity is prohibited. Staff shall promote dignity and assist residents as needed but helping the resident to

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keep urinary catheter covered.

The facility failed to ensure a privacy bag was provided to R3 to cover the urinary catheter collection bag. This placed the resident at risk for undignified experiences and embarrassment.

- R56's Electronic Medical Record (EMR) recorded diagnoses of adult failure to thrive (a syndrome of weight loss, decreased appetite and poor nutrition, and inactivity) and urinary retention (the inability to completely or partially empty the bladder).

R56's "Quarterly Minimum Data Set" (MDS), dated 09/22/23, recorded the resident had a Brief Interview for Mental Status (BIMS) score of 15 (cognitively intact), and an indwelling urinary catheter (a tube in the bladder to drain urine).

R56's "Care Area Assessment" (CAA) documented the resident required a urinary catheter due to urinary incontinence.

R56's "Care Plan" dated 10/11/23, documented the resident had an indwelling urinary catheter.

R56's 10/01/23 "Physician Order" directed a Foley catheter at all times for the diagnosis of urinary retention.

On 11/29/23 at 08:25 AM, observation revealed R56 rested in bed with the uncovered urinary catheter bag hanging on the right side of the bed frame, visible from the door.

On 11/30/23 at 11:30 AM, Administrative Nurse E stated the resident's urinary catheter bag should

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F 550	Continued From page 8 be covered at all times. The facility's "Quality of Life and Dignity" policy, dated December 2021, documented each resident would be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality. The policy documented staff shall promote, maintain and protect resident's privacy, including bodily privacy during assistance with personal cares and during treatment procedures. The facility failed to cover R56's urinary catheter bag, placing the resident at risk for embarrassment and an undignified living environment.	F 550		
F 636 SS=E	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision.	F 636		

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F 636	Continued From page 9 (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months.	F 636		

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This REQUIREMENT is not met as evidenced by:
The facility had a census of 77 residents. The sample included 19 residents. Based on record review and interview, the facility failed to complete comprehensive Minimum Data Set Assessment (MDS) for one sampled resident, Resident (R)31 and eight unsampled residents, R13, R17, R26, R30, R36, R39, R58, and R64. This placed the resident's at risk for unmet care needs and inaccurate assessments.

Findings included:

- R13's Electronic Medical Record (EMR) recorded a quarterly MDS, dated 06/29/23. R13's EMR recorded a comprehensive MDS, dated 09/07/23, was in progress but not completed or submitted as required.

R17's EMR recorded a comprehensive MDS, dated 06/22/23. R17's EMR recorded a significant change MDS, dated 09/15/23, was in progress but not completed or submitted as required.

R26's EMR recorded a quarterly MDS, dated 06/16/23. R26's EMR recorded a comprehensive MDS, dated 08/25/23, was in progress but not completed or submitted as required.

R30's EMR recorded a quarterly MDS, dated 06/04/23. R30's EMR recorded a comprehensive MDS, dated 09/01/23, was in progress but not completed or submitted as required.

R31's EMR recorded a quarterly MDS, dated 07/14/23. R31's EMR recorded a comprehensive MDS, dated 09/29/23, was in progress but not completed or submitted as required.

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R36'sEMR recorded a quarterly MDS, dated 06/29/23. R36's EMR recorded a significant change MDS, dated 09/08/23, was in progress but not completed or submitted as required.

R39's EMR recorded a quarterly MDS, dated 07/15/23. R39's EMR recorded a comprehensive MDS, dated 10/13/23, was in progress but not completed or submitted as required.

R58's EMR recorded a quarterly MDS, dated 06/10/23. R30's EMR recorded a comprehensive MDS, dated 08/18/23, was in progress but not completed or submitted as required.

R64's EMR recorded a quarterly MDS, dated 07/20/23. R64's EMR recorded a comprehensive MDS, dated 010/18/23, was in progress but not completed or submitted as required.

On 11/28/23 at 10:15 AM, Administrative Nurse E stated the facility was aware that the MDS assessments were behind, and staff were trying to get them caught up.

The facility's "MDS Assessment" policy, dated 12/2017, documented residents in the nursing community would have an MDS Assessment completed in accordance with Centers for Medicare and Medicaid Services (CMS) guidelines as outlined in the Resident Assessment Instrument (RAI) Manual. Comprehensive assessments are initiated for residents by the fourteenth day in accordance with CMS guidelines, and other required assessments completed per the RAI Manual.

The facility failed to complete comprehensive

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F 636	Continued From page 12 MDS for R31, R13, R17, R26, R30, R36, R39, R58, and R64. This placed the resident's at risk for unmet care needs and inaccurate assessments.	F 636		
F 638 SS=E	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: The facility had a census of 77 residents. The sample included 19 residents. Based on record review and interview, the facility failed to conduct a quarterly Minimum Data Set (MDS) assessment in the required timeframe for five sampled residents: Resident (R)3, R10, R54, R65, and R180 and 16 unsampled residents: Resident (R)5, R7, R18, R19, R22, R23, R37, R38, R40, R41, R48, R57, R58, R60, R66, and R67. This placed the residents at risk for unmet care needs and inaccurate assessments. Findings included: - R3's Electronic Medical Record (EMR) recorded a comprehensive MDS, dated 07/28/23. R3's EMR recorded a quarterly MDS, dated 09/21/23, was in progress but not completed or submitted as required. R5's EMR recorded a quarterly MDS dated, 07/17/23. R5's EMR recorded a quarterly MDS, dated 10/13/23, was in progress but not completed or submitted as required.	F 638		

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R7's EMR recorded a quarterly MDS, dated 06/15/23. R7's EMR recorded a quarterly MDS, dated 09/15/23, was in progress but not completed or submitted as required.

R10's EMR recorded a quarterly MDS, dated 06/26/23. R10's EMR recorded a quarterly MDS, dated 09/08/23, was in progress but not completed or submitted as required.

R18's EMR recorded a quarterly MDS dated, 06/28/23. R18's EMR recorded a quarterly MDS, dated 09/22/23, was in progress but not completed or submitted as required.

R19's EMR recorded a comprehensive MDS, dated 06/22/23. R19's EMR recorded a quarterly MDS, dated 09/22/23, was in progress but not completed or submitted as required.

R22's EMR recorded a quarterly MDS, dated 07/23/23. R22's EMR recorded a quarterly MDS, dated 09/22/23, was in progress but not completed or submitted as required.

R23's EMR recorded a quarterly MDS dated, 06/16/23. R23's EMR recorded a quarterly MDS, dated 09/01/23, was in progress but not completed or submitted as required.

R37's EMR recorded a comprehensive MDS dated, 07/12/23. R37's EMR recorded a quarterly MDS, dated 10/13/23, was in progress but not completed or submitted as required.

R38's EMR recorded a quarterly MDS, dated 06/16/23. R38's EMR recorded a quarterly MDS, dated 09/15/23, was in progress but not

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completed or submitted as required.

R40's EMR recorded a quarterly MDS, dated 08/08/23. R40's EMR recorded a quarterly MDS, dated 10/27/23, was in progress but not completed or submitted as required.

R41's EMR recorded a quarterly MDS, dated 06/23/23. R41's EMR recorded a quarterly MDS, dated 09/15/23, was in progress but not completed or submitted as required.

R48's EMR recorded a comprehensive MDS, dated 07/17/23. R57's EMR recorded a quarterly MDS, dated 10/13/23, was in progress but not completed or submitted as required.

R54's EMR recorded a quarterly MDS, dated 08/18/23. R54's EMR recorded a quarterly MDS, dated 11/17/23, was in progress but not completed or submitted as required.

R57's EMR recorded a quarterly MDS, dated 07/17/23. R57's EMR recorded a quarterly MDS, dated 10/13/23, was in progress but not completed or submitted as required.

R58's EMR recorded a quarterly MDS, dated 06/10/23. R58's EMR recorded a quarterly MDS, dated 09/29/23, was in progress but not completed or submitted as required.

R60's EMR recorded a quarterly MDS, dated 07/24/23. R60's EMR recorded a quarterly MDS, dated 10/24/23, was in progress but not completed or submitted as required.

R65's EMR recorded a comprehensive MDS, dated 06/16/23. R64's EMR recorded a quarterly

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MDS, dated 09/15/23, was in progress but not completed or submitted as required.

R66's EMR recorded a comprehensive MDS, dated 06/28/23. R66's EMR recorded a quarterly MDS, dated 09/15/23, was in progress but not completed or submitted as required.

R67's EMR recorded a comprehensive MDS, dated 06/29/23. R67's EMR recorded a quarterly MDS, dated 09/22/23, was in progress but not completed or submitted as required.

R180's EMR recorded a quarterly MDS, dated 05/10/23. R180's EMR recorded quarterly MDS, dated 08/04/23 and 10/27/23, were in progress but not completed or submitted as required.

On 11/28/23 at 10:15 AM, Administrative Nurse E stated the facility was aware that the MDS were behind, and staff were trying to get them caught up.

The facility's "MDS Assessment" policy, dated 12/2017, documented residents in the nursing community would have an MDS Assessment completed in accordance with Centers for Medicare and Medicaid Services (CMS) guidelines as outlined in the Resident Assessment Instrument (RAI) Manual. The Interdisciplinary Assessment Team examines each resident no less than once every three (3) months, and after identification of a significant change in accordance with CMS guidelines, and as appropriate may modify the resident's assessment to assure the continued accuracy of the assessment by completing the quarterly review.

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F 638	Continued From page 16 The facility failed to conduct a quarterly MDS assessment within 92 days of the previous assessment for 21 residents. This placed the residents at risk for unmet care needs and inaccurate assessments.	F 638		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes.	F 656		

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(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(iii) Be culturally-competent and trauma-informed.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 77 residents. The sample included 19 residents. Based on observation, record review, and interview, the facility failed to develop a comprehensive plan of care for Resident (R) 14 who was prescribed an anticoagulant (a group of medication that decreases blood ability to clot) which placed the resident at risk for uncommunicated care needs.

Finding included:

- The "Medical Diagnosis" section of R14's Electronic Medical Record (EMR) included diagnoses of acute respiratory failure with hypoxia (inadequate supply of oxygen), encounter for orthopedic (pertaining to bones) aftercare, fracture (broken bone) of around internal prosthesis (artificial body part) of left hip, pulmonary fibrosis (scaring of the lungs), atrial fibrillation (rapid, irregular heart beat), muscle weakness, and cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by

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blockage or rupture of an artery to the brain).

The "Comprehensive Minimum Data Set" (MDS), dated 09/06/23, documented R14 had intact cognition, and required supervision/partial to moderate assistance with functional abilities. R14 was frequently incontinent or urine and occasionally incontinent of bowel. R14 received scheduled pain medication, had major surgery prior to admission and recent surgery requiring skilled nursing facility for hip replacement. The MDS further documented R14 received an anticoagulant, antibiotic (a group of medications used to treat infections), and diuretic (medication to promote the formation and excretion of urine).

The "Activity of Daily Living Care Area Assessment"(CAA), dated 09/12/23, documented during the look back period R14 was incontinent of bladder and bowel, required extensive two staff assistance with bed mobility, transfers and toilet use. R14 required one staff assistance with ambulation, dressing, personal hygiene and bathing.

R14's "Care Plan," dated 08/30/23, documented R14 required assistance with transfers, mobility, dressing, bed mobility, toileting, and personal hygiene. The care plan further documented the use and interventions for the diuretic, but lacked information related to the use and interventions related to the use of an anticoagulant.

R14's "Physician Order" dated 11/20/23, instructed staff to administer Coumadin 7.5 milligrams (mg) once daily on Monday, Wednesday and Friday, and Coumadin 5 mg once daily on Tuesday, Thursday, Saturday and Sunday.

