

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

PRINTED: 12/20/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175263		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/12/2023	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - OLATHE				STREET ADDRESS, CITY, STATE, ZIP CODE 20705 W 151ST STREET OLATHE, KS 66061			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS			F 000			
F 558 SS=D	The following citations represent the findings of a Health Resurvey and Complaint Investigation KS00184412 and KS00183446. The 2567 was sent electronically on 12/20/23. Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: The facility identified a census of 114 residents. The sample included 23 residents with three residents reviewed for accommodation of needs. Based on observation, interview, and record review, the facility failed to ensure Resident (R) 60 and R209 each had a call light within reach. This placed the residents at risk for impaired care. Findings included: - R60'S Electronic Medical Record (EMR), under the "Diagnoses" tab, recorded diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), hemiparesis/hemiplegia (weakness and paralysis on one side of the body) following cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain) and diabetes mellitus			F 558			

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

TITLE

(X6) DATE

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

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F 558	Continued From page 1 (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin). R60's "Quarterly Minimum Data Set [MDS]" dated 10/27/23 recorded a Brief Interview for Mental Status (BIMS) score of zero which indicated severe cognitive impairment. The MDS recorded R60 had impairment of both upper and lower extremities on both sides. The MDS recorded R60 required substantial to maximal assistance to roll left and right. R60's "Care Plan" documented a problem on 08/26/22 and revised on 10/25/23 which documented R60 fell on 08/25/22, 12/20/22, 02/22/23, 05/20/23, 07/24/23, and 10/25/23. The plan directed staff were to ensure a safe environment, provide a wider mattress when available, and a body pillow. On 12/06/23 at 01:37 PM R60 had a flat pad call light in the upper left corner of his low air loss mattress. R60 laid in bed, rolled to the far right. The call light was out of reach. On 12/07/23 at 07:20 AM R60 laid in bed on his right side on the right side of the bed facing the wall. His flat pad call light was placed in the upper left corner of his bed, behind and above and out of reach. On 12/07/23 at 09:31 AM R60 remained in bed on his right side with his flat pad call light at the left corner of bed out of reach. On 12/11/23 at 07:24 AM R60 laid in bed, on his right side. His bed was in the lowest position. His flat pad call light sat on the bedside table	F 558			

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F 558	Continued From page 2 perpendicular to the head of R60's bed, out of reach of the resident. The facility failed to ensure staff provided R60 his call light within easy reach. This deficient practice placed R60 at increased risk for falls and unmet needs. On 12/12/23 10:07 AM Licensed Nurse (LN) H stated staff ensure R60's bed is always in the low position in order to prevent falls. She stated R60 had falls in the past and used a fall mat though he was currently on palliative care and does not fall as much. LN H stated R60 had a flat call light that he was able to use. She said the Certified Nurse's Aides (CNA) were good about making sure they placed the resident's call light where he could reach, and she expected the CNA to ensure the resident always had his call light available. On 12/12/23 at 02:40 PM, Administrative Nurse D stated she expected all residents to have access to the call light while in bed. The facility did not provide a policy related to accommodation of needs. The facility failed to ensure R60 had a call light within reach. This placed the resident at risk for impaired care.	F 558			

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F 558	Continued From page 3 R209's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of need for assistance with personal care, dependence on a wheelchair, dementia (progressive mental disorder characterized by failing memory, confusion), and Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness). The "Admission Minimum Data Set" (MDS) dated 12/08/23 was in progress. R209's "Care Area Assessment" (CAA) was in progress. R209's baseline "Care Plan" dated 11/28/23 lacked who was the hospice provider, how to contact the hospice provider, the frequency of hospice visits, the hospice provided supplies and/or medications, or how communication was to be collaborated between the facility and the hospice provider. Observation on 12/06/23 on 12:10 PM R209 sat in a Broda chair (specialized wheelchair with the ability to tilt and recline) next to his bed. R209 was asleep in the Broda chair. He had several days of facial hair growth noted. The call light was on the bedside table behind R209's Broda chair, outside his reach. Observation on 12/11/23 on 12:54 PM R209 sat in a Broda chair next to his bed. R209 was asleep in the Broda chair. He had several days of facial hair growth noted. The call light was on the floor next to R209's Broda chair, outside his	F 558			

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F 558	Continued From page 4 reach. On 12/12/23 at 02:40 PM, Administrative Nurse D stated she expected all residents to have access to the call light while in bed . The facility did not provide a policy related to accommodation of needs. The facility failed to ensure R60 had a call light within reach. This placed the resident at risk for impaired care.	F 558			
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline	F 655			

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F 655	Continued From page 5 care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: The facility identified a census of 114 residents. The sample included 23 residents. Based on observation, record review, and interviews, the facility failed to develop a person-centered baseline care plan for Resident (R) 209 related to his bathing preferences. This deficient practice placed R209 at risk of impaired care related to uncommunicated care needs. Findings included: - R209's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of need for assistance with personal care, dependence on a wheelchair, dementia (progressive mental disorder characterized by failing memory, confusion), and Parkinson's disease (slowly progressive neurologic disorder	F 655			

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F 655	Continued From page 6 characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness). The "Admission Minimum Data Set" (MDS) dated 12/08/23 was in progress. R209's "Care Area Assessment" (CAA) was in progress. R209's "Care Plan" dated 11/28/23 documented the resident required (specify bathing options [reclining shower chair, drop seat shower chair, shower gurney, bed bath]; staff assist; cueing [specify], etc.). The "Care Plan" lacked person centered direction for R209. Observation on 12/06/23 on 12:10 PM R209 sat in a Broda chair (specialized wheelchair with the ability to tilt and recline) next to his bed. R209 was asleep in the Broda chair. He had several days of facial hair growth noted. The call light was on the bedside table behind R209's Broda chair, outside his reach. On 12/12/23 at 09:53 AM Certified Nurse Aide (CNA) O stated the CNAs had access to the Kardex (nursing tool that gives a brief overview of the care needs of each resident) but not the plan of care. CNA O stated not sure what day or shift R209 received his bath. CNA O stated R209 had not been at the facility very long and hospice provided R209's bath. On 12/12/23 at 11:53 AM Licensed Nurse (LN) G stated the nurses had access to the care plan but not the CNA's. LN G stated they had access to the Kardex which populated from the information from the plan of care. LN G stated R209's bathing	F 655			

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F 655	Continued From page 7 preference should be listed on the plan of care. On 12/12/23 at 02:41 PM Administrative Nurse D stated each resident was asked at the time of their admission what was their preference for bathing such as the time of day, frequency, and type of bath. Administrative Nurse D stated that information was placed on the resident's care plan within 48 hours, which populated onto the Kardex. Administrative Nurse D stated the CNAs had access to the Kardex. The facility's "Care Plan" dated 11/01/23 documented baseline care plan would include instructions needed to provide effective and person- centered care of the resident that met professional standards of quality care. A baseline care plan would be developed upon admission according to federal and state regulations. This plan of care would be modified to reflect the care currently required/provided for the resident. The care plan would emphasize the care and development of the whole person ensuring that the resident would receive appropriate care and services. It would address the relationship of items or services required and facility responsibility for providing these services. The facility failed to develop a person-centered baseline care plan for R209 related to his bathing preferences. This deficient practice placed R209 at risk of impaired care related to uncommunicated care needs.	F 655			
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	F 657			

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F 657	Continued From page 8 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 team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: The facility identified a census of 114 residents. The sample included 23 residents with five residents review for unnecessary medication. Based on observation, interview, and record review, the facility failed to ensure Resident (R) 60's "Care Plan" was revised to include his use of insulin (hormone that lowers the level of glucose in the blood). This placed R60 at risk for complications related insulin use due to uncommunicated care needs. Findings included:	F 657			

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F 657	Continued From page 9 - R60'S Electronic Medical Record (EMR), under the :Diagnoses" tab, recorded diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), hemiparesis/hemiplegia (weakness and paralysis on one side of the body) following cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain) and diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin). R60's "Quarterly Minimum Data Set [MDS]" dated 10/27/23 recorded a Brief Interview for Mental Status (BIMS) score of zero which indicated severe cognitive impairment. The MDS recorded R60 received injections and insulin for days of the observation period. The MDS recorded R60 received multiple high-risk medication during the observation period which included an antianxiety medication (medication used to treat anxiety), an antidepressant (class of medications used to treat depression) an antipsychotic (class of medications used to treat major mood disorders) and a hypoglycemic (medication used to lower blood glucose). R60's "Care Plan" documented a problem on 01/08/20 which recorded the resident had DM. The plan documented intervention dated 01/08/20 which directed staff a licensed nurse would provide foot & nail care and staff referred to a podiatrist for complications. It directed staff to inspect R60's feet daily for open areas, sores, pressure areas, blisters, edema or redness and report abnormalities to the nurse. staff were to	F 657			

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F 657	Continued From page 10 ensure R60's socks/hosiery were clean and dry and make sure that his socks/shoes were not too tight. R60's "Care Plan" lacked direction or interventions related to his insulin use. R60's EMR, under the "Orders" tab, recorded a "Physician's Order" dated 08/31/21 for Accu-check (point of care test to assess blood glucose levels) at meals (AC) and at bedtime (HS). Notify the physician for a blood glucose reading greater than 400 milliliters (ml) per deciliter (dL) or less than 70 mm/dL related to DM. R60's EMR recorded a "Physician's Order" dated 08/10/22 for insulin aspart solution (fast action insulin) inject subcutaneously (under the skin) as per sliding scale: if [blood glucose] 0-150 mm/dL give zero units; 151 - 200 mm/dL give four 4 units; 201 - 250 mm/dL give eight units; 251 - 300 mm/dL give 12 units; 301 - 350 mm/dL give 16 units. Call physician if blood glucose over 351 mm/dL., subcutaneously with meals related to DM. Hold the morning (AM) dose if resident does not eat breakfast. Review of R60's October 2023 "Medication Administration Record/Treatment Administration Record [MAR/TAR]" /dL at 05:00 PM on 10/26/23 436 mm/dL on 10/23/23 at 05:00 PM and a blood glucose of 51 mm/dL at 05:00 PM on 10/26/23. An "eAdmin Note" dated 10/06/23 at 04:44 PM documented the nurse administered the maximum dose of 16 units (insulin). The nurse held dinner R60's until his blood glucose decreased. At 05:59 PM the nurse notified the physician and received an order for more insulin.	F 657			

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F 657	Continued From page 11 An "eAdmin Note" dated 10/23/23 at 06:12 PM documented the maximum scale was administered. The note lacked evidence the physician was notified. R60's EMR lacked evidence the physician was notified of the blood glucose of 51 mm/dL on 10/26/23. R60" November 2023 MAR/TAR recorded blood glucose levels of 392 mm/dL at 05:00 PM on 11/10/23, and 381 mm/dL at 05:00 PM on 11/27/23. An "eAdmin Note" dated 11/10/23 at 04:35 PM documented R60's blood glucose was 392 mm/dL and the nurse administered 16units of insulin. The note recorded food and drink were held, and one hour later R60's blood glucose was 216 mm/dL. The note lacked evidence R60's physician was notified. An "eAdmin Note" dated 11/27/23 at 04:39 PM documented the maximum scale was administered. The note lacked evidence the physician was notified. On 12/07/23 at 02:20 PM, R60 sat in his wheelchair at a dining table and drank a can of cola through a straw. On 12/12/23 at 02:40 PM, Administrative Nurse D stated she expected nursing staff to follow the physician's orders exactly as the order was written. She stated if the order directed staff to notify the physician for specific parameters, she expected the staff to follow the order and document the notification in the resident's record. Administrative Nurse D said each residents care	F 657			