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The "Progress Note", dated 10/29/23, documented R14 received a skin tear to left upper arm when her fingernail caught her skin when she removed her shirt.

The "Progress Note" dated 11/01/23 documented staff noted a skin tear to R14's left lower arm; the cause was unknown.

On 11/28/23 at 03:00 PM, observation revealed R14 walked with a walker in the hallway; staff walked next to the resident holding onto a gait belt which was around the resident's waist.

On 11/29/23 at 03:15 AM, Certified Nurse Assistance (CNA) N reported R14 was mostly independent with cares but required assistance with walking. CNA N was not aware of any precautions related to R14's anticoagulant.

On 11/30/23 at 11:37 AM, Administrative Nurse E verified R14 should have a care plan problem related to the use of an anticoagulant and interventions for skin care.

The facility's "Care Plans-Comprehensive Person-Centered" policy, dated 10/2021, documented a comprehensive person-centered care plan that includes measurable objective and timetables to meet the resident's physical, psychosocial and functional needs, that are identified through evaluation and assessment, is developed and implemented for each resident. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. The comprehensive, person centered care plan will incorporate identified problem areas: incorporate

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F 656	Continued From page 20 risk factors associated with identified problems identify the professional services that are responsible for each element of care and reflect current recognized standards of practice for problem area and conditions. The facility failed to develop a comprehensive person-centered care plan for R14 which placed the resident at risk of complications due to uncommunicated care needs associated with the use of anticoagulant.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary	F 657		

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team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 77 residents. The sampled included 19 residents, with five reviewed for dementia (progressive mental disorder characterized by failing memory, confusion) care. Based on observation, record review, and interview, the facility failed to revise the care plan with person-centered interventions for dementia related behaviors for two sampled residents, Resident (R) 34 and R180. This placed the resident's at risk for abuse and decreased quality of life.

Findings included:

- The Electronic Medical Record (EMR) documented R34 had diagnoses of dementia without behaviors, anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), cognitive communication deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness), and depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, and emptiness).

The "Admission Minimum Data Set" (MDS), dated 09/14/23, documented severe memory problems. The MDS recorded R34 required extensive assistance of two staff for bed mobility, transfers, dressing, toileting, and extensive assistance of one staff for personal hygiene. R34 required limited assistance of one staff for ambulation. The assessment further documented

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R34 did not have any behaviors and received antipsychotic (class of medications used to treat major mental conditions which cause a break from reality) and antidepressant medication.

R34's "Care Plan," dated 09/11/23, directed staff to call him by his preferred name, provide daily orientation to facility routines and activity schedule, and use environmental cues to stimulate memory and promote appropriate behavior. The plan directed staff to provide consistent physical environment and daily routine. The update dated 09/20/23 documented R34's cognition fluctuated greatly, as he could be alert one minute and then extremely confused. R34 had impaired behavior due to wandering and directed staff to intervene to ensure safety of R34 and others, and to redirect R34 when he was disruptive. The update, dated 10/06/23, documented R34 wandered to other residents' rooms and directed staff to orient R34 to his environment and the location of his room.

The "Physician's Order," date 09/13/23, directed staff to administer Remeron (an antidepressant medication), 15 milligrams (mg), by mouth, at bedtime, for the diagnosis of depression.

The "Physician's Order," dated 10/18/23, directed staff to administer Zyprexa (an antipsychotic medication), 10 mg, by mouth, daily, for the diagnosis of hallucination (sensing things while awake that appear to be real, but the mind created), and bipolar disorder (major mental illness that caused people to have episodes of severe high and low moods).

The "Physician's Order," dated 10/20/23, directed staff to monitor for behaviors, and document

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effectiveness of interventions.

The "Physician's Order," dated 10/20/23, directed staff to administer Trazadone (an antidepressant medication), 75 mg, by mouth, daily, for the diagnosis of depression. The medication was discontinued on 11/20/23.

The "Physician's Order," dated 10/20/23, directed staff to contact Geri-psych (psychiatric services specializing in geriatric population) for assistance with behaviors.

The "Physician's Order," dated 10/27/23, directed staff to administer Ativan (antianxiety medication), 0.5 mg, by mouth, twice per day, for the diagnosis of anxiety.

The "Physician's Order," dated 11/21/23, directed staff to administer Trazadone, 150 mg, by mouth, at bedtime, for the diagnosis of depression and insomnia (inability to sleep).

The "Nurse's Note," dated 10/06/23 at 02:38 AM, documented R34 constantly hollered for help and was very restless and agitated. The note further documented R34 stated he was tired, was assisted to bed, was inconsolable and continued to yell for help.

The "Nurse's Note," dated 10/09/23, at 05:26 AM, documented R34 was awake and wandered around the unit and tried to enter other residents' rooms. The note further documented staff tried to intervene and R34 got upset with staff.

The "Psychiatric Care Note," dated 10/09/23 at 11:10 AM, documented R34 was seen due to behaviors of wandering into other resident rooms

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and staff were directed to keep R34 socially engaged.

The "Nurse's Note," dated 10/21/23 at 10:25 PM documented R34 was up in his wheelchair, and he propelled himself throughout the unit and yelled for help. The note recorded r34 refused his medications.

The "Nurse's Note," dated 11/24/23 at 01:51 PM, documented R34 wandered around the neighborhood, tried to move chairs and stand up. The note further documented the morning nurse went to check on R34, but he was not in his bed. The nurse found R34with no clothes on, with a towel on the floor. R34's incontinence brief hung off his left leg and there was urine all over the floor. R34's bed was saturated with urine.

The "Nurse's Note," dated 11/27/23, documented R34 was up in his wheelchair until after 10:00 PM. He wandered around the unit throughout the evening shift but was easily redirected by staff when staff found he had entered other residents' rooms. The note recorded R34 was known to enter other resident rooms unobserved by staff.

On 11/28/23 at 12:34 PM, observation revealed R34 propelled around the 300 neighborhoods in his wheelchair. R34 ran into a pillar by the dining room, then continued to propel around neighborhood. R34 ran into a wall by room 508 and then stood up. Dietary Staff CC told R34 to sit down but did not respond to the direction. Licensed Nurse (LN) H exited the nurse's office and assisted R34 to sit down, then moved him away from the wall. LN H then went back into the nurse office. Further observation revealed R34 propelled his wheelchair into the dining area and

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tried to go between a chair and another resident seated at a table. R34 kept trying to go through and his wheelchair ran into the resident seated at the table. Continued observation revealed the other resident became angry and yelled "Get out of here," and pushed on R34's wheelchair. LN H came back out of the nurse offices and pushed R34 out of the dining room area away from the other resident. Continued observation at 12:52 PM, revealed R34 propelled his wheelchair over to the area where Certified Nurse Aide (CNA) charting was done and started to mess with papers by the computer. CNA P walked over and pushed R34 away from the area then left to assist another resident in their room.

On 11/30/23 at 02:30 PM, CNA Q stated R34 was hard to redirect, and he often tried to go in and out of resident rooms. CNA Q said R34 sometimes tried to go out of the neighborhood, so she usually had to take R34 along when she worked, except when she went to other resident rooms to assist. CNA Q stated it was hard to keep track of R34 at times.

On 10/30/23 at 10:32 AM LN J stated R34 propelled all over the neighborhood, sometimes went into other resident rooms and wandered. LN J stated she usually got R34 up early in the morning because he seemed to do better as far as behaviors if he ate a good breakfast.

On 10/30/23 at 11:45 AM, Administrative Nurse E verified there was not individualized interventions related to R34 in order to direct staff how to care for the resident when he had behaviors and staff were at a loss as to what to do.

The facility's "Care Planning-Interdisciplinary

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Team" policy, dated 02/2022, documented the team was responsible for the development of an individualized comprehensive care plan for each resident and the resident and resident's representative are encouraged to participate in the development of and revision to the resident's care plan.

The facility failed to develop and implement individualize interventions and/or dementia treatment plan for R34 who had dementia and related behaviors. This deficient practice placed the resident at risk for abuse and decreased quality of life.

- The Electronic Medical Record (EMR) for R180 documented diagnoses of dementia without behavioral disturbances, cognitive communication deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear).

The "Quarterly Minimum Data Set," (MDS) doted 05/10/23, documented R180 had severely impaired cognition, inattention, disorganized thinking, and altered level on consciousness. The MDS recorded R180 had verbal behaviors one to three days during the week and was dependent upon two staff for transfers. R180 required extensive assistance of two staff for bed mobility, toileting, and dressing.

The 08/04/23 and 10/27/23 Quarterly MDS were not completed by the facility.

R180's "Care Plan," dated 11/07/23, initiated on

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02/11/23, directed staff to call her by name, and provide daily orientation to facility routines and activity schedules. The plan directed staff to use environmental cues to stimulate memory and promote appropriate behavior and provide cues to promote independence and ensure safety. The plan directed staff to anticipate needs and observe for nonverbal cues; the resident had dementia and had difficulty remembering recent events. Staff were to give reminders for mealtimes, activities, and dates as needed. The update dated 03/26/23 documented R180 preferred to be up in her wheelchair after she woke from naps after lunch. The update dated 10/16/23 directed staff to offer R180 to return to her room following meals. The update dated 11/17/23 documented R180 sometimes banged on the table with objects to gain others attention.

The "Physician's Order," dated 05/02/23, directed staff to administer buspirone (an antidepressant medication), 5 milligrams (mg), by mouth, daily, for the diagnosis of anxiety.

The "Physician's Order," dated 05/02/23, directed staff to administer mirtazapine (an antidepressant), 15 mg, by mouth, at bedtime for insomnia (inability to sleep)

The "Physician's Order," dated 06/23/23, directed staff to administer escitalopram (an antidepressant), 5 mg, by mouth, daily for anxiety.

The "Physician's Order," dated 07/19/23, directed staff to apply an Exelon patch (treats mild to moderate dementia), 4.6 mg/24 hours, daily, for dementia.

The "Nurse's Note," dated 06/06/23 at 04:48 PM,

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documented R180 quickly became incredibly anxious when staff left the room, and staff heard R180 state "You're killing me" to a Certified Nurse Aide (CNA) when R180 was brought out to the supper table despite having requested multiple times to be brought out.

The "Nurse's Note," dated 06/21/23 at 07:02 AM, documented R180 called out incessantly and made the same needs known repeatedly.

The "Nurse's Note," dated 06/28/23 at 01:32 PM, documented R180 yelled out multiple times during lunch that day and began to recite the Lord's Prayer.

The "Nurse's Note," dated 09/01/23 at 01:11 PM, documented staff observed R180 banging her cup on the table, and she repeated requests frantically twice during mealtime. R180 called out from her room but calmed quickly with reassurance.

The "Nurse's Note," dated 09/29/23 at 02:26 PM, documented R180 hollered a majority of the morning before and after breakfast and hit her cup on the table.

The "Nurse's Note," dated 10/9/23 at 03:48 AM, documented R180 yelled out for staff for different things. Staff attempted to give R180 fluids and reassurance.

The "Nurse's Note," dated 10/25/23 at 09:54 PM, documented R180 frequently yelled come here, "want some water, want some water" and other incoherent comments. Staff provided reassurance and staff checked R180's water and the mug was full each time. Staff assured R180

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her room was safe.

The "Nurse's Note," dated 10/26/23 at 03:14 PM, documented R180 called out frequently throughout night stating "Hey, hey, I need some water, I need some water" though R180 had two mugs withing her reach.

The "Nurse's Note," dated 10/30/23 at 04:11 AM, documented R180 was awake at night and yelled out nonsense and said the Lord's Prayer.

The "Nurse's Note," dated 10/31/23 at 03:54 PM, documented R180 had several episodes of yelling that day before breakfast and after her afternoon nap. She was also tearful once but was easily redirected.

The "Nurse's Note," dated 11/09/23 at 04:08 AM, documented R180 called out nonsensical words but when staff spoke with her, she stated she was fine.

The "Nurse's Note," dated 11/13/23 at 11:31 AM, documented R180 yelled out multiple times that morning.

The "Nurse's Note," dated 11/29/23 at 11:39 AM, documented R180 had repetitive behaviors and called out for her daughter over and over.

The "Nurse's Note," dated 11/30/23 at 03:39 AM, documented R180 yelled "water, water, water" though she had water.

R180's EMR lacked evidence professional mental health support services were provided to R180.

On 11/30/23 at 07:79 AM, observation revealed

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R180 sat at the dining room table. She appeared restless and vocalized, "I want to get away, I need to get away, I want to get away from everybody" over and over. Observation revealed no staff were present in the dining room. Further observation revealed R180 remained in the dining room and stated, "Let's get going, I want to get away, hurry, hurry, I don't like it here." At 08:50 AM, Licensed Nurse (LN) J told R180 she would take R180 to the resident's room later and told R180 to drink her water. R180 did not drink her water. At 09:00 AM, R180 repeated "Can I wiggle out, can I wiggle out, can I wiggle out?" Further observation revealed Consultant GG conducted rounds in the dining room. Consultant GG went to R180 and asked if it "hurt to pee." Consultant GG listened to R180's lungs, asked her if she had any questions, and then left. R180 repeated "Can I get out, can I get out, can I get out, help me, help me," over and over. Continued observation at 09:20 AM revealed R180 repeated, "I won't kill you; I won't kill you, underground, I'd rather be up here, I'd rather be up here, help me, help me!" At 09:51 AM, staff took R180 to her room.

On 11/30/23 at 10:00 AM, CNA M stated R180 was anxious, and staff provided reassurance and always told her what they were doing.

On 11/30/23 at 10:22 AM, LN J stated staff provided R180 a lot of reassurance and redirection when she was anxious and stated the resident's daughter saw her every night which seemed to calm the resident down.

On 10/30/23 at 1145 AM, Administrative Nurse E verified there was not individualized interventions or plans to direct staff how to care for R180 when she was anxious except for a lot of reassurance.

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F 657	Continued From page 31 The facility's "Care Planning-Interdisciplinary Team" policy, dated 02/2022, documented the team was responsible for the development of an individualized comprehensive care plan for each resident and the resident and resident representative are encouraged to participate in the development of and revision to the resident's care plan. The facility failed to develop and implement individualize interventions and/or dementia treatment plan for R180 who had dementia periods of anxiety. This deficient practice placed the resident at risk for a decreased quality of life.	F 657		
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	F 690		

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demonstrates that catheterization is necessary; and
(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.

§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 77 residents. The sample included 19 residents, with six reviewed for bowel/bladder incontinence, indwelling catheter (tube placed in the bladder to drain urine into a collection bad), and urinary tract infections (UTI). Based on observation, record review, and interview, the facility failed to provide Resident (R) 28, R180, and R3 with appropriate catheter care which placed the residents at risk for infection.

Findings included:

- R28's "Care Plan," dated 09/14/23, initiated on 03/16/23, directed staff to monitor for signs and symptoms of a UTI, and directed staff to maintain a closed drainage system per facility protocol; secure the catheter to R28's leg to avoid tension on urinary meatus; assess for adequate output, color, and odor of urine. The plan documented R28 had potential for reoccurrence of UTIs and directed staff to assess, record, and report to physician any signs and symptoms of a UTI. The

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plan directed staff to obtain and monitor lab work as order, assist with perineal care as need and remind R28 to wipe front to back.

R28's "Physician's Order," dated 05/26/21, directed staff to perform catheter care every shift.

R28's "Physician's Order," dated 10/21/22, directed staff to change indwelling catheter as needed; catheter size 16 and balloon size 30.

R28's "Physician's Order," dated 12/03/22, directed staff to change catheter bag monthly.

The "Physician's Order," dated 07/11/23, directed staff to administer cefuroxime axetil (antibiotic), 250 milligrams (mg), by mouth, daily, for UTI prophylaxis with Foley.

On 11/28/23 at 12:18 PM, observation revealed Certified Nurse Aide (CNA) P removed R28's catheter bag from the dignity bag and proceeded to drain the urine from the catheter bag into a container. CNA P then reattached the drainage port to the bag and threw the catheter bag onto the floor.

On 11/28/23 at 12:18 PM, CNA P stated she should have disinfected the port before reattaching it to the bag and she should not have thrown the bag onto the floor.

On 11/30/23 at 11:00 AM, Licensed Nurse J stated an alcohol swab should be used to disinfect the catheter ports after draining and said the drainage bags should never be thrown on the floor.

On 11/30/23 at 11:45 AM, Administrative Nurse E

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stated the catheter bag port should be disinfected with an alcohol swab and said staff should not let the catheter bags touch the floor.

The facility's "Catheter Care, Urinary" procedure, dated 12/2017, documented the procedure was to prevent catheter-associated urinary tract infections, and directed staff ensure the urinary drainage bag was held or positioned lower than the bladder at all times to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder, maintain clean technique when handling or manipulating the drainage system, empty the drainage bag regularly using a separate, clean collection container for each resident, avoid splashing, and prevent contact of the drainage spigot with the nonsterile container, empty the bag every 8 hours, and keep the bag below the level of the bladder.

The facility failed to provide R28, who had a history of UTI, with appropriate catheter care while draining the urine drainage bag. This placed the resident's at risk for infection.

- R180's Electronic Medical Record (EMR) documented diagnoses of urinary retention (lack of ability to urinate and empty the bladder), hypertension (high blood pressure), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and dementia (progressive mental disorder characterized by failing memory, confusion).

The "Quarterly Minimum Data Set" (MDS), dated 05/10/23, documented R180 had severely impaired cognition, and required extensive assistance of two staff for bed mobility, dressing, and toileting. R180 was frequently incontinent of

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bowel and had an indwelling catheter.

R180's "Care Plan," dated 11/07/23 and initiated on 04/24/23, directed staff to report temperature elevation, administer an antibiotic, and assess for side effects. An update, dated 05/12/23, directed staff to monitor for signs and symptoms of UTI and maintain a closed drainage system. The plan directed staff to secure the catheter to R180's leg to avoid tension on the urinary meatus, change her catheter as directed, offer and encourage fluids/juices to reduce infection potential, and assess for adequate output, color, and odor of urine.

R180's "Physician's Order," dated 02/12/23, directed staff to perform Foley catheter care every shift for urinary retention.

R180's "Physician's Order," dated 07/20/23, directed staff to change R180's Foley catheter monthly on the 16th.

R180's "Physician's Order," dated 10/07/23, directed staff to administer Macrobid (an antibiotic), 100 milligrams (mg), by mouth, twice per day, for UTI. This medication was discontinued on 10/14/23.

R180's "Physician's Order," dated 10/15/23, directed staff to administer nitrofurantoin (an antibiotic), 50 mg, by mouth, daily, for 30 days for UTI. This medication was discontinued on 10/27/23.

R180's "Physician's Order," dated 11/03/23, directed staff to administer Bactrim DS (an antibiotic), 800-160 mg, by mouth, daily for UTI prophylactic.

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The "Nurse's Note," dated 09/15/23 at 02:08 AM, documented staff encouraged R180 to drink water rather than coffee or juice to assist with flushing out the kidneys and bladder and staff encouraged R180 to call for any changes.

The "Nurse's Note," dated 10/23/23 at 03:46 PM by Consultant GG documented R180 was getting frequent UTI's, and she may need to consider prophylactic antibiotics.

The "Nurse's Note," dated 10/25/23 at 09:54 PM, documented R180 frequently yelled "want some water, want some water" and other incoherent comments. Staff provided reassurance and staff checked R180's water; the mug was full each time. Staff assured R180 her room was safe.

The "Nurse's Note," dated 10/26/23 at 03:14 PM, documented R180 called out frequently throughout night stating "Hey, hey, I need some water, I need some water" though R180 had two mugs within her reach.

On 11/29/24, at 08:56 AM, observation revealed R180 sat at the dining table with a mug of water in front of her. She had not taken a drink and staff had not offered R180 a drink. Further observation revealed at 09:45 AM, R180 still sat at the table and had still not taken a drink from her mug of water. Continued observation revealed Licensed Nurse (LN) I sat beside R180 and administered her medication in applesauce but did not give or offer R180 any fluids to drink after. Observation revealed at 09:58 AM, Dietary Staff (DS) CC stood beside R180 and asked if she wanted a drink. R180 stated she did want one and DS CC assisted the resident with a drink of water from

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her mug. R180 continued to ask DS CC for more. Dietary CC stated, "That is just water, would you like some juice?" R180 said she did want juice and DS CC got R180 some grape juice, but she did not drink any.

On 11/30/23 at 08:50 AM, observation revealed R180 sat at the dining table with a mug of water. Licensed Nurse (LN) J told R180 to drink her water but did not assist her and R180 did not drink. Further observation revealed at 09:16 AM, R180 yelled, "Hey, hey you" and Certified Nurse Aide (CNA) MM assisted the resident with a drink, and then left. R180 stated, "You got to help me, you got to help me." Continued observation revealed at 09:51 AM, CNA MM took R180 to her room, and took her catheter bag out of the dignity bag. R180's catheter bag had 100 cubic centimeters (cc) of amber (dark yellow) colored urine. CNA MM drained the urine into a container and then reattached the port to the bag but did not disinfect it.

On 11/29/23 at 09:51 AM, CNA MM stated she should have disinfected the port with a wipe or alcohol swab after she drained the catheter bag.

On 11/29/23 at 10:00 AM, LN I verified he did not give R180 any water after he administered all her pills because he had put them in applesauce. LN I stated the catheter port should be disinfected after staff drain the urine from the bag.

On 11/30/23 at 11:45 AM, Administrative Nurse E stated the catheter bag port should be disinfected with an alcohol swab. Administrative Nurse E said R180 should be assisted with her drinks as she had two mugs in her room and the staff were to be offering the fluids to her because of her UTI.

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The facility's "Catheter Care, Urinary" procedure, dated 12/2017, documented the procedure was to prevent catheter-associated urinary tract infections, and directed staff ensure the urinary drainage bag was held or positioned lower than the bladder at all times to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder, maintain clean technique when handling or manipulating the drainage system, empty the drainage bag regularly using a separate, clean collection container for each resident, avoid splashing, and prevent contact of the drainage spigot with the nonsterile container, empty the bag every 8 hours, and keep the bag below the level of the bladder.

The facility failed to provide R180, who had a history of UTI, with appropriate catheter care while draining the urine drainage bag. This placed the resident at risk for infection.

- The "Medical Diagnosis" section of R3's Electronic Medical Record (EMR) included diagnoses of congested heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), chronic respiratory failure with hypoxia (inadequate supply of oxygen), urinary tract infection (UTI-an infection in any part of the urinary system), chronic kidney disease, retention of urine, and major depressive disorder (major mood disorder which causes persistent feelings of sadness).

The "Comprehensive Minimum Data Set" (MDS), dated 07/28/23, documented R3 had moderately impaired cognition, was dependent on staff for oral hygiene, toileting hygiene, and dressing. R3 had an indwelling urinary catheter (tube placed in

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the bladder to drain urine into a collection bag) and was always incontinent of bowel. The MDS further documented R3 had pain and received scheduled and as needed pain medication. R3 took an anticoagulant (a group of medication that decreases blood ability to clot), antibiotic (medication used to treat infection) and diuretic (medication to promote the formation and excretion of urine) daily.

The "Urinary Incontinent/Indwelling Catheter Care Area Assessment" (CAA), dated 10/10/23, documented R3 had a catheter due to urine retention. R3 took a diuretic for CHF and required maximum assistance with activities of daily living (ADL).