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F 657	Continued From page 12 plan included the necessary information staff need to provide care. Administrative Nurse D stated all nurses had access and ability to review care plans. The facility's "Care Plan" dated 11/01/23 documented the facility would develop a comprehensive care plan using an interdisciplinary team approach. A comprehensive care plan would include measurable objectives and timeframes that met a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment. The care plan would emphasize the care and development of the whole person ensuring that the resident would receive appropriate care and services. It would address the relationship of items or services required and facility responsibility for providing these services.	F 657			
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: The facility identified a census of 114 residents. The sample included 23 residents. Based on observation, record review, and interviews, the facility failed to provide consistent bathing for Resident (R) 7 and R209. This deficient practice	F 677			

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

PRINTED: 12/20/2023
FORM APPROVED
OMB NO. 0938-0391

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F 677	Continued From page 13 had the risk for poor hygiene, skin infections, decreased self-esteem and impaired dignity. Findings included: - R7's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of hearing loss, intellectual disabilities, major depressive disorder (major mood disorder which causes persistent feelings of sadness) and need for assistance with personal care. The "Annual Minimum Data Set" (MDS) dated 06/16/23 documented a staff interview R7's long term memory was ok, short-term memory was ok and some difficulty in new situations. The MDS documented that R7 required extensive assistance of one staff member for activities of daily living (ADLs). The "Quarterly MDS" dated 09/08/23 documented a staff interview revealed R7's short term memory was ok, long-term memory was ok, and she was consistent/reasonable with decision making. The MDS documented that R7 required limited assistance of one staff member for ADLs. R7's "ADL Functional/Rehabilitation Potential Care Area Assessment" (CAA) dated 06/26/23 documented R7 required assistance with her ADLs. R7's "Care Plan" dated 04/29/19 documented R7 preferred a whirlpool two times weekly. She preferred a female staff member and needed assistance with shaving and nail care weekly. Review of the EMR under "Documentation Survey Reports" tab for bathing reviewed for the	F 677			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 677	Continued From page 14 following dates for R7 from 09/01/23 to 12/07/23 (98 days) documented three "Whirlpool" (W) on 09/04/23, 09/21/23, and 10/16/23. "Did not Occur" (DO) was documented one time on 09/14/23. "Not Applicable" was documented four times on 10/02/23, 10/30/23, 11/02/23, and 12/04/23. "Resident Refused" was documented two times on 11/16/23 and 11/30/23. The clinical record revealed two refusals for bathing. Observation on 12/11/23 at 09:25AM R7 sat in her wheelchair alone in the hallway. Her clothes were soiled with food from breakfast. On 12/12/23 at 12:22 PM Certified Nurse Aide (CNA) P stated R7 did refuse her bath at times and the staff would reapproach her at different times. CNA P stated the staff offered her alternative bathing. CNA P stated staff charted the baths or the refusals in the EMR. CNA P stated staff would check the bath list or Kardex (nursing tool that gives a brief overview of the care needs of each resident) to know which resident was due for a bath. On 12/12/23 at 12:28 PM Licensed Nurse (LN) I stated R7 refused her whirlpool at times. LN I stated different staff offered to bathe R7. LN I stated staff documented bathing the EMR. On 12/12/23 at 02:41 PM Administrative Nurse D stated each resident was asked at the time of their admission what was their preference for bathing such as the time of day, frequency, and type of bath. Administrative Nurse D stated that information was placed on the resident's care plan within 48 hours, which populated onto the Kardex. Administrative Nurse D stated the assistant director of nursing ensured the new	F 677			

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

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OMB NO. 0938-0391

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F 677	Continued From page 15 residents were placed on the bath list on their preferred days. Administrative Nurse D stated most of the resident received a bath two times weekly. Administrative Nurse D stated the nursing staff should chart every shift the care that was provided. The facility's "Bathing" policy dated 08/29/23 documented the facility was to promote cleanliness and general hygiene. To stimulate circulation of the skin. To promote comfort, relaxation, and well-being. To observe resident's condition. To assist resident with personal care. To promote safety for the resident in the bath. The facility failed to provide consistent bathing for R7. This deficient practice placed R7 at risk for complications related to poor hygiene and impaired dignity. - R209's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of need for assistance with personal care, dependence on a wheelchair, dementia (progressive mental disorder characterized by failing memory, confusion), and Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness). The "Admission Minimum Data Set" (MDS) dated 12/08/23 was in progress. R209's "Care Area Assessment" (CAA) was in progress. R209's "Care Plan" dated 11/28/23 documented the resident required (specify bathing options	F 677			

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

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F 677	Continued From page 16 [reclining shower chair, drop seat shower chair, shower gurney, bed bath]; staff assist; cueing [specify], etc.). The "Care Plan" lacked person centered direction for R209. Review of the EMR under "Documentation Survey Reports" tab for bathing reviewed for the following dates for R209 from 11/28/23 to 12/10/23 (13 days) lacked documentation of a bath was provided for R209. The clinical record lacked a refusal of care. Observation on 12/06/23 on 12:10 PM R209 sat in a Broda chair (specialized wheelchair with the ability to tilt and recline) next to his bed. R209 was asleep in the Broda chair. He had several days of facial hair growth noted. The call light was on the bedside table behind R209's Broda chair, outside his reach. On 12/12/23 at 09:53 AM Certified Nurse Aide (CNA) O stated the charge nurse made the assignment every morning and assigned the baths. CNA O stated he was not sure what day or shift R209 received his bath. CNA O stated R209 had not been at the facility very long and hospice provided R209's bath. On 12/12/23 at 11:53 AM Licensed Nurse (LN) G stated the nurse managers updated the bath list with any new admissions. LN G checked the bath list to check what days R209 was to be bathed. LN G stated R209 was scheduled on Monday evening shift, usually the resident received a bath two times a week. LN G stated she was not sure what days hospice provided R209's additional bathing. On 12/12/23 at 02:41 PM Administrative Nurse D	F 677			

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

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F 677	Continued From page 17 stated each resident was asked at the time of their admission what was their preference for bathing such as the time of day, frequency, and type of bath. Administrative Nurse D stated that information was placed on the resident's care plan within 48 hours, which populated onto the Kardex. Administrative Nurse D stated the assistant director of nursing ensured the new residents were placed on the bath list on their preferred days. Administrative Nurse D stated most of the resident received a bath two times weekly. Administrative Nurse D stated the nursing staff should chart every shift the care that was provided. The facility's "Bathing" policy dated 08/29/23 documented the facility was to promote cleanliness and general hygiene. To stimulate circulation of the skin. To promote comfort, relaxation, and well-being. To observe resident's condition. To assist resident with personal care. To promote safety for the resident in the bath. The facility failed to provide consistent bathing for R209. This deficient practice placed R209 at risk for complications related to poor hygiene and impaired dignity.	F 677			
F 679 SS=E	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the	F 679			

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

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F 679	Continued From page 18 physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: The facility identified a census of 114 residents. The sample include 23 residents. Based on observation, record review, and interviews, the facility failed to provide consistent activities for Resident (R) 7 and the other cognitively impaired residents who resided outside of the locked unit. This deficient practice placed the affected residents at risk for decreased psychosocial wellbeing and boredom. Findings included: - On 12/11/23 at 09:50 a group of cognitively impaired residents sat in the fireplace social area. The residents were not alerted or invited to attend the scheduled 10:00AM. The residents did not attend the planned activity event from 10:00AM to 11:00AM. On 12/11/23 at 10:00AM the facility held a "Name that Christmas song" activity. The activity provided snacks for the residents as they listened for the mystery Christmas songs played. At 10:33AM R7 () wheeled herself down the hall and into the activities room. R7 wheeled herself around the room and residents attending the event. R7 wheeled herself to the front of the room by the activities staff. Staff did not invite R7 to the game or provide her with a snack. R7 then wheeled herself to the adjoined chapel area and sat in the dark. At 10:45AM R7 wheeled herself out of the activity room and to the vending machine room. R7 sat in the vending machine room until 12:33PM.	F 679			

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F 679	Continued From page 19 On 12/11/23 at 01:24PM R84, R41, R66, R100, and R309 (all cognitively impaired residents) sat at the fireplace social area. The listed residents sat in the common area with their eyes closed. They were not asked if they would like to attend the scheduled Bingo game at 02:00 PM. The residents missed the Bingo events. Residents remained in the seated area with minimal interactions or engagement from staff. No activities were offered or provided to the residents. On 12/12/23 at 09:50AM R309 sat by the fireplace common area. Activities Staff Z began escorting residents to the activities room for "Christmas Ornament Painting" event. R309 was not asked by staff if she wanted to attend the event and was left in the area with several other residents. At 10:10AM the event began and R309 was still at the fireplace sitting area. R309 stated she wanted to attend the event. 12/11/23 at 02:30PM Certified Nurse Aid M stated staff were expected to communicate with the resident the scheduled activities and ask them if they prefer something else. He stated staff should be offering options to the residents like attending activities, social hour, television, and games. He stated cognitively impaired resident should receive sensory activities. On 12/12/23 at 11:22AM Activities Staff Z stated she R7 usually was "anxious" during the events and would often have to leave due to disruptions. She stated the activities calendars are given out to all the residents and posted on the bulletin board. She stated impaired residents are provided with painting activities on one-one basis.	F 679			

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F 679	Continued From page 20 She stated a lot of the more cognitively impaired residents don't like to attend the social events or activities. She stated every should be asked to attend or invited. She stated R7 liked to paint, color, and watch others. She stated the activities provided for each resident was charted in the EMR. On 12/12/23 at 02:30PM Administrative Nurse D stated all resident should be invited to the activity events. She stated it is the resident's choice not to attend but the activities should include everyone. She stated staff should provide engagement and offer activities if the resident did not want to go to the scheduled events. A review of the facility's "Activities" indicated the facility was responsible for providing beneficial activities that meet each resident's needs, interest, and functional level. The policy noted the activities should build community, spirituality, and cognitive opportunities for the residents. The facility failed to provide consistent activities for the cognitively impaired residents who did not reside on the locked unit. This deficient practice placed the affected residents at risk for decreased psychosocial wellbeing and boredom.	F 679			
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of	F 684			