R3's "Care Plan", dated 02/10/23, documented R3 had altered elimination related to use of an indwelling catheter. The care plan directed staff to monitor for signs/symptoms of urinary tract infections, maintain a closed drainage system, and catheter care per facility policy. The care plan lacked instruction for the use of a privacy bag, to maintain dignity of the resident.

The "Physician Order" dated 07/29/22 directed staff to provide catheter care every shift.

The "Physician Order" dated 07/15/23 directed staff to change indwelling catheter every month for urinary retention.

The "Physician Order" dated 06/20/23 directed staff to administer nitrofurantoin 100 milligrams (mg) daily for prophylaxis (preventative in nature).

The "Progress Note" dated 05/09/23 at 02:32 PM documented a catheter change recorded a fax

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was sent to R3's Primary Care Practitioner (PCP) requesting a urine analysis (UA-lab analysis of urine) due to R3 had cloudy urine with a foul odor.

The "Progress Note" dated 05/12/23 at 04:07 PM documented the PCP ordered to start an antibiotic for seven days.

The "Progress Note" dated 06/09/23 at 04:26 PM documented when staff changed the catheter, the urine in the bag and tube was cloudy. R3 seemed a bit more confused. The PCP was faxed for a UA order.

The "Progress Note" dated 06/14/23 at 05:37 PM documented the PCP ordered an antibiotic treatment every other day for three doses based on the results from the UA.

The "Progress Note" dated 09/06/23 at 05:04 PM documented R3 complained of being achy all over with increased fatigue and dizziness. Staff reported cloudy urine and requested an UA.

The "Progress Note" dated 09/08/23 at 01:54 AM documented the PCP returned fax and ordered staff to obtain a UA.

The "Progress Note" dated 09/11/23 at 03:22 PM documented the UA order was canceled as the urine was not collected.

The "Progress Note" dated 09/14/23 at 05:00 PM documented R3's PCP ordered another UA.

The "Progress Note" dated 09/15/23 at 03:51 PM documented R3 had a catheter change and staff collected urine for the UA.

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R3's EMR lacked evidence the urine was collected from the 09/06/23 order until seven days later and multiple UA orders.

The "Progress Note" dated 09/18/23 at 11:37 AM documented R3's PCP ordered an antibiotic treatment for seven days.

On 11/27/23 at 11:57 AM, observation revealed R3 sat in the dining room, in a wheelchair, with the catheter drainage bag attached to the underside of the wheelchair. The bag touched the floor and was not covered with a privacy bag.

On 11/28/23 at 07:49 AM, observation revealed R3 sat in the dining room with a privacy bag attached to the underside of the wheelchair.

On 11/29/23 at 09:28 AM, observation revealed R3 remained in bed. The catheter drainage bag was hooked to the bed frame at the foot of the bed, did not have a privacy bag, and touched the floor. It was visible from the hallway.

On 11/29/23 at 10:03 AM, observation revealed Certified Nurse Aide (CNA) M assisted R3 with ADLs. CNAM provided perirectal cleaning due to incontinence of bowel then, with the same gloved hands, emptied the drainage bag into a measuring container. CNA M did not cleanse the drainage spout and placed the spout back into the holder. Licensed Nurse (LN) G assisted with R3's mechanical lift transfer from R3's bed to recliner. During the transfer, the catheter drainage bag was hooked to the loops of the sling which placed the urine drainage bag above R3's bladder. Once R3 was placed in the recliner, staff unhooked the drainage bag and placed it on the floor. Once the mechanical lift was removed, staff

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hooked the catheter drainage bag onto the trash can next to the recliner, which remained touching the floor.

On 11/27/23 at 12:41 PM, LN H verified catheter bags should not touch the floor. LN H stated he thought it was the residents' family that provided privacy bags and said he would have to find out if the facility had privacy bags.

On 11/29/23 at 01:58 PM CNA M verified the catheter bag should not touch the floor. CNA M said when emptying catheter bags, she shook the spout of the drainage bag to remove any residual urine and placed the spout back into the holder but did not wipe it off. CNA M stated R3 should have a privacy bag covering the drainage bag and said she was not sure if R3 had one.

On 11/30/23 at 11:37 AM Administrative Nurse E verified R3 should have a privacy cover for the catheter. Administrative Nurse E stated the bag should not touch the floor or be raised above the bladder level of the resident. Administrative Nurse E also stated the catheter drainage spout should be cleansed with an alcohol swab after being emptied and replaced in the spout holder and UAs should be collected when the physician ordered them.

The facility's "Catheter Care, Urinary" policy, dated 12/2017, documented the purpose of the procedure is to prevent catheter-associated urinary tract infections. If breaks in aseptic technique, disconnection, or leakage occur, replace the catheter and collecting system using aseptic technique and sterile equipment, as ordered. The urinary drainage bag must be held or positioned lower than the bladder at all times to

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F 690	Continued From page 43 prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder. Be sure the catheter tubing and drainage bag are kept off the floor. Observe for other signs and symptoms of urinary tract infection or urinary retention. Report findings to the physician or supervisor immediately. The facility failed to provide acceptable catheter care for R3 who was at risk for urinary tract infections and had a history of repeated UTI. This placed R3 at risk for complications related to catheter use.	F 690		
F 744 SS=D	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: The facility had a census of 77 residents. The sample included 19 residents, with five reviewed for dementia (progressive mental deterioration characterized by confusion and memory failure) care. Based on observation, record review, and interview, the facility failed to develop and implement an individualized dementia treatment plan for Resident (R) 34 and R180, who had dementia and behaviors, and failed to provide the necessary dementia care and services to attain or maintain the highest level of practicable physical, mental, and psychosocial wellbeing for R180. This placed the residents at risk for abuse and decreased quality of life.	F 744		

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Findings included:

- The Electronic Medical Record (EMR) documented R34 had diagnoses of dementia without behaviors, anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), cognitive communication deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness), and depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, and emptiness).

The "Admission Minimum Data Set" (MDS), dated 09/14/23, documented severe memory problems. The MDS recorded R34 required extensive assistance of two staff for bed mobility, transfers, dressing, toileting, and extensive assistance of one staff for personal hygiene. R34 required limited assistance of one staff for ambulation. The assessment further documented R34 did not have any behaviors and received antipsychotic (class of medications used to treat major mental conditions which cause a break from reality) and antidepressant medication.

R34's "Care Plan," dated 09/11/23, directed staff to call him by his preferred name, provide daily orientation to facility routines and activity schedule, and use environmental cues to stimulate memory and promote appropriate behavior. The plan directed staff to provide consistent physical environment and daily routine. The update dated 09/20/23 documented R34's cognition fluctuated greatly, as he could be alert one minute and then extremely confused. R34 had impaired behavior due to wandering and directed staff to intervene to ensure safety of R34

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and others, and to redirect R34 when he was disruptive. The update, dated 10/06/23, documented R34 wandered to other residents' rooms and directed staff to orient R34 to his environment and the location of his room.

The "Physician's Order," date 09/13/23, directed staff to administer Remeron (an antidepressant medication), 15 milligrams (mg), by mouth, at bedtime, for the diagnosis of depression.

The Physician's Order," dated 09/18/23, directed staff to administer Zyprexa (an antipsychotic medication)10 mg, by mouth, at bedtime, for the diagnosis of hallucination (sensing things while awake that appear to be real, but the mind created), and bipolar disorder (major mental illness that caused people to have episodes of severe high and low moods).

The "Physician's Order," dated 10/18/23, directed staff to administer Zyprexa, 10 mg, by mouth, daily, for the diagnosis of hallucination and bipolar disorder.

The "Physician's Order," dated 10/20/23, directed staff to monitor for behaviors, and document effectiveness of interventions.

The "Physician's Order," dated 10/20/23, directed staff to administer Trazadone (an antidepressant medication), 75 mg, by mouth, daily, for the diagnosis of depression. The medication was discontinued on 11/20/23.

The "Physician's Order," dated 10/20/23, directed staff to contact Geri-psych (psychiatric services specializing in geriatric population) for assistance

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with behaviors.

The "Physician's Order," dated 10/27/23, directed staff to administer Ativan (antianxiety medication), 0.5 mg, by mouth, twice per day, for the diagnosis of anxiety.

The "Physician's Order," dated 11/21/23, directed staff to administer Trazadone, 150 mg, by mouth, at bedtime, for the diagnosis of depression and insomnia (inability to sleep).

The "Nurse's Note," dated 10/06/23 at 02:38 AM, documented R34 constantly hollered for help and was very restless and agitated. The note further documented R34 stated he was tired, was assisted to bed, was inconsolable and continued to yell for help.

The "Nurse's Note," dated 10/09/23, at 05:26 AM, documented R34 was awake and wandered around the unit and tried to enter other residents' rooms. The note further documented staff tried to intervene and R34 got upset with staff.

The "Psychiatric Care Note," dated 10/09/23 at 11:10 AM, documented R34 was seen due to behaviors of wandering into other resident rooms and staff were directed to keep R34 socially engaged.

The "Nurse's Note," dated 10/21/23 at 10:25 PM documented R34 was up in his wheelchair, and he propelled himself throughout the unit and yelled for help. The note recorded r34 refused his medications.

The "Nurse's Note," dated 11/24/23 at 01:51 PM,

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documented R34 wandered around the neighborhood, tried to move chairs and stand up. The note further documented the morning nurse went to check on R34, but he was not in his bed. The nurse found R34with no clothes on, with a towel on the floor. R34's incontinence brief hung off his left leg and there was urine all over the floor. R34's bed was saturated with urine.

The "Nurse's Note," dated 11/27/23, documented R34 was up in his wheelchair until after 10:00 PM. He wandered around the unit throughout the evening shift but was easily redirected by staff when staff found he had entered other residents' rooms. The note recorded R34 was known to enter other resident rooms unobserved by staff.

On 11/28/23 at 12:34 PM, observation revealed R34 propelled around the 300 neighborhood in his wheelchair. R34 ran into a pillar by the dining room, then continued to propel around neighborhood. R34 ran into a wall by room 508 and then stood up. Dietary Staff CC told R34 to sit down but did not respond to the direction. Licensed Nurse (LN) H exited the nurse's office and assisted R34 to sit down, then moved him away from the wall. LN H then went back into the nurse office. Further observation revealed R34 propelled his wheelchair into the dining area and tried to go between a chair and another resident seated at a table. R34 kept trying to go through and his wheelchair ran into the resident seated at the table. Continued observation revealed the other resident became angry and yelled "Get out of here," and pushed on R34's wheelchair. LN H came back out of the nurse offices and pushed R34 out of the dining room area away from the other resident. Continued observation at 12:52 PM, revealed R34 propelled his wheelchair over

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to the area where Certified Nurse Aide (CNA) charting was done and started to mess with papers by the computer. CNA P walked over and pushed R34 away from the area then left to assist another resident in their room.

On 11/30/23 at 02:30 PM, CNA Q stated R34 was hard to redirect, often tried to go in and out of resident rooms, and sometimes tried to go out of the neighborhood so she usually had to take R34 along when she worked, except when she went to other resident rooms to assist. CNA Q stated it was hard to keep track of R34 at times.

On 10/30/23 at 10:32 AM LN J stated R34 propelled all over the neighborhood, sometimes went into other resident rooms and wandered LN J stated she usually got R34 up early in the morning because he seemed to do better as far as behaviors if he ate a good breakfast.

On 10/30/23 at 11:45 AM, Administrative Nurse E verified there was not individualized interventions related to R34 in order to direct staff how to care for the resident when he had behaviors and staff were at a loss as to what to do.

The facility's "Memory Support" policy, dated 05/2021, documented the facility provided services to help support the resident's goals, personal preferences, lifelong interests, routines for daily living activities, privacy, and freedom of choice. Residents with behavioral expressions and/or anxiety who may benefit from a supportive residence that offered safety, security, meaningful activities and an environment that minimizes distress.

The facility failed to develop and implement

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individualize interventions and/or dementia treatment plan for R34 who had dementia and related behaviors. This deficient practice placed the resident at risk for abuse and decreased quality of life.

- The Electronic Medical Record (EMR) for R180 documented diagnoses of dementia without behavioral disturbances, cognitive communication deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear).

The "Quarterly Minimum Data Set," (MDS) doted 05/10/23, documented R180 had severely impaired cognition, inattention, disorganized thinking, and altered level on consciousness. The MDS recorded R180 had verbal behaviors one to three days during the week and was dependent upon two staff for transfers. R180 required extensive assistance of two staff for bed mobility, toileting, and dressing.

The 08/04/23 and 10/27/23 Quarterly MDS were not completed by the facility.

R180's "Care Plan," dated 11/07/23, initiated on 02/11/23, directed staff to call her by name, and provide daily orientation to facility routines and activity schedules. The plan directed staff to use environmental cues to stimulate memory and promote appropriate behavior and provide cues to promote independence and ensure safety. The plan directed staff to anticipate needs and observe for nonverbal cues; the resident had dementia and had difficulty remembering recent

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events. Staff were to give reminders for mealtimes, activities, and dates as needed. The update dated 03/26/23 documented R180 preferred to be up in her wheelchair after she woke from naps after lunch. The update dated 10/16/23 directed staff to offer R180 to return to her room following meals. The update dated 11/17/23 documented R180 sometimes banged on the table with objects to gain others attention.

The "Physician's Order," dated 05/02/23, directed staff to administer buspirone (an antidepressant medication), 5 milligrams (mg), by mouth, daily, for the diagnosis of anxiety.

The "Physician's Order," dated 05/02/23, directed staff to administer mirtazapine (an antidepressant), 15 mg, by mouth, at bedtime for insomnia (inability to sleep)

The "Physician's Order," dated 06/23/23, directed staff to administer escitalopram (an antidepressant), 5 mg, by mouth, daily for anxiety.

The "Physician's Order," dated 07/19/23, directed staff to apply an Exelon patch (treats mild to moderate dementia), 4.6 mg/24 hours, daily, for dementia.

The "Nurse's Note," dated 06/06/23 at 04:48 PM, documented R180 quickly became incredibly anxious when staff left the room, and staff heard R180 state "You're killing me" to a Certified Nurse Aide (CNA) when R180 was brought out to the supper table despite having requested multiple times to be brought out.

The "Nurse's Note," dated 06/21/23 at 07:02 AM, documented R180 called out incessantly and

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made the same needs known repeatedly.

The "Nurse's Note," dated 06/28/23 at 01:32 PM, documented R180 yelled out multiple times during lunch that day and began to recite the Lord's Prayer.

The "Nurse's Note," dated 09/01/23 at 01:11 PM, documented staff observed R180 banging her cup on the table, and she repeated requests frantically twice during mealtime. R180called out from her room but calmed quickly with reassurance.

The "Nurse's Note," dated 09/29/23 at 02:26 PM, documented R180 hollered a majority of the morning before and after breakfast and hit her cup on the table.

The "Nurse's Note," dated 10/9/23 at 03:48 AM, documented R180 yelled out for staff for different things. Staff attempted to give R180 fluids and reassurance.

The "Nurse's Note," dated 10/25/23 at 09:54 PM, documented R180 frequently yelled come here, "want some water, want some water" and other incoherent comments. Staff provided reassurance and staff checked R180's water and the mug was full each time. Staff assured R180 her room was safe.

The "Nurse's Note," dated 10/26/23 at 03:14 PM, documented R180 called out frequently throughout night stating "Hey, hey, I need some water, I need some water" though R180 had two mugs withing her reach.

The "Nurse's Note," dated 10/30/23 at 04:11 AM,

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documented R180 was awake at night and yelled out nonsense and said the Lord's Prayer.

The "Nurse's Note," dated 10/31/23 at 03:54 PM, documented R180 had several episodes of yelling that day before breakfast and after her afternoon nap. She was also tearful once but was easily redirected.

The "Nurse's Note," dated 11/09/23 at 04:08 AM, documented R180 called out nonsensical words but when staff spoke with her, she stated she was fine.

The "Nurse's Note," dated 11/13/23 at 11:31 AM, documented R180 yelled out multiple times that morning.

The "Nurse's Note," dated 11/29/23 at 11:39 AM, documented R180 had repetitive behaviors and called out for her daughter over and over.

The "Nurse's Note," dated 11/30/23 at 03:39 AM, documented R180 yelled "water, water, water" though she had water.

R180's EMR lacked evidence professional mental health support services were provided to R180.

On 11/30/23 at 07:79 AM, observation revealed R180 sat at the dining room table. She appeared restless and vocalized, "I want to get away, I need to get away, I want to get away from everybody" over and over. Observation revealed no staff were present in the dining room. Further observation revealed R180 remained in the dining room and stated, "Let's get going, I want to get away, hurry, hurry, I don't like it here." At 08:50 AM, Licensed Nurse (LN) J told R180 she would

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take R180 to the resident's room later and told R180 to drink her water. R180 did not drink her water. At 09:00 AM, R180 repeated "Can I wiggle out, can I wiggle out, can I wiggle out?" Further observation revealed Consultant GG conducted rounds in the dining room. Consultant GG went to R180 and asked if it "hurt to pee." Consultant GG listened to R180's lungs, asked her if she had any questions, and then left. R180 repeated "Can I get out, can I get out, can I get out, help me, help me," over and over. Continued observation at 09:20 AM revealed R180 repeated, "I won't kill you; I won't kill you, underground, I'd rather be up here, I'd rather be up here, help me, help me!" At 09:51 AM, staff took R180 to her room.

On 11/30/23 at 10:00 AM, CNA M stated R180 was anxious, and staff provided reassurance and always told her what they were doing.

On 11/30/23 at 10:22 AM, LN J stated staff provided R180 a lot of reassurance and redirection when she was anxious and stated the resident's daughter saw her every night which seemed to calm the resident down.

On 10/30/23 at 1145 AM, Administrative Nurse E verified there was not individualized interventions or plans to direct staff how to care for R180 when she was anxious except for a lot of reassurance.

The facility's "Memory Support" policy, dated 05/2021, documented the facility provide services to help support the resident's goals, personal preferences, lifelong interests, routines for daily living activities, privacy, and freedom of choice. Residents with behavioral expressions and/or anxiety who may benefit from a supportive residence that offered safety, security, meaningful

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F 744	Continued From page 54 activities and an environment that minimizes distress. The facility failed to develop and implement individualize interventions and/or dementia treatment plan for R180 who had dementia periods of anxiety. This deficient practice placed the resident at risk for a decreased quality of life.	F 744		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending	F 756		

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physician should document his or her rationale in the resident's medical record.

§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 77 residents. The sample included 19 residents, with six reviewed for unnecessary medications. Based on observations, interview, and record review, the facility failed to ensure the Consultant Pharmacist (CP) identified and reported the lack of a 14-day stop date for Resident (R)12's as needed (PRN) lorazepam (Ativan-medication used to treat anxiety) and failed to identify and report the lack an appropriate indication, or a documented physician rationale which included the multiple unsuccessful attempts for nonpharmacological symptom management and risk versus benefits for the use of an antipsychotic for R6 and R65. This placed the affected residents at risk for unintended affects related to psychotropic (affects mind or thoughts) drug medications.

Findings included:

- R12's Electronic Medical Record (EMR) recorded diagnoses of anxiety (mental, uncertainty and irrational fear), and chronic respiratory failure.

R12's "Significant Change Minimum Data Set" (MDS), dated 10/22/33, documented the resident

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had severely impaired cognition. R12 required extensive assistance with activities of daily living (ADL). The MDS lacked documentation R12 received an antianxiety medication during the look back days.

The "Cognitive Loss Care Area Assessment" (CAA), dated 11/02/23, documented R12 had a significant change in condition and is unable to verbalize, but able to make simple needs know.

The "Physician's Order," dated 10/17/23, directed the staff to administer Ativan 0.5 milligrams (mg), every two hours as needed for anxiety and agitation. The order lacked a stop date.

Review of the "Medication Administration Record" in the EMR revealed R12 last received the Ativan 0.5mg on 11/26/23 for anxiety.

The "Pharmacy Medication Regimen Review Progress Note" recorded on 10/31/23 documented there were no irregularities.

On 11/29/23 at 08:50 AM, observation revealed the resident sat in bed with head of bed elevated approximately 30 degrees, oxygen on per nasal cannula and Certified Nurse Aide (CNA) NN sat to the right of the resident and assisted her to eat super cereal.

On 11/29/23 at 10:45 AM, Administrative Nurse E verified the resident received Ativan, with a physician order date of 10/17/23. Administrative Nurse E verified the facility failed to obtain the 14 days stop date or reason for continued use with the appropriate rational.

The facility "Pharmacy Services-Role of the

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Consultant Pharmacist" policy, dated 06/2022, documented the pharmacist the Medication Regimen Review would be conducted monthly irregularities includes, but not limited to, the use of any drug that meets the criteria for an unnecessary drug. The pharmacist would report on the MRR and will submit recommendations to the physician and DON>he DON, or designee would ensure that recommendations are followed thoroughly on a timely basis, which does not exceed 30 days. Irregularities would be addressed immediately, but not to exceed 24 hours. The attending physician would document in the resident's medical record that the irregularity was received and what action was taken to accommodate it. Copies of drug regimen review reports, including physician response, will be maintained as part of the permanent medical record. The Consulting Pharmacist would perform a medication regimen review (MRR) for residents in the community routinely.

The facility failed to ensure the CP identified and reported the lack of a 14-day stop date for R12's PRN lorazepam. This placed the resident at risk for inappropriate use of an as needed psychotropic medication with side effects.

- The "Medical Diagnosis" section with in R6's Electronic Medical Record (EMR) included diagnoses of encounter for other orthopedic (pertaining to bones) aftercare, fracture (broken bone) of right femur (thigh bone) , problems related to living residential institution, impulsiveness (sudden, forceful, irresistible urges to do something), muscle weakness, reduced mobility, altered mental status, dementia (progressive mental disorder characterized by

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failing memory, confusion) without behavior, psychosis (any major mental disorder characterized by a gross impairment in reality perception)/mood/anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear).

The "Quarterly Minimum Data Set" (MDS), dated 10/21/23, documented R6 had moderate cognitive impairment, and an acute change in mental status and inattention which fluctuated. R6 required supervision or touch assistance with activities of daily living (ADL). R6 was continent of urine and bowel and had pain which rarely effected sleep or interfered with therapy sessions. The MDS further documented high risk medications of antipsychotic (class of medications used to treat major mental conditions which cause a break from reality) and antidepressant (class of medications used to treat mood disorders). The antipsychotic was received on a routine basis only and recorded no gradual dose reduction or physician documentation of a gradual dose reduction as clinically contraindicated.

The "Psychotropic Care Area Assessment" (CAA), dated 09/17/23, documented to proceed to care planning to include risperidone (antipsychotic) 0.25 milligrams (mg) daily for unspecified dementia without behavioral disturbance.

R6's "Care Plan," dated 09/05/23, documented R6 had potential for drug related complications associated with the use of psychotropic medications related to antidepressant and antipsychotic use. The care plan directed staff to observe, document, and report to physician signs

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and/or symptoms of drug related complications. The pharmacy consultant would review the drug regimen and consult with pharmacy and medical doctor to consider dose reduction when clinically appropriate.