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F 684	Continued From page 21 practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: The facility identified a census of 114 residents. The sample included 23 residents with one resident reviewed for. Based on observation, record review, and interviews, the facility failed to follow a physician order for daily weights to monitor for fluid overload for Resident (R) 97. This deficient practice placed R97 at risk for delay in treatment related to fluid overload and untreated illness. Findings included: - R97's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), muscle weakness, need for assistance with personal care, and history of falls. The "Significant Change Minimum Data Set" (MDS) dated 11/08/23 documented a Brief Interview of Mental Status (BIMS) score of five which indicated severely impaired cognition. The MDS documented that R97 required partial/moderate assistance moving from a sitting position to standing. The MDS documented R97 received a diuretic (medication to promote the formation and excretion of urine) during the observation period. R97's "Cognitive Loss/Dementia Care Area Assessment" (CAA) dated 11/16/23 documented R97 had displayed memory loss. R97's "Care Plan" dated 05/30/23 documented	F 684			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 684	Continued From page 22 nursing staff would monitor R97 based on clinical practice guidelines or clinical standards of practice related to diuretic use. The "Care Plan" lacked direction related to daily weight monitoring for fluid overload. Review of the EMR under "Orders" tab revealed physician orders: Lasix (diuretic) oral tablet 40 milligram (mg) give one tablet by mouth daily for CHF dated 09/08/23. Daily weights every day dated 09/11/23. Review of R97's "Medication Administration Record" (MAR) from 09/11/23 to 12/06/23 (87 days) lacked evidence staff measured and recorded R97's weight) on following dates 09/14/23, 09/28/23, 09/30/23, 10/18/23, 10/22/23, 10/23/23, 10/25/23, 10/27/23, 10/28/23, 10/30/23, 11/02/23, 11/03/23, 11/05/23, 11/09/23, 11/13/23, 11/20/23, 11/21/23, 11/22/23, 11/23/23, 11/25/23, 11/30/23, and 12/05/23. The clinical record lacked documentation of physician notification of daily weight was not obtained. Observation on 12/07/23 at 07:59 AM R97 sat in her wheelchair at the dining room table with non-skid socks on her lower extremities and drank her coffee. On 12/12/23 at 09:00 AM Certified Medication Aide (CMA) R stated the nurse would let the staff know which residents needed a daily weight obtained. CMA R stated the staff would notify the nurse of the of the weight. On 12/12/23 at 11:53 AM Licensed Nurse (LN) G stated R97 was a daily weight for CHF. LN G stated the physician should be notified of any weight gain of two pounds or more in day or five	F 684			

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F 684	Continued From page 23 pounds in a week. LN G was unaware that R97's daily weight did not have a weight parameter when the physician was to be notified. LN G stated she was not aware of R97 every refusing to be weighed. On 12/12/23 at 02:41 PM Administrative Nurse D stated daily weights should have parameter of gain or loss when the physician would be notified. Administrative Nurse D stated the charge was responsible to monitor daily weights. The facility's "Physician/Practitioner Orders" policy dated 03/29/23 documented to provide individualized care to each resident by obtaining appropriate, accurate and timely physician/practitioner orders. To provide a procedure that facilitates the timely and accurate process of physician/practitioner orders. Physician/practitioner orders are a critical component to providing quality care to residents. Accurate processing of physician/practitioner orders are important. The nursing services and health information management (HIM) departments each have responsibilities for processing physician/practitioner orders in a timely and accurate manner. Teamwork and communication between the two departments is essential. Once the order is entered into PCC, depending on order category, the order would populate the appropriate electronic administration documentation location within the application. The facility failed to follow a physician order for daily weights to monitor weight gain for fluid overload for R97. This deficient practice placed R97 at risk of adverse side effects for unnecessary medication or complications related to fluid overload.	F 684			

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F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility identified a census of 114 residents. The sample included 23 residents with seven reviewed for accidents. Based on observation, record review, and interviews, The facility failed to provide consistent Roam Alert (bracelet that sets off an alarm when residents wearing one attempt to exit the building without an escort) functionality checks on Residents (R) 25's Roam Alert band. This deficient practice placed the resident at risk for elopement. The facility additionally failed to prevent avoidable accidents during R33's Hoyer (full body lift) lift transfers resulting in minor injuries and failed to utilize R87's care planned Hoyer lift while transferring her to her bed resulting in a non-injury fall. These deficient practices placed the residents at risk for preventable accidents and injuries. Findings included: - The electronic medical record (EMR) for R25 documented diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), needs for assistance for personal cares, Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the	F 689			

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

PRINTED: 12/20/2023
FORM APPROVED
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F 689	Continued From page 25 fingers, masklike faces, shuffling gait, muscle rigidity and weakness), history of falls, and abnormalities of gait/mobility. R25 "Annual Minimum Data Set (MDS)" completed 11/15/23 noted a Brief Interview for Mental Status (BIMS) score of four indicating severe cognitive impairment. The MDS indicated she was independently mobile with staff supervision while walking. The MDS noted she had delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue) but no wandering behaviors at the time of assessment. R25's "Cognitive Loss Care Area Assessment (CAA)" completed 11/17/23 noted a BIMS score of four. The CAA noted she usually had confusion, disorientation, forgetfulness. The CAA listed her goal was to maintain her current level of function. R25's "Fall CAA" indicated she was at risk for falls related to her medical diagnoses and history. The CAA noted therapy services were initiated to improve her gait during walking. R25's "Care Plan" initiated 12/16/22 indicated she had potential for elopement related to her medical diagnoses. The plan noted she had a Wander Guard placed on her walker to Alert staff to her movements. The plan instructed staff check for functionality every shift to ensure its working order. A review of R25's "Physician's orders" revealed an order dated 09/02/23 instructed staff to check her Roam Alert placement every night shift.	F 689			

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F 689	Continued From page 26 A review of R25's "Treatment Administration Report (TAR)" indicated the placement of the Roam Alert bracelet was being completed lacked documentation showing the functionality was tested. The facility Roam Alert logs located on the "Cozy Cottage" unit indicated R25's Roam Alert Functionality had not been tested since 10/27/23. Licensed Nurse (LN) PP verified that the checks were not completed for the resident. She stated maybe the residents on the locked unit were only being checked by the night shift. On 12/07/23 at 09:23AM R25 walked through the fireplace social area. Her Roam Alert bracelet was fastening under the front strap of her walker. On 12/12/23 at 11:30 Certified Nurses Aid (CNA) M stated the placement of the Roam Alerts were check daily by direct care staff, but the function was checked by the night staff. He stated they had a wand that tested the bands to see if they worked. On 12/12/23 at 02:30 Administrative Nurse D stated all residents with Roam Alert devices should be check nightly for placement and functionality. She stated the logs were kept on the secured unit and night shift should be checking and logging the checks. She stated each unit had binders with at-risk resident pictures. She stated staff should check the placement of the bands each shift and keep eyes on resident's that wander. The facility's "Elopement" policy revised 07/11/23 indicated the facility will monitor all residents at risk for elopement will be closely monitored. The			F 689			

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

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F 689	Continued From page 27 policy noted staff will follow each resident's individualized care interventions as well as facility wide processes. The facility did not provide a policy related to Roam Alert systems. The facility failed to provide consistent functionality checks on R25's Roam Alert bands. This deficient practice placed the resident at risk for elopement. - The electronic medical record (EMR) for R33 documented diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), dysphagia (swallowing difficulty), muscle weakness, and abnormalities of gait/posture. R33 "Quarterly Minimum Data Set (MDS)" completed 11/10/23 noted a Brief Interview for Mental Status (BIMS) score of seven indicating severe cognitive impairment. The MDS indicated she was dependent for staff assistance for all Activities of Daily Living (ADLs) except eating. The MDS noted she had a history of verbal aggression. R33's "Delirium Care Area Assessment (CAA)" and "Cognitive Loss CAA" completed 08/22/23 indicated she had impaired cognitive function related to her medical diagnoses. The CAA noted she had impaired memory recall and trouble sleeping. The CAA indicated her goal was to maintain her current level of functioning.	F 689			

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

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F 689	Continued From page 28 R33's "Activities of Daily Living (ADLs) CAA" completed 08/22/23 indicated she required extensive assistance with her ADLs. The CAA indicated she was not always aware of her needs but asks to go to restroom. The CAA indicated she required a Hoyer lift for transfers. The CAA indicated her goal was to maintain her current level of functioning. R33's "Behaviors CAA" completed 10/22/23 indicated she had a history of verbal behaviors with a diagnosis of anxiety, depression, and delusions. The CAA noted she had increased frustration when extra noise was present. The CAA indicated her goal was to maintain her current level of functioning. R33's "Care Plan" initiated 07/05/20 indicated she was at risk for decreased physical mobility, ADL performance, and communication related to her medical diagnoses. The plan noted she had a communication deficit related to confusion, hearing deficits, and delusions (07/05/20). The plan encourage staff to allow R33 to express her thoughts and use techniques which enhanced interactions (decrease background noise, keep conversation simple). The plan noted she required assistance from two staff members for toileting, transfers, and bathing. The plan noted she required a total lift for transfers and a Sit-to-stand lift for toileting. The plan indicated she had grief and loss related to her husband's passing in March 2022. The plan indicated she had loss support through counseling and therapy services to support emotional stability (04/06/22). R33's EMR revealed "Health Status" note dated 11/22/23 indicating R33's left hand got caught in a Hoyer lift sling during a transfer in the shower	F 689			

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

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FORM APPROVED
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F 689	Continued From page 29 room. The note indicated her hand slipped multiple times. The note identified bruising on her left thumb and hand. R33's EMR revealed a "Progress Note" dated 07/10/23 that indicated she obtained a small cut to her right lower back while being lowered into her Broda chair (specialized wheelchair with the ability to tilt and recline). The noted indicated the areas was cleansed and a Band-aid was applied. An "Occupational Therapy" note completed 07/13/23 indicated R33's Broda chair was adjusted to support her leg, hip, and back positioning. On 12/07/23 at R33 sat at the fireplace social area. R33 asked to be moved to her room. R33 stated she did not remember the incident but remember being rushed to go to bed. She stated CNA LL was rude to her and got her bed when she wanted to go. She couldn't remember if two staff were present that evening but had received injuries before when being transferred. On 12/12/23 at 11:24AM Certified Nurse's Aide (CNA) M stated R33 always required a Hoyer lift for transfers. He stated staff had to make sure she kept her hands positioned safely because she would move around a lot during transfers. He stated staff received Hoyer lift training while orienting with the facility. He stated two staff should assist during the transfer with the lift. He stated one person lifts the resident while to other maneuvers the resident. On 12/12/23 at 11:50AM Licensed Nurse (LN) J stated staff should check the resident's positioning while using the lift to prevent injuries	F 689			

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

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F 689	Continued From page 30 from occurring. She stated the resident's hands should be positioned over their chest and not near the sling or machine. On 12/12/23 at 02:41PM Administrative Nurse D stated staff have been re-educated on sling use and proper positioning. She stated occupational therapy was consulted to adjust R33 chair to prevent positional injuries from occurring during transfer. She stated two staff were expected to completed Hoyer transfers and ensure the residents safety. The facility's "Restorative_ Identifying Decline in Activities of Daily Living" policy revised 12/16/22 indicated the facility would assess and develop to ensure ADLs are carried out in a consistent and safe manner based on each resident's needs and care planned interventions. The facility's "Fall Prevention and Management" policy revised 03/29/23 indicated staff were to follow the appropriate preventative interventions documented in the care plan, Kardex, or physician's orders to prevent falls. The facility failed to prevent avoidable accidents during R33's Hoyer lift transfers resulting in minor injuries. This deficient practice placed R33 at risk for preventable injuries and falls. - The "Medical Diagnosis" section within R87's Electronic Medical Records (EMR) included diagnoses of cognitive communication disorder, type two diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), chronic obstructive pulmonary disease (COPD- progressive and irreversible condition	F 689			