The "Physician Order" dated 07/28/21, directed staff to administer risperidone 0.25 mg every day for unspecified dementia without behavioral disturbance.

The "Consultant Pharmacist Review" dated 07/31/23, 08/30/22 and 09/30/23, documented no recommendations.

The facility's "Nurse/Physician Faxed Communication" dated 10/03/23 documented per CMS guidelines, "Unspecified Dementia without behavioral disturbance is not an approved diagnosis for risperidone. Please provide an approved diagnosis, thank you."

The "Physician response," dated 10/12/23, documented "off label use (common in medicine) agitation/dementia with anxiety and delusions. Initiated by psychotherapist 03/2021 (low dose) with significant improvement according to staff and family. Family aware of potential adverse effects."

R6's EMR lacked evidence of a documented physician rationale which included the multiple unsuccessful attempts for nonpharmacological symptom management and risk versus benefits for the continued use of the risperidone.

On 11/28/23 at 08:08 AM, observation revealed R6, addressed and groomed for the day, walked out of his room with a walker. Staff greet him

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appropriately and walked next to him to the dining room table for breakfast.

On 11/29/23 at 02:10 PM, Certified Nurse Aide (CNA) M reported she had not observed R6 exhibit behaviors. She said R6 was mostly independent with activities of daily living and needed occasional reminders to complete tasks.

On 11/29/23 at 02:15 PM, Licensed Nurse (LN) G stated R6 exhibited more confusion after experiencing mini strokes and would forget to use his walker. LN G stated she had not observed R6 demonstrate any physical aggression with others.

On 11/30/23 at 11:37 AM, Administrative Nurse E verified the pharmacy consultant had not identified and reported the dementia diagnosis for the use of risperidone.

The facility's "Pharmacy Service-Role of the Consultant Pharmacist" policy, dated 07/2020, the community provides pharmaceutical services including procedures that assure the accurate acquisition, receipt, dispensing, and administering of drug and biologicals) to meet the need of each resident: determines that drug records are in order and that an account of controlled drugs is maintained and periodically reconciled through MMR. If any irregularity is noted during the MMR, the pharmacist is required to notify the attending physician, Don, and the medical director. The MMR will be conducted monthly. Irregularity includes, but not limited to, the use of any drug that meets the criteria for an unnecessary drug. The pharmacist will report on the MMR and will submit recommendations to the physician and DON. The attending physician will document in the resident's medical record that the irregularity

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was received and what action was taken to accommodate it. Assist with Gradual Dose Reduction reviews and recommendations. Reviews evaluate the pharmaceutical services by helping the community identify, evaluate, and address medication issues that may affect resident care, medical care and quality of life. Is the responsible for helping the community obtain and maintain appropriate pharmaceutical service that supports resident's health-care needs, goals, and quality of life that meet State and federal requirements.

The CP failed to identify and report R6's inappropriate indication for the use of an antipsychotic medication. This placed the resident at risk for unnecessary medications.

- The "Medical Diagnosis" section within R65's Electronic Medical Record (EMR) included diagnoses of unspecified dementia (progressive mental disorder characterized by failing memory, confusion) unspecified severity with other behavioral disturbance and agitation (feeling of aggravation or restlessness brought on by a provocation or a medical condition), dizziness and giddiness, major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest) , generalized anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), altered mental status, muscle weakness and need assistance with personal care.

The "Comprehensive Minimum Data Set" (MDS), dated 06/16/23, documented R65 had severe cognitive impairment, had disorganized thinking

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which fluctuated, and no indicators or psychosis (any major mental disorder characterized by a gross impairment in reality perception). R65 had verbal and other behavioral symptoms, and rejection of care and significantly disrupted care or living environment which occurred one to three days of the look back period. R65 required extensive to total assistance of one to two staff for activities of daily living (ADL). The MDS further documented R65 received an antipsychotic (class of medications used to treat major mental conditions which cause a break from reality), antianxiety (class of medications that calm and relax people), and an anticoagulant (a group of medication that decreases blood ability to clot). The last gradual dose reduction attempt was 05/25/23 and there was no physician documentation the GDR was clinically inappropriate.

The "Psychotropic Drug Use Care Area Assessment" (CAA), dated 07/03/23, documented R65 took risperidone (antipsychotic) 0.5 milligrams (mg) for Alzheimer's dementia with behavioral disturbance.

R65's "Care Plan," dated 03/28/23, documented R65 had potential for drug related complications associated with the use of psychotropic medication. The plan directed staff to observe, document, and report to physician as needed sign and symptoms of drug related complications. The pharmacy consultant would review the drug regimen and consult with pharmacy and physician to consider dose reduction when clinically appropriate.

The "Physician Order" dated 09/16/23 directed staff to administer risperidone 0.5 mg every day

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for unspecified dementia with behavior disturbance.

The "Pharmacist Review" dated 09/30/23 and 10/31/23, had no recommendations.

R65's EMR lacked evidence of a documented physician rationale which included the multiple unsuccessful attempts for nonpharmacological symptom management and risk versus benefits for the continued use of the risperidone.

On 11/29/23 at 07:59 AM, observation revealed staff assisted R65 into a wheelchair and with his morning routine. R65 is alert and calls out for help, staff reassure the resident and explain what they are doing to the resident.

On 11/29/23 at 03:11 PM, Certified Nurse Aide (CNA) N reported R65 had yelling behaviors which disturbed other residents on the unit. CNA N stated R65 can be difficult to redirect.

On 11/30/23 at 11:37 AM, Administrative Nurse E verified the diagnosis for R65 risperidone was dementia and the consultant pharmacist had not identified and reported this during the monthly review.

The facility's "Pharmacy Service-Role of the Consultant Pharmacist" policy, dated 07/2020, the community provides pharmaceutical services including procedures that assure the accurate acquisition, receipt, dispensing, and administering of drug and biologicals) to meet the need of each resident: determines that drug records are in order and that an account of controlled drugs is maintained and periodically reconciled through MMR. If any irregularity is noted during the MMR,

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F 756	Continued From page 64 the pharmacist is required to notify the attending physician, Don, and the medical director. The MMR will be conducted monthly. Irregularity includes, but not limited to, the use of any drug that meets the criteria for an unnecessary drug. The pharmacist will report on the MMR and will submit recommendations to the physician and DON. The attending physician will document in the resident's medical record that the irregularity was received and what action was taken to accommodate it. Assist with Gradual Dose Reduction reviews and recommendations. Reviews evaluates the pharmaceutical services by helping the community identify, evaluate, and address medication issues that may affect resident care, medical care and quality of life. Is the responsible for helping the community obtain and maintain appropriate pharmaceutical service that supports resident's health-care needs, goals, and quality of life that meet State and federal requirements. The CP failed to identify and report R65's inappropriate indication for the use of an antipsychotic medication. This placed the resident at risk for unnecessary medications.	F 756		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and	F 758		

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F 758	Continued From page 65 (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. This REQUIREMENT is not met as evidenced by:	F 758		

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The facility had a census of 77 residents. The sample included 19 residents, with six reviewed for unnecessary medications. Based on observations, interview, and record review, the facility failed to ensure a 14-day stop date for Resident (R)12's as needed (PRN) lorazepam (Ativan-medication used to treat anxiety). The facility further failed to ensure R6 and R65 had an appropriate indication, or a documented physician rationale which included the multiple unsuccessful attempts for nonpharmacological symptom management and risk versus benefits for the use of an antipsychotic. This placed the affected residents at risk for unintended affects related to psychotropic (affects mind or thoughts) drug medications.

Findings included:

- R12's Electronic Medical Record (EMR) recorded diagnoses of anxiety (mental, uncertainty and irrational fear), and chronic respiratory failure.

R12's "Significant Change Minimum Data Set" (MDS), dated 10/22/33, documented the resident had severely impaired cognition. R12 required extensive assistance with activities of daily living (ADL). The MDS lacked documentation R12 received an antianxiety medication during the observation period.

The "Cognitive Loss Care Area Assessment" (CAA), dated 11/02/23, documented R12 had a significant change in condition and was unable to verbalize, but able to make simple needs know.

R12's "Physician's Order," dated 10/17/23, directed the staff to administer Ativan

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0.5milligrams (mg), every two hours as needed for anxiety and agitation. The order lacked a stop date.

R12's "Medication Administration Record" in the EMR revealed R12 last received the Ativan 0.5mg on 11/26/23.

R12's EMR lacked evidence of a physician rationale with a specified duration for continued use of the PRN Ativan.

On 11/29/23 at 08:50 AM, observation revealed the resident sat in bed with the head of the bed elevated approximately 30 degrees. R12 wore oxygen per nasal cannula and Certified Nurse Aide (CNA) NN sat to the right of the resident and assisted R12 to eat super cereal.

On 11/29/23 at 10:45 AM, Administrative Nurse E verified R12 received Ativan, with a physician order date of 10/17/23. Administrative Nurse E verified the facility failed to obtain the 14-day stop date or reason for continued use with the duration specified.

The facility's "Psychotropic Medication" policy dated November 2022 documented residents would not receive PRN doses of psychotropic medications unless that medication was necessary to treat a specific condition that was documented in the clinical record. The policy further documented the need to continue PRN orders for psychotropic medications beyond 14 days required the practitioner to document the rationale for the extended order, and the PRN orders of psychotropic medication would not be renewed beyond 14 days unless the health care practitioner had evaluated the resident for

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appropriateness of the medication.

The facility failed to ensure R12 was free of the use of unnecessary psychotropic drugs when staff failed to obtain a stop date for the use of PRN Ativan, placing R12 at risk for adverse effects from the continued use of those medications.

- The "Medical Diagnosis" section with in R6's Electronic Medical Record (EMR) included diagnoses of encounter for other orthopedic (pertaining to bones) aftercare, fracture (broken bone) of right femur (thigh bone) , problems related to living residential institution, impulsiveness (sudden, forceful, irresistible urges to do something), muscle weakness, reduced mobility, altered mental status, dementia (progressive mental disorder characterized by failing memory, confusion) without behavior, psychosis (any major mental disorder characterized by a gross impairment in reality perception)/mood/anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear).

The "Quarterly Minimum Data Set" (MDS), dated 10/21/23, documented R6 had moderate cognitive impairment, and an acute change in mental status and inattention which fluctuated. R6 required supervision or touch assistance with activities of daily living (ADL). R6 was continent of urine and bowel and had pain which rarely effected sleep or interfered with therapy sessions. The MDS further documented high risk medications of antipsychotic (class of medications used to treat major mental conditions which cause a break from reality) and antidepressant (class of medications used to treat

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mood disorders). The antipsychotic was received on a routine basis only and recorded no gradual dose reduction or physician documentation of a gradual dose reduction as clinically contraindicated.

The "Psychotropic Care Area Assessment" (CAA), dated 09/17/23, documented to proceed to care planning to include risperidone (antipsychotic) 0.25 milligrams (mg) daily for unspecified dementia without behavioral disturbance.

R6's "Care Plan," dated 09/05/23, documented R6 had potential for drug related complications associated with the use of psychotropic medications related to antidepressant and antipsychotic use. The care plan directed staff to observe, document, and report to physician signs and/or symptoms of drug related complications. The pharmacy consultant would review the drug regimen and consult with pharmacy and medical doctor to consider dose reduction when clinically appropriate.

The "Physician Order" dated 07/28/21, directed staff to administer risperidone 0.25 mg every day for unspecified dementia without behavioral disturbance.

The facility's "Nurse/Physician Faxed Communication" dated 10/03/23 documented per CMS guidelines, "Unspecified Dementia without behavioral disturbance is not an approved diagnosis for risperidone. Please provide an approved diagnosis, thank you."