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F 689	Continued From page 31 characterized by diminished lung capacity and difficulty or discomfort in breathing), morbid obesity (severely overweight), acute kidney failure, and need for assistance with personal care. R87's "Significant Change Minimum Data Set (MDS)" completed 11/10/23 noted a Brief Interview for Mental Status (BIMS) score of 10 indicating mild cognitive impairment. The MDS indicated she required substantial/maximal assistance for transfers, toileting, bathing, and dressing. The MDS indicated she used a manual wheelchair for mobility. The MDS indicated she had no falls since admission. R87's "Activities of Daily Living (ADL) Care Area Assessment (CAA)" completed 11/14/23 indicated she required extensive assistance for her ADLs. The MDS noted she started hospice services and needed a total lift for transfers. R87's "Fall CAA" completed 11/14/23 indicated she was at risk for falls related to her medications. Poor safety awareness, and medical diagnoses. The CAA encouraged staff to provide a consistent care routine and anticipate her needs. R87's "Care Plan" initiated 10/20/23 indicated she had an ADL self-care deficit related to her medical diagnoses and cognitive impairment. The plan noted she required staff assistance for toileting, bathing, bed mobility, personal hygiene, and transfers. The plan noted she required a total lift (Hoyer) with a large high back sling for all transfers (10/20/23). A review of R87's EMR revealed an "Incident"	F 689			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 689	Continued From page 32 note dated 12/03/23 indicating she fell while being transported from the restroom by staff. The note indicated she was transported with a Sit-to-stand lift and slipped off the lift. The note indicated staff lowered her to the floor. The note indicated she had no injuries from the fall. A review of a "Fall Investigation" completed 12/03/23 indicated a Sit-to-stand lift was used for her transfers and staff were educated to use the total (Hoyer) lift. On 12/06/23 at 08:00AM R87 sat in her wheelchair as she ate her breakfast. R87 report no concerns with her care and reported she was receiving hospice services. On 12/12/23 at 10:41AM Certified Nurse's Aide (CNA) M indicated R87 required a total lift due to her declining health and weakness. He stated all staff had access to each resident's Kardex (nursing tool that gives a brief overview of the care needs of each resident) and should review each resident's transfer requirements before caring for them. On 12/12/23 at 11:50AM Licensed Nurse (LN) J indicated R87 transferred with a total lift and was too weak to use the Sit-to-stand lift. On 12/12/23 at 02:41PM Administrative Nurse D stated R87'S "Care Plan" indicated she needed a total lift for transfers since 10/20/23. She stated she expected staff to follow the care plan interventions. She stated all staff were required to receive training on mechanical lifts before working at the facility. She stated the facility held frequent training sessions if patterns or concerns were found with certain care areas.	F 689			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 689	Continued From page 33 The facility's "Restorative_ Identifying Decline in Activities of Daily Living" policy revised 12/16/22 indicated the facility would assess and develop to ensure ADLs are carried out in a consistent and safe manner based on each resident's needs and care planned interventions. The facility's "Fall Prevention and Management" policy revised 03/29/23 indicated staff were to follow the appropriate preventative interventions documented in the care plan, Kardex, or physician's orders to prevent falls. The facility failed to utilize R87's care planned Hoyer lift while transferring her to her bed resulting in a non-injury fall. This deficient practice placed R87 at risk for preventable accidents and injuries.	F 689			
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2) For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (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;	F 690			

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

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F 690	Continued From page 34 (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: The facility identified a census of 114 residents. The sample included 23 residents with two reviewed for incontinence management and urinary catheters. Based on observation, record review, and interviews, the facility failed to provide individualized incontinence interventions based on Resident (R)55's significant status change. The facility additionally failed to provide consistent monitoring of urinary catheter care for R101. This deficient practice placed the residents at risk for complications related to incontinence and/or urinary tract infections (UTIs). Findings Included: - The "Medical Diagnosis" section within R55's Electronic Medical Records (EMR) included diagnoses of dysphagia (difficulty swallowing), Recent fracture (Bone Break) of the left femur	F 690			

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

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F 690	Continued From page 35 (large leg bone), dementia (progressive mental disorder characterized by failing memory, confusion), and cognitive communication deficit. R55's "Significant Minimum Data Set (MDS)" completed 11/10/23 noted a Brief Interview for Mental Status (BIMS) score of six indicating severe cognitive impairment. The MDS indicated she was always incontinent of urine and occasionally incontinent of bowel with no toileting program. The MDS noted she required partial to moderate assist with toileting and substantial/maximal assist with toileting transfers. R55's "Urinary Incontinence Care Area Assessment" completed 10/24/23 indicated she was incontinent and required assistance from staff to toileting. The CAA noted she had limited mobility due to here left hip fracture and required incontinence briefs. R55's "Activity of Daily Living (ADL) CAA" completed 10/24/23 noted she had a functional decline in her ADLs and required assistance with toileting. R55's "Care Plan" initiated 10/17/23 indicated she had bladder incontinence related to dementia and the aging process. The plan noted she required incontinence brief and check and change for incontinence. The plan noted she had resolved urinary tract infections related to her incontinence. The plan failed to address her bowel incontinence and peri-care. A review an "Incident Report" dated 10/06/23 indicated R55 indicated R55 had a major injury fall while toileting herself in the shower room. The plan noted she was independent mobile and able	F 690			

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

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F 690	Continued From page 36 to toilet herself at the time of her fall. The report noted she was hospitalized with a left femur fracture. A review of R55's EMR revealed no incontinence screening to identify her specific needs or recommended interventions. The facility was unable to provide a toileting trial as requested on 12/12/23. On 12/07/23 at 02:23PM R55 sat in her room. R55 was smelled of urine. R55 reported she required assistance with toileting and often had issue with bladder episodes. On 12/12/23 at 11:00AM Certified Nurses Staff (CNA) M stated all resident were on a two-hour check and change and provided peri-care. He stated R55 recently had a fall and her need levels changed. On 12/12/23 at 11:45AM Licensed Nurse (LN) J stated R55 was on a check and change and would often let staff know when she needed assistance. She stated R55 had an ADL decline after her recent leg fracture which required her need more assistance. She stated R55 was incontinent of both bowel and bladder. On 12/12/23 at 02:30PM Administrative Nurse D stated all residents are screened upon admission for incontinence and provided care planned interventions. She stated residents in need of more individualized interventions would have a bladder trail completed, two hour toileting, and individualized interventions depending on the reason and type of incontinence.	F 690			

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175263	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/12/2023
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - OLATHE			STREET ADDRESS, CITY, STATE, ZIP CODE 20705 W 151ST STREET OLATHE, KS 66061		
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F 690	Continued From page 37 A review of the facility's "Bowel and Bladder Incontinence" policy 08/22/23 indicated the facility would appropriately screen and implement individualized toileting interventions. The policy indicated the facility will continue ongoing evaluations of the effectiveness of the interventions in place. The facility will provide treatment to help each resident maintain the highest level of function. The facility failed to provide individualized incontinence interventions based on R55's significant status change. This deficient practice placed both residents at risk for complications related to incontinence. - The electronic medical record (EMR) for R101 documented diagnoses of hemiplegia & hemiparesis (weakness and paralysis on one side of the body), retention of urine (a condition where an individual is unable to completely empty the bladder), hypertension (HTN- elevated blood pressure), and cerebral infarction (stroke). The "Significant Change Minimum Data Set (MDS)" for R101 dated 10/27/23 documented a Brief Interview for Mental Status (BIMS) score of 12 which indicated moderately impaired cognition. R101 had impairment to both upper and lower extremities on one side. R101 was dependent on staff for toileting. R101 required the use of an indwelling catheter (a flexible tube inserted through a narrow opening into a body cavity, particularly the bladder, for removing fluid). The "Urinary Incontinence and Indwelling Catheter Care Area Assessment" (CAA) dated 11/14/23 for R101 documented she needed a foley catheter due to urine retention.	F 690			

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F 690	Continued From page 38 The "Catheter Care Plan" revised 05/18/23 for R101 directed staff to monitor/record/report to the health care provider signs and symptoms of a urinary tract infection (UTI - an infection in any part of the urinary system). The care plan directed staff to perform catheter care by the certified nurse aide (CNA) every shift and ensure the catheter was anchored to the thigh with a catheter secure device. Staff was directed to report unusual observations/conditions to nurse. The "Orders" tab of the EMR documented an "Order Summary" for R101 documented a physician's order dated 05/18/23 to check anchor placement daily on day shift. The "Orders" tab of the EMR documented an "Order Summary" for R101 documented a physician's order dated 05/18/23 to empty catheter bag every shift and as needed. The "Orders" tab of the EMR documented an "Order Summary" for R101 documented a physician's order dated 08/03/23 to insert an indwelling foley catheter to dependent drainage. Change every night shift every 28 days for urinary retention. Review of R101's September 2023 "Documentation Summary Report" documented toileting/catheter care/output was performed/documented on 25 of 88 opportunities. Review of R101's October 2023 "Documentation Summary Report" documented toileting/catheter care was performed/documented on 12 of 63 opportunities that month.	F 690			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 690	Continued From page 39 Review of R101's November 2023 "Documentation Summary Report" documented toileting/catheter care was performed/documented on 36 of 90 opportunities that month. Review of R101's December 2023 "Documentation Summary Report" documented toileting/catheter care was performed/documented on 25 of 34 opportunities for the month. On 12/11/23 at 01:09 PM R101 sat in her wheelchair in her room watching tv. Her left hand/wrist had a splint present and resting on an arm support on the wheelchair. R101's catheter bag was present on the left side of wheelchair with a dignity bag noted. On 12/12/23 at 11:41 AM Certified Medication Aide (CMA)/CNA R stated the aide was responsible for catheter cares. CMA R stated the aide should document each shift the amount of urine emptied and report any changes noted to the color or smell along with any resident complaints to the nurse. On 12/12/23 at 10:50 AM Licensed Nurse (LN) G stated that typically only when a resident initially got a catheter would staff document the output. LN G stated the aides recorded the amount of urine emptied each shift in their point of care (POC). LN G stated the aides should report any changes noted during the catheter care to the nurse. On 12/12/23 at 02:45 PM Administrative Nurse D stated the aides provided the catheter care for residents and should chart in POC the amount of	F 690			

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F 690	Continued From page 40 urine that was emptied from the catheter bag each shift or anytime catheter care was performed. Administrative Nurse D stated the aides should also report any changes noted in urine color or smell to the charge nurse. The facility policy "Catheter: Care, Insertion and Removal, Drainage Bags, Irrigation, Specimen" last revised 04/25/22 documented the purpose for catheter care was to continuously monitor urinary output and maintain correct urinary drainage. Catheter care would be completed with morning and bedtime cares and as needed. If a resident was on Intake and Output measure urine volume and record in POC. The facility failed to ensure staff provided appropriate treatment and services, including monitoring urine output (including amount, color, odor) for R101. who had an indwelling catheter. This placed R101 at risk for infection and further urinary problems.	F 690			
F 692 SS=G	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident	F 692			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 692	Continued From page 41 preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: The facility identified a census of 114 residents. The sample included 23 residents with eight reviewed for nutrition. Based on observation, record review, and interviews, the facility failed to provide consistent weight monitoring per the professional standards of practice after admission, failed to obtain weekly weights as ordered by the physician, and failed to provide cueing for meals as needed for Resident (R) 38. The facility further failed to implement nonpharmacological interventions to prevent weight loss for R38 until after a significant unplanned loss occurred. These deficient practices resulted in a loss of 12.15% in three months. Findings Included: - The "Medical Diagnosis" section within R38's Electronic Medical Records (EMR) included diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), muscle weakness, chronic kidney disease, type two diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), cerebral infarction (CVA-stroke-	F 692			

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F 692	Continued From page 42 sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), and major depressive disorder (major mood disorder). A review of R38's "Admission Minimum Data Set (MDS)" completed 08/23/23 noted a Brief Interview for Mental Status (BIMS) score of four, indicating severe cognitive impairment. The MDS noted she ate independently but required set-up assistance from staff. The MDS noted she weighed 171 pounds (lbs.) with no known weight loss. No dental or swallowing concerns were noted in the MDS. R38's "Significant Change MDS" completed 11/15/23 indicated her weight was 151 lbs. The MDS noted she had significant weight loss but was not on a prescribed weight loss regimen. No dental or swallowing concerns were noted in the MDS and R38 received an antidepressant (class of medications used to treat mood disorders and relieve symptoms of depression) medication. The MDS indicated she required supervision or touch assistance while eating. The MDS noted the staff provided verbal cues or touching/steadying assistance as resident completed activity. R38's "Nutritional Care Area Assessment (CAA)" completed 08/29/23 indicated she had actual nutritional impairment. The CAA noted she needed occasional cueing for meals and chose to eat in her room. The CAA noted she could communicate her needs but had difficulty finding the words. The CAA noted her goal to maintain weight within five percent of her admitting weight. R38's "Nutritional CAA" completed 11/17/23 indicated she had unplanned weight loss. The	F 692			

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F 692	Continued From page 43 CAA noted she did not have an order for nutritional supplements and Boost supplements would be added. The resident often said no to meals due to confusion from her dementia. The CAA instructed staff to anticipate her needs. The resident was started on Remeron (antidepressant medication often used to stimulate appetite) on 10/20/23. The CAA indicated she would benefit from eating in the assisted area but preferred to eat in her room. The CAA further noted "Hopefully she will gain or at least not lose more weight." Staff were to weigh the resident weekly and the Registered Dietician (RD) would see her for weight loss. R38's "Care Plan" initiated 08/16/23 indicated she had nutritional problems related to her medical diagnoses, poor appetite, and new admission. The plan noted staff were to weigh her weekly and R38 would be followed in nutritional risk group (08/16/23). The plan noted R38 would maintain a weight goal within five pounds of 150 lbs. (08/16/23). The plan instructed staff to provide a calm, quiet setting at mealtimes with adequate mealtime (08/16/23). The plan noted she preferred to dine in her room but often refused lunch (11/21/23). The plan indicated medical nutritional supplements were ordered (11/21/23). The care plan lacked interventions regarding R38's level of assistance and supervision required during meals per her 11/15/23 "Significant Change MDS". R38's "Physician Orders" recorded an order dated 08/16/23 for a regular diet with regular texture and thin consistency. R38's EMR under "Weights Report" documented her admission weight as 171.2 lbs. on 08/17/23.	F 692			

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F 692	Continued From page 44 A "Dietician Assessment" completed 08/23/23 for R38 indicated she had a history of inadequate nutrient intake related to her medical diagnoses. The note indicated staff assisted the resident with meals and reported meal intake. The report indicated her intake varied and she did not meet the requirement for malnutrition. R38's EMR under "Weights Report" revealed she weighed 165.6 lbs. on 09/07/23, which indicated a 5.6 lbs. loss from the previous weight, dated 08/17/23. A 09/21/23 "Health Status" revealed R38 slept through the shift and refused to get up for meals. The note indicated R38's responsible party recommended giving her drinks and noted she drank a Boost supplement drink when offered. R38's "Weights Report" on 10/11/23 revealed she weighed 155.8 lbs. (a 15.4 lbs. loss since admission to the facility). The report lacked evidence staff obtained a weight between 09/07/23 and 10/11/23. A "Communication Note" dated 10/15/23 revealed R38's responsible party voiced concern to the facility about R38's continued weight loss and not eating meals. R38's "Weights Report" indicated on 10/20/23 she weighed 156.4 lbs. R38's "Physician Orders" documented an order dated 10/20/23 for mirtazapine (antidepressant medication often used to stimulate appetite) at bedtime to increase her appetite and prevent weight loss.	F 692			

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F 692	Continued From page 45 R38's "Physician Orders" documented an order for weekly weights every Friday dated 10/20/23. The 11/10/23 "Weights Report" revealed R38 weighed 151 lbs., which indicated a total loss of 20.2 lbs. since admission. R38's EMR lacked evidence the staff obtained a weekly weight as ordered on Friday 10/27/23 and 11/03/23. A "Mini-Nutritional Assessment" completed on 11/15/23 indicated R38 had a moderate decrease in food intake and a weight loss greater than 6.6 lbs. The assessment scored her at six, indicating she was malnourished. The assessment recommended a referral to the dietician. R38's "Physician Orders" indicated she received diabetic house supplements twice daily starting on 11/17/23. A review of a "Dietician Note" completed 11/22/23 indicated the resident weighed 150.4 lbs. and she received a regular diet. The note indicated she was on diabetic house supplements twice daily and she recommended Nutren (nutritional supplement) 1.5 supplement, three times daily. R38's "Physician Orders" indicated she received Nutren Protein three times daily starting on 11/24/23. On 12/06/23 at 08:00 AM R38 lay flat in her bed with her head and shoulders propped up by her pillows. R38 had her bedside table pulled over the bed and she attempted to eat her breakfast. R38 reported she did not want to eat her breakfast but	F 692			

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F 692	Continued From page 46 needed to. She struggled to express why she did not want to eat her meal. She stated she chose to eat in her room. Staff were not in her room during the resident breakfast to provide assist. R38 only ate 25 percent of her meal. R38 refused lunch but drank her supplement. On 12/07/23 at 08:15 AM R83 sat up in her bed while eating her breakfast. R38 consumed 80 percent of her meal and 100 percent of her supplement. Staff were not present while R38 ate her meal. On 12/06/23 at 11:45 AM R38's responsible party stated R38 struggled with appetite and weight loss in the past few months. She stated R38 chose to eat in her room and often refused to eat meals. She stated she talked to the facility about her concerns with R38's decreased appetite. She stated R38 received medication to help with her weight but wondered if providing more supplement options or meal assistance would be more helpful. On 12/12/23 at 11:50 AM Licensed Nurse (LN) J stated R38 struggled with weight loss due to her poor appetite and refusals for meals. She stated R38 often would not eat lunch but ate breakfast in her room. She stated R38 was recently started on supplements to help her maintain weight. She stated any resident with noticeable weight loss would be reported to the RD for review. She stated the RD was onsite weekly to provide consults. She stated the resident were weighed based on their orders and if a resident refused weights, it would be noted in the EMR. On 12/12/23 at 02:20PM Administrative Nurse D stated every resident received nutritional	F 692			

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F 692	Continued From page 47 assessments upon admission. She stated residents with identified weight loss or nutritional risks received interventions that included specialized diets, supplements, and review for meal assistance. She stated the interdisciplinary team reviewed at-risk residents for potential losses and provided interventions. She stated the nursing staff were expected to report weight losses and the RD was onsite weekly to see the residents. On 12/13/23 at 10:14AM Consultant HH was unavailable for interview. A review of the facility's "Weight" policy revised 09/18/23 indicated residents with nutritional risk were weighed weekly. The policy indicated the medical provider and registered dietician will be notified upon significant weight loss. The policy noted interventions will be placed to address weight loss and prevent potential losses. The facility failed to provide consistent weight monitoring per the professional standards of practice after admission, failed to obtain weekly weights as ordered by the physician, and failed to provide cueing for meals as needed for R38. The facility further failed to implement nonpharmacological interventions to prevent weight loss until after a significant unplanned loss occurred for R38. These deficient practices resulted in a loss of 12.15% in three months for R38.	F 692			
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	F 756			

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F 756	Continued From page 48 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 physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: The facility identified a census of 114 residents. The sample included 23 residents with five	F 756			

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F 756	Continued From page 49 residents review for unnecessary medication. Based on observation, interview, and record review, the facility failed to ensure the Consultant Pharmacist (CP) identified and reported irregularities with Resident (R) 60's insulin (hormone that lowers the level of glucose in the blood). This placed R60 at risk for complications related to insulin use. Findings included: - R60'S Electronic Medical Record (EMR), under the "Diagnoses" tab, recorded diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), hemiparesis/hemiplegia (weakness and paralysis on one side of the body) following cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain) and diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin). R60's "Quarterly Minimum Data Set [MDS]" dated 10/27/23 recorded a Brief Interview for Mental Status (BIMS) score of zero which indicated severe cognitive impairment. The MDS recorded R60 received injections and insulin for days of the observation period. The MDS recorded R60 received multiple high-risk medication during the observation period which included an antianxiety medication (medication used to treat anxiety), an antidepressant (class of medications used to treat depression) an antipsychotic (class of medications used to treat major mood disorders) and a hypoglycemic (medication used to lower blood glucose).	F 756			

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

PRINTED: 12/20/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175263	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/12/2023
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F 756	Continued From page 50 R60's "Care Plan" documented a problem on 01/08/20 which recorded the resident had DM. The plan documented intervention dated 01/08/20 which directed staff a licensed nurse would provide foot & nail care and staff referred to a podiatrist for complications. It directed staff to inspect R60's feet daily for open areas, sores, pressure areas, blisters, edema or redness and report abnormalities to the nurse. staff were to ensure R60's socks/hosiery were clean and dry and make sure that his socks/shoes were not too tight. R60's "Care Plan" lacked direction or interventions related to his insulin use. R60's EMR, under the "Orders" tab, recorded a "Physician's Order" dated 08/31/21 for Accu-check (point of care test to assess blood glucose levels) at meals (AC) and at bedtime (HS). Notify the physician for a blood glucose reading greater than 400 milliliters (ml) per deciliter (dL) or less than 70 mm/dL related to DM. R60's EMR recorded a "Physician's Order" dated 08/10/22 for insulin aspart solution (fast action insulin) inject subcutaneously (under the skin) as per sliding scale: if [blood glucose] 0-150 mm/dL give zero units; 151 - 200 mm/dL give four 4 units; 201 - 250 mm/dL give eight units; 251 - 300 mm/dL give 12 units; 301 - 350 mm/dL give 16 units. Call physician if blood glucose over 351 mm/dL. Hold the morning (AM) dose if resident does not eat breakfast. Review of R60's October 2023 "Medication Administration Record/Treatment Administration Record [MAR/TAR]" /dL at 05:00 PM on 10/26/23436 mm/dL on 10/23/23 at 05:00 PM and	F 756			