The "Physician response," dated 10/12/23, documented "off label use (common in medicine)

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agitation/dementia with anxiety and delusions. Initiated by psychotherapist 03/2021 (low dose) with significant improvement according to staff and family. Family aware of potential adverse effects."

R6's EMR lacked evidence of a documented physician rationale which included the multiple unsuccessful attempts for nonpharmacological symptom management and risk versus benefits for the continued use of the risperidone.

On 11/28/23 at 08:08 AM, observation revealed R6, addressed and groomed for the day, walked out of his room with a walker. Staff greet him appropriately and walked next to him to the dining room table for breakfast.

On 11/29/23 at 02:10 PM, Certified Nurse Aide (CNA) M reported she had not observed R6 exhibit behaviors. She said R6 was mostly independent with activities of daily living and needed occasional reminders to complete tasks.

On 11/29/23 at 02:15 PM, Licensed Nurse (LN) G stated R6 exhibited more confusion after experiencing mini strokes and would forget to use his walker. LN G stated she had not observed R6 demonstrate any physical aggression with others.

On 11/30/23 at 11:37 AM, Administrative Nurse E verified the dementia diagnosis for R6's use of risperidone.

The facility's "Pharmacy Service-Role of the Consultant Pharmacist" policy, dated 07/2020, the community provides pharmaceutical services including procedures that assure the accurate acquisition, receipt, dispensing, and administering

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of drug and biologicals) to meet the need of each resident: determines that drug records are in order and that an account of controlled drugs is maintained and periodically reconciled through MMR. If any irregularity is noted during the MMR, the pharmacist is required to notify the attending physician, Don, and the medical director. The MMR will be conducted monthly. Irregularity includes, but not limited to, the use of any drug that meets the criteria for an unnecessary drug. The pharmacist will report on the MMR and will submit recommendations to the physician and DON. The attending physician will document in the resident's medical record that the irregularity was received and what action was taken to accommodate it. Assist with Gradual Dose Reduction reviews and recommendations. Reviews evaluate the pharmaceutical services by helping the community identify, evaluate, and address medication issues that may affect resident care, medical care and quality of life. Is the responsible for helping the community obtain and maintain appropriate pharmaceutical service that supports resident's health-care needs, goals, and quality of life that meet State and federal requirements.

The facility failed to ensure appropriate indication, or the required documentation, for the use of an antipsychotic. This placed R6 at risk for adverse side effects related to psychotropic medication.

- The "Medical Diagnosis" section within R65's Electronic Medical Record (EMR) included diagnoses of unspecified dementia (progressive mental disorder characterized by failing memory, confusion) unspecified severity with other behavioral disturbance and agitation (feeling of aggravation or restlessness brought on by a

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provocation or a medical condition), dizziness and giddiness, major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest) , generalized anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), altered mental status, muscle weakness and need assistance with personal care.

The "Comprehensive Minimum Data Set" (MDS), dated 06/16/23, documented R65 had severe cognitive impairment, had disorganized thinking which fluctuated, and no indicators or psychosis (any major mental disorder characterized by a gross impairment in reality perception). R65 had verbal and other behavioral symptoms, and rejection of care and significantly disrupted care or living environment which occurred one to three days of the look back period. R65 required extensive to total assistance of one to two staff for activities of daily living (ADL). The MDS further documented R65 received an antipsychotic (class of medications used to treat major mental conditions which cause a break from reality), antianxiety (class of medications that calm and relax people), and an anticoagulant (a group of medication that decreases blood ability to clot). The last gradual dose reduction attempt was 05/25/23 and there was no physician documentation the GDR was clinically inappropriate.

The "Psychotropic Drug Use Care Area Assessment" (CAA), dated 07/03/23, documented R65 took risperidone (antipsychotic) 0.5 milligrams (mg) for Alzheimer's dementia with behavioral disturbance.

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R65's "Care Plan," dated 03/28/23, documented R65 had potential for drug related complications associated with the use of psychotropic medication. The plan directed staff to observe, document, and report to physician as needed sign and symptoms of drug related complications. The pharmacy consultant would review the drug regimen and consult with pharmacy and physician to consider dose reduction when clinically appropriate.

The "Physician Order" dated 09/16/23 directed staff to administer risperidone 0.5 mg every day for unspecified dementia with behavior disturbance.

The "Pharmacist Review" dated 09/30/23 and 10/31/23, had no recommendations.

R65's EMR lacked evidence of a documented physician rationale which included the multiple unsuccessful attempts for nonpharmacological symptom management and risk versus benefits for the continued use of the risperidone.

On 11/29/23 at 07:59 AM, observation revealed staff assisted R65 into a wheelchair and with his morning routine. R65 is alert and calls out for help, staff reassure the resident and explain what they are doing to the resident.

On 11/29/23 at 03:11 PM, Certified Nurse Aide (CNA) N reported R65 had yelling behaviors which disturbed other residents on the unit. CNA N stated R65 was difficult to redirect.

On 11/30/23 at 11:37 AM, Administrative Nurse E verified the diagnosis for R65's risperidone was dementia.

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F 758	Continued From page 74 The facility's "Pharmacy Service-Role of the Consultant Pharmacist" policy, dated 07/2020, the community provides pharmaceutical services including procedures that assure the accurate acquisition, receipt, dispensing, and administering of drug and biologicals) to meet the need of each resident: determines that drug records are in order and that an account of controlled drugs is maintained and periodically reconciled through MMR. If any irregularity is noted during the MMR, the pharmacist is required to notify the attending physician, Don, and the medical director. The MMR will be conducted monthly. Irregularity includes, but not limited to, the use of any drug that meets the criteria for an unnecessary drug. The pharmacist will report on the MMR and will submit recommendations to the physician and DON. The attending physician will document in the resident's medical record that the irregularity was received and what action was taken to accommodate it. Assist with Gradual Dose Reduction reviews and recommendations. Reviews evaluates the pharmaceutical services by helping the community identify, evaluate, and address medication issues that may affect resident care, medical care and quality of life. Is the responsible for helping the community obtain and maintain appropriate pharmaceutical service that supports resident's health-care needs, goals, and quality of life that meet State and federal requirements. The facility failed to ensure appropriate indication, or the required documentation, for the use of an antipsychotic. This placed R65 at risk for adverse side effects related to psychotropic medication.	F 758		
F 760 SS=D	Residents are Free of Significant Med Errors	F 760		

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F 760	Continued From page 75 CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: The facility had a census of 77 residents. The sample included 19 residents. Based on observation, record review, and interview, the facility failed to prevent a significant medication error for Resident (R) 34, whose Zyprexa (an antipsychotic medication) was not given for two days. The facility further failed to prevent medication errors when staff crushed three medications for R52 that were supposed to be given whole. This placed the residents at risk for decreased well-being and ineffective medication regimen. Findings included: - R34's Electronic Medical Record (EMR) documented R34 had diagnoses of dementia without behaviors, anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), cognitive communication deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness), and depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, and emptiness). The "Admission Minimum Data Set" (MDS) dated 09/14/23 documented severe memory problems. The MDS recorded R34 required extensive assistance of two staff for bed mobility, transfers, dressing, toileting, and extensive assistance of	F 760		

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one staff for personal hygiene. R34 required limited assistance of one staff for ambulation. The assessment further documented R34 did not have any behaviors and received antipsychotic (class of medications used to treat major mental conditions which cause a break from reality) medication.

R34's "Care Plan," dated 09/11/23, directed staff to observe and document the effectiveness of his mood enhancement medication, monitor for depression, and ensure he received his medication as ordered by the physician.

The "Physician's Order," date 09/13/23, directed staff to administer Remeron (an antidepressant medication), 15 milligrams (mg), by mouth, at bedtime, for the diagnosis of depression.

The "Physician's Order," dated 09/18/23, directed staff to administer Zyprexa,10 mg, by mouth, at bedtime, for the diagnosis of hallucination (sensing things while awake that appear to be real, but the mind created), and bipolar disorder (major mental illness that caused people to have episodes of severe high and low moods). This medication was discontinued on 10/18/23.

The "Physician's Order," dated 10/18/23, directed staff to administer Zyprexa, 10 mg, by mouth, daily, for the diagnosis of hallucination and bipolar disorder.

The "Physician's Order," dated 10/20/23, directed staff to monitor for behaviors, and document effectiveness of interventions.

The "Medication Administration Record" (MAR) for October 2023, documented the Zyprexa

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medication on 10/14/23 and 10/15/23 was unavailable.

The "Investigation" dated 10/16/23, documented R34 was sent to the emergency room (ER) on 10/16/23 due to behaviors that were unable to be redirected. The resident wandered and threatened staff. The investigation noted that R34 had missed a dose of his Zyprexa on 10/14/23 and 10/15/23. The investigation further documented the Certified Medication Aides (CMA) that worked could not find the medication and did not notify the charge nurse or the pharmacy. The investigation documented R34 returned from the ER on 10/16/23 with orders to follow up with his physician regarding his behaviors.

On 11/28/23 at 12:34 PM, observation revealed R34 propelled around the 500 neighborhood in his wheelchair. R34 ran into a pillar by the dining room, then continued to propel around neighborhood. R34 ran into a wall by room 508 and then stood up. Dietary Staff CC told R34 to sit down but did not respond to the direction. Licensed Nurse (LN) H exited the nurse's office and assisted R34 to sit down, then moved him away from the wall. LN H then went back into the nurse office. Further observation revealed R34 propelled his wheelchair into the dining area and tried to go between a chair and another resident seated at a table. R34 kept trying to go through and his wheelchair ran into the resident seated at the table. Continued observation revealed the other resident became angry and yelled "Get out of here," and pushed on R34's wheelchair. LN H came back out of the nurse offices and pushed R34 out of the dining room area away from the other resident. Continued observation at 12:52

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PM, revealed R34 propelled his wheelchair over to the area where Certified Nurse Aide (CNA) charting was done and started to mess with papers by the computer. CNA P walked over and pushed R34 away from the area then left to assist another resident in their room.

On 11/30/23 at 11:45 AM, Administrative Nurse E stated the employees were agency staff and said she was unsure if they still worked at the facility. Administrative Nurse E stated the agency staff received coaching and the facility policy was reviewed with them as well as all the CMAs in the facility.

The facility's "Adverse Effects and Medication Errors" policy, dated 12/2021, documented a medication error was defined as the preparation or administration of drugs or biological's which are not in accordance with physicians' orders, manufacturer specification or accepted professional standards and principles of the professional providing the services. Examples of a medication error would include omission of a drug.

The facility failed to prevent significant medication errors for R34, whose Zyprexa was not given for two days. This placed the resident at risk for decreased well-being.

- R52's Electronic Medical Record (EMR) recorded diagnoses of osteoarthritis (abnormal loss of bone density and deterioration of the bone tissue with an increased fracture risk), dementia (progressive mental disorder characterized by failing memory, confusion), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), and

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F 760	Continued From page 79	F 760		

right knee pain.

R52's EMR recorded the following "Physicians Orders" dated 11/17/23:
Aspirin one time daily (81 milligrams).
Namenda XR (memantine- medication used to enhance cognition) 10 milligrams (mg) twice daily.
Docusate sodium capsule (Colace-stool softener) 100 mg daily.

On 11/28/23 at 08:10 AM, observation revealed License Nurse (LN) G dispensed all of R52's 08:00 AM medication in a plastic medication cup and poured all of the medication except Culturelle (probiotic) but including the aspirin, Colace, and Namenda XR, into a plastic bag and crushed all the medications together. LN g then opened the Culturelle and sprinkled it into applesauce. LN G placed approximately one teaspoon of applesauce in a medication cup and then mixed the crushed medication with the applesauce and administered the medication to R52 who sat at the dining room table.