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

PRINTED: 12/20/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175263	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/12/2023
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F 756	Continued From page 51 a blood glucose of 51 mm/dL at 05:00 PM on 10/26/23. An "eAdmin Note" dated 10/06/23 at 04:44 PM documented the nurse administered the maximum dose of 16 units (insulin). The nurse held dinner R60's until his blood glucose deceased. At 05:59 PM the nurse notified the physician and received an order for more insulin. An "eAdmin Note" dated 10/23/23 at 06:12 PM documented the maximum scale was administered. The note lacked evidence the physician was notified. R60's EMR lacked evidence the physician was notified of the blood glucose of 51 mm/dL on 10/26/23. Review of R60's CP Medication Regimen Review (MRR) dated 11/06/23 lacked evidence the CP identified and reported the above irregularities. R60's November 2023 MAR/TAR recorded blood glucose levels of 392 mm/dL at 05:00 PM on 11/10/23, and 381 mm/dL at 05:00 PM on 11/27/23. An "eAdmin Note" dated 11/10/23 at 04:35 PM documented R60's blood glucose was 392 mm/dL and the nurse administered 16units of insulin. The note recorded food and drink were held, and one hour later R60's blood glucose was 216 mm/dL. The note lacked evidence R60's physician was notified. An "eAdmin Note" dated 11/27/23 at 04:39 PM documented the maximum scale was administered. The note lacked evidence the	F 756			

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

PRINTED: 12/20/2023
FORM APPROVED
OMB NO. 0938-0391

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F 756	Continued From page 52 physician was notified. Review of R60's CP MRR dated 12/04/23 revealed the CP documented no recommendations. On 12/07/23 at 02:20 PM, R60 sat in his wheelchair at a dining table and drank a can of cola through a straw. On 12/12/23 10:07 AM Licensed Nurse (LN) H stated if R60's blood glucose were high or low, or outside of the parameters, the nurses passed that information in report. LN H stated if R60's blood glucose was on the lower side, like 90 mm/dL, she would try to encourage juice. If R60's blood sugar were 51, she would call the physician, to get orders, right away. LN H said R60's blood glucose did occasionally get higher in the evenings. LN H reviewed R60's insulin order and stated the orders for insulin at maximum dose was for a blood glucose reading of 300-350 mm/dL and if the blood glucose was higher, she would call the physician for orders since the order did not specify to give the 16 units if over 350 mm/dL. LN H stated all physician notifications should be documented in the EMR. On 12/12/23 at 02:40 PM, Administrative Nurse D stated she expected nursing staff to follow the physician's orders exactly as the order was written. She stated if the order directed staff to notify the physician for specific parameters, she expected the staff to follow the order and document the notification in the resident's record. Administrative Nurse D said the CP reports were faxed to several key staff in the facility and the staff then reviewed the recommendations with the physician and noted any orders or changes.	F 756			

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

PRINTED: 12/20/2023
FORM APPROVED
OMB NO. 0938-0391

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F 756	Continued From page 53 Administrative Nurse D stated she expected the CP to identify and report irregularities associated with the use of insulin and indicated the facility's CP typically did review all relevant measurements associated with medication use. The facility policy "Medication: Drug Regimen Review- R/S, LTC" dated 02/10/23 documented the drug regimen review (DRR), an important piece of medication management, was vital to reducing medication errors. By verifying, clarifying and reconciling medications at each point of care, pharmacists and nurses played a vital role in improving health care. The DRR would identify the following: Review of medications to assure that doses and duration are appropriate to each resident's clinical condition, age and comorbidities; Monitoring of medications for efficacy and adverse consequences; Potential medication irregularities and response to these irregularities; Medication-related errors; Gradual dose reduction and lowering costs. The facility failed to ensure the CP identified and reported irregularities with R60's insulin. This placed R60 at risk for complications related to insulin use.	F 756			
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or	F 757			

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

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FORM APPROVED
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F 757	Continued From page 54 §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: The facility identified a census of 114 residents. The sample included 23 residents with five residents review for unnecessary medication. Based on observation, interview, and record review, the facility failed to ensure Resident (R) 60 received his insulin (hormone that lowers the level of glucose in the blood) as ordered by the physician and failed to ensure blood glucose levels outside of physician ordered parameters were reported to the physician as ordered. This placed R60 at risk for complications related to insulin use. Findings included: - R60'S Electronic Medical Record (EMR), under the "Diagnoses" tab, recorded diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), hemiparesis/hemiplegia (weakness and paralysis on one side of the body) following cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood	F 757			

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

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FORM APPROVED
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F 757	Continued From page 55 flow to the brain by blockage or rupture of an artery to the brain) and diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin). R60's "Quarterly Minimum Data Set [MDS]" dated 10/27/23 recorded a Brief Interview for Mental Status (BIMS) score of zero which indicated severe cognitive impairment. The MDS recorded R60 received injections and insulin for days of the observation period. The MDS recorded R60 received multiple high-risk medication during the observation period which included an antianxiety medication (medication used to treat anxiety), an antidepressant (class of medications used to treat depression) an antipsychotic (class of medications used to treat major mood disorders) and a hypoglycemic (medication used to lower blood glucose). R60's "Care Plan" documented a problem on 01/08/20 which recorded the resident had DM. The plan documented intervention dated 01/08/20 which directed staff a licensed nurse would provide foot & nail care and staff referred to a podiatrist for complications. It directed staff to inspect R60's feet daily for open areas, sores, pressure areas, blisters, edema or redness and report abnormalities to the nurse. staff were to ensure R60's socks/hosiery were clean and dry and make sure that his socks/shoes were not too tight. R60's "Care Plan" lacked direction or interventions related to his insulin use. R60's EMR, under the "Orders" tab, recorded a "Physician's Order" dated 08/31/21 for Accu-check (point of care test to assess blood glucose levels) at meals (AC) and at bedtime	F 757			

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

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F 757	Continued From page 56 (HS). Notify the physician for a blood glucose reading greater than 400 milliliters (ml) per deciliter (dL) or less than 70 mm/dL related to DM. R60's EMR recorded a "Physician's Order" dated 08/10/22 for insulin aspart solution (fast action insulin) inject subcutaneously (under the skin) as per sliding scale: if [blood glucose] 0-150 mm/dL give zero units; 151 - 200 mm/dL give four 4 units; 201 - 250 mm/dL give eight units; 251 - 300 mm/dL give 12 units; 301 - 350 mm/dL give 16 units. Call physician if blood glucose over 351 mm/dL., subcutaneously with meals related to DM. Hold the morning (AM) dose if resident does not eat breakfast. Review of R60's October 2023 "Medication Administration Record/Treatment Administration Record [MAR/TAR]" /dL at 05:00 PM on 10/26/23 436 mm/dL on 10/23/23 at 05:00 PM and a blood glucose of 51 mm/dL at 05:00 PM on 10/26/23. An "eAdmin Note" dated 10/06/23 at 04:44 PM documented the nurse administered the maximum dose of 16 units (insulin). The nurse held dinner R60's until his blood glucose decreased. At 05:59 PM the nurse notified the physician and received an order for more insulin. An "eAdmin Note" dated 10/23/23 at 06:12 PM documented the maximum scale was administered. The note lacked evidence the physician was notified. R60's EMR lacked evidence the physician was notified of the blood glucose of 51 mm/dL on 10/26/23.	F 757			

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

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FORM APPROVED
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F 757	Continued From page 57 R60's November 2023 MAR/TAR recorded blood glucose levels of 392 mm/dL at 05:00 PM on 11/10/23, and 381 mm/dL at 05:00 PM on 11/27/23. An "eAdmin Note" dated 11/10/23 at 04:35 PM documented R60's blood glucose was 392 mm/dL and the nurse administered 16units of insulin. The note recorded food and drink were held, and one hour later R60's blood glucose was 216 mm/dL. The note lacked evidence R60's physician was notified. An "eAdmin Note" dated 11/27/23 at 04:39 PM documented the maximum scale was administered. The note lacked evidence the physician was notified. On 12/07/23 at 02:20 PM, R60 sat in his wheelchair at a dining table and drank a can of cola through a straw. On 12/12/23 10:07 AM Licensed Nurse (LN) H stated if R60's blood glucose were high or low, or outside of the parameters, the nurses passed that information in report. LN H stated if R60's blood glucose was on the lower side, like 90 mm/dL, she would try to encourage juice. If R60's blood sugar were 51, she would call the physician, to get orders, right away. LN H said R60's blood glucose did occasionally get higher in the evenings. LN H reviewed R60's insulin order and stated the orders for insulin at maximum dose was for a blood glucose reading of 300-350 mm/dL and if the blood glucose was higher, she would call the physician for orders since the order did not specify to give the 16 units if over 350 mm/dL. LN H stated all physician notifications	F 757			

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

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FORM APPROVED
OMB NO. 0938-0391

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F 757	Continued From page 58 should be documented in the EMR. On 12/12/23 at 02:40 PM, Administrative Nurse D stated she expected nursing staff to follow the physician's orders exactly as the order was written. She stated if the order directed staff to notify the physician for specific parameters, she expected the staff to follow the order and document the notification in the resident's record. The facility policy "Medication: Administration Including Scheduling and Medication Aides-R/S, LTC" dated 03/29/23 documented medications were administered to the resident according to the "Six Rights." All employees passing medications were familiar with action and adverse reactions of medications. The facility failed to ensure R60 received his insulin as ordered by the physician and failed to ensure blood glucose levels outside of physician ordered parameters were reported to the physician as ordered. This placed R60 at risk for complications related to insulin use.	F 757			
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and	F 761			

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

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F 761	Continued From page 59 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 identified a census of 114 residents. The facility had three medication rooms and seven medication carts. Based on observation, record review and interview the facility failed to ensure accurate labeling of medications to facilitate consideration of precautions and safe administration of medications in accordance with professional standards. The facility failed to ensure safe and secure storage of medications. This deficient practice created a risk for adverse side effects and ineffective medication administration. Findings included: - On 12/06/23 during the initial tour, the Exam Room was unlocked. Inspection of the room revealed an unlocked medication refrigerator with multiple boxes of Covid-19 vaccine and multiple doses of pneumococcal vaccine. The refrigerator contained one vial of opened but undated tuberculin serum.. The November temperature log was posted on the refrigerator and the			F 761			

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

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FORM APPROVED
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F 761	Continued From page 60 temperatures stopped at 11/27/23 with no further evidence staff assessed temperatures after 11/27/23. There was no December log present. On 12/06/23 at 07:29 AM observation of the nurse's cart in 300 hall outside room 316 revealed an opened Admelog insulin lispro (a fast-acting insulin) pen opened and no open and discard date noted for R38. A Toujeo (long-acting) insulin pen was opened and undated for R38. A glargine (long-acting) insulin pen for R109 was opened and undated. There was multiple expired vials of B12 injection dated 09/20/23. On 12/06/23 at 07:50 AM the 300 Hall Cart contained Systane gel open with no dates or resident name. There was an albuterol (a medication used to relax the muscles around the airways so they open up and you can breathe more easily) 90 mcg inhaler with resident name blacked out opened on 09/7/23. The shift medication count log on Ridges 300 noted 10 opportunities where the narcotic count was not done in December 2023. On 12/06/23 at 11:08 AM during inspection of the medication room for 200 hall it was noted that medication refrigerator temperature logs for the month of December were missing entries for dates of December 1, 2023, through December 4, 2023. A bottle of liquid lorazepam (a sedative medication used to treat anxiety disorders) for R94 was opened and not dated (label missing from bottle). On 12/06/23 at 07:29 AM Licensed Nurse (LN) L stated the insulin should be labeled and dated and all expired medications should be removed from cart. LN L took the insulin pens and expired	F 761			