The "Pharmacist Therapeutic Research" dated February 2023 documented the following medications should not be crushed when administered: aspirin due to "modified release" and a gastric irritant Colace due to leaving a bad taste, and Namenda XR due to it was modified release.

On 11/30/23 at 11:30 AM, Administrative Nurse D verified the physician orders and stated the medications should not be crushed.
Administrative Nurse D said staff would contact the physician for further orders for medication administration and route.

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F 760	Continued From page 80 The facility's "Adverse Effects and Medication Errors" policy, dated 12/2021, documented a medication error was defined as the preparation or administration of drugs or biological's which are not in accordance with physicians' orders, manufacturer specification or accepted professional standards and principles of the professional providing the services. In the event of the significant medication related error or adverse. Examples of medication errors include a drug ordered but not administered, a drug administered without a physician order, wrong dose, wrong route of administration, wrong dosage form, and wrong drug, wrong time, and failure to follow manufactures instructions and/or acceptable professional standards such as failure to shake medications that is labeled "shake well and crushing a medication on the "do not crush list" without an order. The physician is notified promptly of any significant error or adverse effect. The facility failed to prevent a significant medication error when staff crushed and administered medication which were not to be crushed to R52. This placed the resident at risk for adverse reaction from the medication.	F 760		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 761		

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F 761	Continued From page 81 §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 had a census of 77 residents. The sample included 19 residents. Based on observation, interview, and record review, the facility failed to discard Resident (R)53's outdated insulin (hormone which allows cells throughout the body to uptake glucose) flex pen. This deficient practice placed the affected resident at risk for ineffective medications. Findings included: - On 11/27/23 at 10:10AM, observation revealed R53's Novolog (rapid acting insulin) flex pen had an open date of 07/11/23 (149 days) and lacked a discard date. On 11/27/23 at 10:10 AM, Licensed Nurse (LN) H verified the nurses were to date the flex pens when opened and discard the insulin pen when expired.	F 761		

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F 761	Continued From page 82 On 11/28/23 at 01:30 PM, Administrative Nurse D verified the nurses should label and date the flex pens with the resident's name and discard expired and/or outdated pens. According to www.Medlineplus.gov, Novolog pens can be used within 28 days, but after that time they must be discarded. The facility's "Storage of Medications" policy, dated December 2023, documented the facility shall store all drugs and biologicals in a safe, secure, and orderly manner. The community shall not use discontinued, outdated, or deteriorated drugs and biologicals. The facility failed to dispose outdated insulin flex pen for R53 placing the resident at risk for ineffective medication.	F 761		
F 801 SS=F	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e) This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified	F 801		

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nutrition professional is one who-
(i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose.
(ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional.
(iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section.
(iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law.

§483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services.
(i) The director of food and nutrition services must at a minimum meet one of the following qualifications-
(A) A certified dietary manager; or
(B) A certified food service manager; or
(C) Has similar national certification for food

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service management and safety from a national certifying body; or
D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; or
(E) Has 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, 2023, that includes topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving; and
(ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and
(iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 77 residents. The sample included 19 residents. Based on observation, record review, and interview the facility failed to provide the services of a full time certified dietary manager for the 77 residents who resided in the facility and received their meals from the kitchen.

Findings included:

- On 11/27/23 at 09:05 AM, observation revealed dietary staff in the kitchen prepared the lunch meal of macaroni and cheese, broccoli, and chocolate peanut butter brownie.

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F 801	Continued From page 85 On 11/27/23 at 09:10 AM, Dietary Staff BB verified he worked at the facility for a few months. He said he was enrolled in a dietary manager course. Dietary Staff BB stated four residents received a pureed (foods with soft, pudding like consistency) diet. On 11/30/23 at 11:45 AM, Administrative Nurse D verified Dietary Staff BB was not certified and was currently enrolled in the dietary manager online course. The Facility's "Director of Dining Services " dated 5/2023 documented the day-to-day functions of the dining services department shall be under the supervision of Director of Dining Services, Registered Dietician or a Certified Dietary Manager that has been certified by the Association of Nutritional Food Services Professionals (Required for Long Term Care only) or shall be a Certified service Manager or has similar national certification for food service management or hospitality and shall meet all State requirements. The director of dining services shall be a full-time employee and is responsible for the day-to day function of the Dining Services department. The facility failed to employ a full time certified dietary manager to evaluate residents' nutritional concerns and oversee the ordering, preparing, and storage of food for the 77 residents in the facility, placing the residents at risk for inadequate nutrition.	F 801		
F 804 SS=F	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2)	F 804		

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F 804	Continued From page 86 §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: The facility had a census of 77 residents. Based on observation, record review, and interview, the facility failed to serve palatable food during meals that maintained appetizing temperatures and conserved nutritive values for the residents who resided in the facility and received food from the facility kitchen. This placed the residents at risk for decreased enjoyment of meals and increased risk for weight loss. Findings included: - The 11/27/23 lunch menu recorded tortellini with Alfredo sauce, fresh steamed broccoli, whole wheat dinner roll, and a peanut butter brownie. On 11/27/23 at 11:20 AM, observation during the noon meal revealed staff brought the insulated food cart to the 600-hall dining area. At 11:30 AM, staff uncovered the food on the steam table and obtained the following temperatures: Tortellini with cheese sauce was 161.7 degrees Fahrenheit (F) Broccoli was 171.7 degrees F. The broccoli was brown with no green visible; the broccoli was not readily identifiable as broccoli. An unidentified dietary staff said she obtained a temperature on broccoli and stated the facility did	F 804		

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not usually serve brown broccoli.

On 11/27/22 at 11:30 AM, Dietary Staff (DS) BB, the dietary manager, arrived at the 600-hall kitchenette and when asked to identify the brown vegetable, Dietary Staff BB stated is the food item was "dead broccoli." DS BB said the broccoli should not have left the kitchen looking as it did and said he would have the kitchen staff make more broccoli and deliver it to the kitchenette shortly.

On 11/27/23 at 11:35 AM, the unidentified dietary staff plated a resident's food and included the brown broccoli on the plate; the plate was served to the resident who started to eat the brown broccoli.

On 11/27/23 at 12:10 PM a cook brought up a fresh-cooked container of green broccoli and the dietary staff proceeded to serve the rest of the residents.

On 11/27/23 at 12:35 AM, Resident (R)29 stated her food was often cold, had no flavor, and frequently gave her diarrhea.

On 11/30/23 at 01:30 PM, DS BB stated he had only worked at the facility for a few months, and he was in the process of training staff on cooking, serving, and recording temperatures. DS BB said he would continue to work with the staff regarding cooking and policies. DS BB verified the brown broccoli should not have been served to the residents.

The "Meal Service" policy, dated January 2021, documented it is the policy of the facility that food should be maintained at proper temperatures

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during service and transport in a sanitary manner. Foods should be prepared on a schedule ensuring that food is served at the peak of quality; hot foods should be served at a temperature as directed by state regulations. The Nutrition and Dining Services Director or designee should follow standards of acceptable quality pf food to be served.

The facility failed to serve palatable food during meals that maintained appetizing nutritive values for the residents who resided in the facility and received food from the facility kitchen, placing the residents at risk for nutritional status problems and weight loss.
- On 11/29/23 at 11:45 AM, observation during the noon meal revealed Dietary Staff (DS) CC obtained the food temperature for a hamburger at 127 degrees Fahrenheit (F.) and stated he would probably microwave the hamburger to get it to the right temperature. In continued observation at 11:55 AM, DS CC gave the hamburger to the resident without reheating it and stated he "spaced it off" and did not go back and get it from the resident. Continued observation revealed the resident did not eat the hamburger.

On 11/30/23 at 12:45 PM, DS BB stated DS CC should have reheated the hamburger to bring it up the right temperature.

The "Meal Service" policy, dated January 2021, documented it is the policy of the facility that food should be maintained at proper temperatures during service and transport in a sanitary manner. Foods should be prepared on a schedule ensuring that food is served at the peak of quality; hot foods should be served at a temperature as directed by state regulations. The Nutrition and

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F 804	Continued From page 89 Dining Services Director or designee should follow standards of acceptable quality of food to be served. The facility failed to serve a hamburger to one resident at the proper temperature. This placed the resident at risk for food borne illness and decreased palatability.	F 804		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify	F 880		

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F 880	Continued From page 90 possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: The facility had a census of 77 residents. The	F 880		

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sample included 19 residents, with six reviewed for indwelling catheter (tube placed in the bladder to drain urine into a collection bad), and urinary tract infections (UTI). Based on observation, record review, and interview, the facility failed to use acceptable infection control practices related to caring for indwelling catheters for three residents. This placed the residents at increased risk for infectious disease.

Findings included:

- On 11/28/23 at 12:18 PM, observation revealed Certified Nurse Aide (CNA) P removed Resident (R)28's catheter bag from the dignity bag and proceeded to drain the urine from the catheter bag into a container. CNA P then reattached the drainage port to the bag and threw the catheter bag onto the floor.

On 11/29/23 at 09:28 AM, observation revealed R3 remained in bed. The catheter drainage bag was hooked to the bed frame at the foot of the bed, did not have a privacy bag, and touched the floor. It was visible from the hallway.

On 11/29/23 at 10:03 AM, observation revealed CNA M assisted R3 with ADLs. CNA M provided perirectal cleaning due to incontinence of bowel then, with the same gloved hands, emptied the drainage bag into a measuring container. CNA M did not cleanse the drainage spout and placed the spout back into the holder. Licensed Nurse (LN) G assisted with R3's mechanical lift transfer from R3's bed to recliner. During the transfer, the catheter drainage bag was hooked to the loops of the sling which placed the urine drainage bag above R3's bladder. Once R3 was placed in the recliner, staff unhooked the drainage bag and

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placed it on the floor. Once the mechanical lift was removed, staff hooked the catheter drainage bag onto the trash can next to the recliner, which remained touching the floor.

On 11/30/23 at 09:51 AM, CNA MM took R180 to her room, and took her catheter bag out of the dignity bag. R180's catheter bag had 100 cubic centimeters (cc) of amber (dark yellow) colored urine. CNA MM drained the urine into a container and then reattached the port to the bag but did not disinfect it.

On 11/29/23 at 01:58 PM CNA M verified the catheter bag should not touch the floor. CNA M said when emptying catheter bags, she shook the spout of the drainage bag to remove any residual urine and placed the spout back into the holder but did not wipe it off.

On 11/27/23 at 12:41 PM, LN H verified catheter bags should not touch the floor.

On 11/29/23 at 09:51 AM, CNA MM stated she should disinfect the catheter port with a wipe or alcohol swab after she drained the catheter bag.

On 11/29/23 at 10:00 AM, LN I stated the catheter port should be disinfected after staff drain the urine from the bag.

On 11/30/23 at 11:45 AM, AM Administrative Nurse E stated the catheter bag should not touch the floor or be raised above the bladder level of the resident. Administrative Nurse E also stated the catheter drainage spout should be cleansed with an alcohol swab after being emptied and replaced in the spout holder.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175498	A. BUILDING _____ B. WING _____	11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE - HAYS INC	2225 CANTERBURY DR HAYS, KS 67601

(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 880	Continued From page 93 The facility's "Catheter Care, Urinary" policy, dated 12/2017, documented the purpose of the procedure is to prevent catheter-associated urinary tract infections. If breaks in aseptic technique, disconnection, or leakage occur, replace the catheter and collecting system using aseptic technique and sterile equipment, as ordered. The urinary drainage bag must be held or positioned lower than the bladder at all times to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder. Be sure the catheter tubing and drainage bag are kept off the floor. Observe for other signs and symptoms of urinary tract infection or urinary retention. Report findings to the physician or supervisor immediately. The facility failed to use acceptable infection control practices related to caring for indwelling catheters for three residents. This placed the residents at increased risk for infectious disease.	F 880		