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

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F 761	Continued From page 61 medication and stated they would be discarded. On 12/06/23 at 07:35 LN K stated the Systane drops she believed was R27's as her son brought them from home. On 12/06/23 at 11:08 AM LN G stated the medication refrigerator temperature logs was to be completed by the night shift nurse every night. On 12/12/23 at 02:41 PM Administrative Nurse D stated staff should ensure that medication/exam rooms be kept locked and secured, as well as refrigerators being secured. Administrative Nurse D stated her expectation was for her staff to date insulin pen when opened with open date and expiration date on label. Administrative Nurse D stated medications should be discarded when expired. Administrative Nurse D stated she had been working with her two Assistant Director of Nursing (ADON) on educating staff on discarding medications, ensuring medications had an open date, and the importance of completing the narcotic count at the end of each shift. The facility policy "Medication Acquisition Receiving Dispensing and Storage" revised 03/02/23 documented: medications would be stored in a locked medication cart, drawer, or cupboard. The location would routinely check for expired medications and necessary disposal would be done in accordance with regulations. Refrigerators holding medications would be kept between 36 degrees Fahrenheit (F) and 46 degrees F. Medication rooms would be kept between 59 degrees F and 86 degrees F. Refrigerator temperature was to be checked once in the morning and once in the evening. Controlled drugs would be reconciled at least	F 761			

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

PRINTED: 12/20/2023
FORM APPROVED
OMB NO. 0938-0391

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F 761	Continued From page 62 daily through an appropriate system of records of receipt and disposition. Medications brought into the facility by the resident or family members were used only upon written order by the attending physician. The facility policy "Medication: Insulin Administration, Insulin Pens" revised 04/26/23 documented Insulin pens containing multiple doses of insulin are meant for use on a single person only and should never be used for more than one person, even when the needle was changed. Insulin pens must be clearly labeled with the name or other identifiers to verify that the correct pen was used on the correct person. Verify provider order, the expiration date, and the number of days the pen had been open. The facility failed to ensure accurate labeling of medications to facilitate consideration of precautions and safe administration of medications in accordance with professional standards. The facility failed to ensure safe and secure storage of medications. This deficient practice created a risk for adverse side effects and ineffective medication administration.	F 761			
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.	F 812			

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

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F 812	Continued From page 63 (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: The facility identified a census of 114 residents with one kitchen and two main dining rooms. Based on observation, record review, and interviews, the facility failed to follow sanitary dietary standards related to cleanliness of the kitchen/dining room equipment, clean ventilation, equipment storage, hygienic serving practices, and food storage. This placed the residents at risk for food borne illness. Finding Included- - On 12/06/23 at 07:02AM an initial walkthrough of the kitchen was completed. An inspection of the air conditioning vents above the food warming station, stove/grill, food prep table, sink, and clean plates storage revealed layered debris/dust covering the vents. An inspection of the spice storage shelf revealed spilled spice particles covering the bottle and shelf. An inspection of the wet condiment shelf revealed sticky residue underneath the honey, vanilla, and vinegar bottles.	F 812			

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

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F 812	Continued From page 64 An inspection of the storage area outside the kitchen revealed a buffet table with piles of clean cloth napkins covering the top of the buffet table exposed to the environment. An inspection of refrigerator number two revealed a package of opened pancakes with no opened date. An inspection of refrigerator number three revealed a measuring container with slimy yellowish liquid substance with no label or date. An inspection of the clean bowl/plate storage rack revealed them to be stored upward with nothing covering them. An inspection of the 300 Hall nutrition fridge revealed an unlabeled/undated paper plate wrapped in a plastic bag, an open container of apple juice with no open date, a brown square unidentifiable food item with no label or date and an opened small container of milk which lacked a date opened or name. On 12/06/23 at 11:45AM an inspection of lunch service revealed multiple staff repeatedly adjusting their face masks during meal service without completing hand hygiene. Dietary Staff CC carried drinks while touching the drinking surface of the glass with her bare hands. Further observation revealed a white PVC storage bin heavily soiled with old food and debris. An uncovered, wheeled bin contained clean place mats and napkins was pushed against the trash can and touched the soiled storage bin. Dietary Staff CC wore her mask with her mouth exposed. On 12/06/23 at 12:03PM Dietary staff CC stated	F 812			

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

PRINTED: 12/20/2023
FORM APPROVED
OMB NO. 0938-0391

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F 812	Continued From page 65 clean surfaces should not be in contact with soiled surfaces. She stated the trash can should not touch the clean linen carts but was not sure if the clean linen should have been covered. On 12/06/23 at 12:30PM Dietary Staff BB stated staff were expected to clean and wipe down the storage bin and cart after use or when they became soiled. She stated all food and items stored should be labeled and dated in the refrigerators. She stated maintenance was coming to clean the vents above to kitchen area and they were responsible for maintaining them. She stated staff were expected to complete hand hygiene during meal service and should not be touching their masks. She stated the bowl and plate cart was usually covered with a dome when not in use. A review of the facility's "Food Services and Nutrition" policy 11/27/23 indicated the facility would promote a system that identified proper service, cleaning, and food storage. The policy noted all surfaces within the dining room and kitchen were to be cleaned and sanitized per professional standards. The policy indicated food would be label/dated and stored in a manner that is safe and maintains nutrition value. The policy indicated staff were to ensure safe food handling practices to prevent cross-contamination and food-borne illness. The policy indicated staff should complete hand hygiene in between touching surfaces related to direct food preparation, handling, and serving. The policy noted all kitchen ad dining equipment be stored in a manner that prevent soiling or contamination of clean items. The facility failed to follow sanitary dietary	F 812			

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

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F 812	Continued From page 66 standards related to cleanliness of the kitchen/dining room equipment, clean ventilation, equipment storage, hygienic serving practices, and food storage. This placed the residents at risk for food borne illness.	F 812			
F 849 SS=D	Hospice Services CFR(s): 483.70(o)(1)-(4) §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining	F 849			

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

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F 849	Continued From page 67 the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related	F 849			

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

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F 849	Continued From page 68 conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation. (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff. §483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following:	F 849			

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

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F 849	Continued From page 69 (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(o)(4) Each LTC facility providing hospice	F 849			

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

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F 849	Continued From page 70 care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by: The facility identified a census of 114 residents. The sample included 23 residents with two residents reviewed for hospice services. Based on observation, record review and interview, the facility failed to establish a communication process, including how the communication will be documented between the facility and the hospice provider, to ensure that the needs of the resident were addressed and met 24 hours per day for Resident (R) 47 and R202. The facility failed to ensure that R47 and R202's written plan of care included both the most recent hospice plan of care and a description of the services furnished by both the facility and hospice. This placed R47 and R202 at risk of decline and/or from maintaining the highest practicable physical, mental, and psychosocial well-being. Findings included: - The electronic medical record (EMR) for R47 documented diagnoses of sequelae of cerebral infarction (conditions produced after the acute phase of an illness or injury due to a stroke), altered mental status (-a change in mental function that stems from illnesses, disorders and injuries affecting your brain), major depressive disorder with psychotic behaviors (-a mental disorder in which a person has depression along with loss of touch with reality), and a pressure	F 849			

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F 849	Continued From page 71 ulcer (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction) of left buttock. The "Admission Minimum Data Set (MDS)" dated 10/09/23 for R47 documented a Brief Interview for Mental Status (BIMS) score of three which indicated severely impaired cognition. R47 was dependent of staff for toileting and required substantial/maximal staff assist with self-care. R47 utilized a manual wheelchair for mobility. The "Pressure Ulcer Care Area Assessment (CAA)" dated 10/13/23 for R47 documented R47 had a blister to her heel. R47 had a pressure relieving mattress, a chair cushion and a moisture associated skin damage (MASD- inflammation or skin erosion caused by prolonged exposure to a source of moisture such as urine, stool, sweat, wound drainage, saliva or mucous) which was being treated. The "Terminal Prognosis Care Plan" for R47 initiated 12/04/23 directed staff to assess residents coping strategies. The care plan directed staff to consult with the health care provider and social services to have hospice care for the resident in the facility. Staff was to encourage a support system of family and friends. Staff was directed to review the resident's' advance care planning choices and assist other to respect choices. R47's "Care Plan" lacked a care area for hospice services that directed staff on who the hospice provider was, how to contact the hospice provider, the hospice provided supplies and/or medications, or how communication was to be	F 849			

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

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F 849	Continued From page 72 collaborated between the facility and the hospice provider. A verbal "Physician's Order" dated 11/21/23 directed hospice services due to sequelae of cerebral infarction. On 12/07/23 at 08:33 AM, R47 rested in bed on her left side, bed in low position, the call light was with reach. On 12/12/23 at 11:41 AM, Certified Medication Aide (CMA)/Certified Nurse Aide (CNA) R stated the nursing staff would let the aides know when a resident entered on hospice services as well as it showed on a resident's dashboard in the EMR. CMA R stated the Kardex (nursing tool that gives a brief overview of the care needs of each resident) listed when a resident was on hospice. CMA R stated she was not certain what supplies/medications hospice provided or how often hospice came to visit R47. On 12/12/23 at 10:50 AM Licensed Nurse (LN) G stated the facility did not have a hospice book for each resident. LN G stated when a resident was placed on hospice, the hospice provider came in to do an assessment with the resident and provided the facility with the plan of care as well as a list of supplies hospice would provide. LN G stated after a hospice visit, the facility was provided with a printed summary of the visit that would then be given to medical records to be scanned. LN G stated she believed that R47's care plan had information about hospice on it but was not certain without looking at the care plan herself. On 12/12/23 at 02:48 PM Administrative Nurse D	F 849			

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

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F 849	Continued From page 73 stated that the facility did not keep a hospice book for each resident. Administrative Nurse D stated typically when a resident was placed on hospice services the nursing staff would be notified. Administrative Nurse D stated hospice provided the facility with the plan of care, the list of supplies and medications that were provided. Administrative Nurse D stated the care plan for R47 documented on 12/04/23 that she was on hospice care. Administrative Nurse D stated on R47's profile in the EMR documented who the hospice provider was. The "Hospice and Nursing Facility Services Agreement" dated 09/01/23 documented: Hospice would furnish and/or assume financial responsibility for medication, and any durable medical equipment (DME) and supplies that were needed for management of each resident's terminal illness. Hospice would deliver to the facility medications for each resident to be administered by the facility. Hospice and the facility shall communicate with one another regularly and as needed for each hospice patient. Each party shall document the communication in its respective clinical records to ensure that the needs of the resident were met 24 hours per day. The facility nurse responsibilities included coordination with hospice staff in the implementation and update of the joint plan of care; administration of medication; supervision of facility DME; notify hospice of change in condition of the resident; communication with hospice nurse regarding needs for medication refills, new medications, x-ray, lab studies, therapy, consults and supplies. The facility failed to establish a communication process, including how the communication will be	F 849			

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

PRINTED: 12/20/2023
FORM APPROVED
OMB NO. 0938-0391

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F 849	Continued From page 74 documented between the facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day for R47. The facility failed to ensure, that R47's written plan of care included both the most recent hospice plan of care, a description of the services furnished by the facility, and the contact and address information for the hospice provider. This placed R47 at risk of decline and/or maintaining the highest practicable physical, mental, and psychosocial well-being. - R209's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of need for assistance with personal care, dependence on a wheelchair, dementia (progressive mental disorder characterized by failing memory, confusion), and Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness). The "Admission Minimum Data Set" (MDS) dated 12/08/23 was in progress. R209's "Care Area Assessment" (CAA) was in progress. R209's baseline "Care Plan" dated 11/28/23 lacked who was the hospice provider, how to contact the hospice provider, the frequency of hospice visits, the hospice provided supplies and/or medications, or how communication was to be collaborated between the facility and the hospice provider. R209's clinical record lacked documentation of communication between the facility and the	F 849			

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

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OMB NO. 0938-0391

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F 849	Continued From page 75 hospice provider. Observation on 12/06/23 on 12:10 PM R209 sat in a Broda chair (specialized wheelchair with the ability to tilt and recline) next to his bed. R209 was asleep in the Broda chair. He had several days of facial hair growth noted. The call light was on the bedside table behind R209's Broda chair, outside his reach. On 12/12/23 at 11:41 AM, Certified Medication Aide (CMA) R stated the nursing staff would let the aides know when a resident entered on hospice services as well as it showed on a resident's dashboard in the EMR. CMA R stated the Kardex (nursing tool that gives a brief overview of the care needs of each resident) listed when a resident was on hospice. CMA R stated she was not certain what supplies/medications hospice provided or how often hospice came to visit R47. On 12/12/23 at 10:50 AM Licensed Nurse (LN) G stated the facility did not have a hospice book for each resident. LN G stated when a resident was placed on hospice, the hospice provider came in to do an assessment with the resident and provided the facility with the plan of care as well as a list of supplies hospice would provide. LN G stated after a hospice visit, the facility was provided with a printed summary of the visit that would then be given to medical records to be scanned. LN G stated she was not sure that R209's care plan had information related to hospice on it but was not certain without looking at the care plan herself. On 12/12/23 at 02:48 PM Administrative Nurse D stated that the facility did not keep a hospice	F 849			

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

PRINTED: 12/20/2023
FORM APPROVED
OMB NO. 0938-0391

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F 849	Continued From page 76 book for each resident. Administrative Nurse D stated typically when a resident was placed on hospice services the nursing staff would be notified. Administrative Nurse D stated hospice shared the care plan with facility care plan. Administrative Nurse D stated hospice information should be added to the resident's care plan within 48 hours after being admitted onto hospice services. Administrative Nurse D stated the care plan would not always contain the items provided by the hospice provider, frequency of visits, or the medication covered by the hospice provider. Administrative Nurse D stated these things were subject to change at any time. Administrative Nurse D stated those things were communicated to the nursing staff during the hospice visits. The "Hospice and Nursing Facility Services Agreement" dated 09/01/23 documented: Hospice would furnish and/or assume financial responsibility for medication, and any durable medical equipment (DME) and supplies that were needed for management of each resident' terminal illness. Hospice would deliver to the facility medications for each resident to be administered by the facility. Hospice and the facility shall communicate with one another regularly and as needed for each hospice patient. Each party shall document the communication in its respective clinical records to ensure that the needs of the resident were met 24 hours per day. The facility nurse responsibilities included coordination with hospice staff in the implementation and update of the joint plan of care; administration of medication; supervision of facility DME; notify hospice of change in condition of the resident; communication with hospice nurse regarding needs for medication refills, new	F 849			

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

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F 849	Continued From page 77 medications, x-ray, lab studies, therapy, consults and supplies. The facility failed to establish a communication process, including how the communication would be documented between the facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day for R209. The facility failed to ensure, that R209's written plan of care included both the most recent hospice plan of care, a description of the services furnished by the facility, and the contact and address information for the hospice provider. This placed R209 at risk of decline and/or maintaining the highest practicable physical, mental, and psychosocial well-being.	F 849			
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §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	F 880			

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

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F 880	Continued From page 78 arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable 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	F 880			

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

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F 880	Continued From page 79 transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: The facility identified a census of 114 residents. The sample included 23 residents. Based on observation, interview, and record review, the facility failed to implement appropriate infection control practices. This placed the residents at risk for transmission of infectious disease. Findings included: - Observation On 12/06/23 during the initial tour, the Exam Room was unlocked. The room had a bin of hair products including clippers and a hairbrush with gray hairs in it. The brush was in with the clippers, on the counter, and was unlabeled with any resident name or room number. The desk-type chair in the exam room had short gray hairs all over the seat surface. The handwashing sink in the exam room was not equipped with paper towels for drying. Observation on 12/06/23 at 07:12 AM an unidentified staff member walked down the hall with no mask. The staff member held a piece of paper up to her face to cover her mouth and nose. Observation on 12/06/23 at 09:06 AM two sit to stand lifts and a Hoyer (total body mechanical lift) sat in the hallway and all three- of the lifts had debris and were visibly soiled.	F 880			

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

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F 880	Continued From page 80 Observation on 12/06/23 at 07:23 AM an ice cooler sat on the 300 halls next to fish tank. The inside of the ice cooler had black particles or debris mixed with scant amount of melted ice. Observation on 12/06/23 at 07:30 AM a laundry cart with residents' clothes on the rack sat uncovered and unattended in the hallway. A pillow, a lap blanket, and a clothes hanger sat on the handrail behind a chair in hallway alcove. Observation on 12/06/23 at 07:40 AM the unlocked clean linen room had clean linen stored uncovered in the room with a walking frame and wheelchair also stored in room. The walking frame was visibly soiled. Bumper pads stored on the lowest shelf hung off and touched the floor. Observation on 12/07/23 at 08:38 AM staff pushed Resident (R) 101 from the dining room in her wheelchair with her catheter (a flexible tube inserted through a narrow opening into a body cavity, particularly the bladder, for removing fluid) bag dragging on the floor under the wheelchair. Observation on 12/07/23 at 02:29 PM a large bag of trash sat on the floor in the hallway outside the bath/spa room unattended. Observation on 12/11/23 at 07:30 AM R81's catheter bag with amber colored urine rested on the floor. Observation on 12/12/23 at 08:39 AM R81's catheter bag with amber colored urine rested on the floor next to his bed. Observation on 12/12/23 at 11:13 AM Certified Nurse Aide (CNA) Q parked the Hoyer (total	F 880			

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

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F 880	Continued From page 81 mechanical lift) lift in hallway after use and failed to disinfect the lift before walking away to enter another room. On 12/12/23 at 09:00 AM Certified Medication Aide (CMA) R stated a catheter bag should never touch the floor and all lifts should be disinfected between each use. CMA R stated trash bags should never be stored on the floor., CMA R stated only clean linen should be stored in the clean linen room and the personal clothes cart should be covered when in the halls. On 12/12/23 at 11:53 AM Licensed Nurse (LN) G stated staff should disinfect the shared lifts between each use. LN G stated she was not sure if the lifts where routinely cleaned. LN G stated trash bags should never be left on the floor in the hallways and catheter bags should never touch the floor. LN G the clean linen cart should always be covered when in the hallway. LN G stated only clean linens should be stored in the clean linen room. On 12/12/23 at 02:43 PM Administrative Nurse D stated the lifts should be disinfected between each use and open unattended trash bags should never be stored on the floor in the hallways. Administrative Nurse D stated Sani-wipes should never be within reach of the residents. Administrative Nurse D stated nothing other than clean linens should be stored in the clean linen room. Administrative Nurse D stated clean linen carts should be covered when in the hallways. Administrative Nurse D stated catheter bag should not be placed on the floor. The facility's "Infection Prevention and Control Program" policy dated 10/21/22 documented the	F 880			

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

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F 880	Continued From page 82 facility would 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. Appropriate employees would integrate state-specific regulations from the location's state health department or regulatory agency into their infection control procedures. Appropriate employees would include the infection preventionist at the rehabilitation/skilled care location. The procedures would be reviewed by the QAPI committee, quality improvement team or safety committee as applicable to each setting. Infection control policies and procedures would be communicated to employees by location leaders via memos, emails, in-services, and ongoing training, as appropriate. The infection prevention and control program would be accessible to employees and reviewed and updated by the infection prevention specialist or designee at least annually based on the facility assessment and infection prevention risk assessment. The facility failed to implement appropriate infection control practices. This placed the residents at risk for transmission of infectious disease.	F 880			
F 943 SS=F	Abuse, Neglect, and Exploitation Training CFR(s): 483.95(c)(1)-(3) §483.95(c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on-	F 943			

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

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F 943	Continued From page 83 §483.95(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. §483.95(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property §483.95(c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: The facility reported a census of 114 residents. Five Certified Nurse Aide's (CNA) were sampled for prevention of abuse, neglect, and exploitation training. Based on record review and interview the facility failed to provide evidence of the required prevention of abuse, neglect, and exploitation training for one of the five CNAs that were sampled. This placed the residents at risk for abuse. Findings included: - Employee record review of CNA OO revealed the facility failed to provide evidence that CNA OO received the required abuse, neglect, and exploitation training. On 12/11/12 at 02:24 PM Administrative Nurse D stated she contacted CNA OO and asked him to come in and complete the required education. On 12/12/23 at 02:41 PM Administrative Nurse D stated Consultant II oversaw and tracked the compliance and education requirements/hours for the employees at the facility. Administrative Nurse D stated it was also her responsibility to make sure employees were up to date on required	F 943			

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

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F 943	Continued From page 84 training. An education policy was not provided by the facility. The facility failed to provide evidence of the required prevention of abuse, neglect, and exploitation training for one of the five CNAs that were sampled. This placed the residents at risk for abuse.	F 943			
F 947 SS=F	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: The facility had a census of 114 residents. Five Certified Nurse Aides (CNA) were sampled for required in-service training. Based on record	F 947			

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

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F 947	Continued From page 85 review and interview, the facility failed to ensure two of the five CNA staff reviewed had the required 12 hours of in-service education which included dementia (progressive mental disorder characterized by failing memory, confusion) care training. This placed the residents at risk for decreased quality of life and/or inadequate care. Findings included: - Review of the facility's in-service records revealed the following: CNA OO, hired on 11/30/05, had 1.75 hours of in-service in the past 12 months. Review of trainings for CNA OO for past year lacked evidence of the required education on the topic of dementia. CNA QQ, hired on 08/31/16, had 6.59 hours of in-service in the past 12 months. Review of trainings for CNA QQ for past year lacked evidence of the required education on the topic of dementia. On 12/11/12 at 02:24 PM Administrative Nurse D stated she contacted CNA OO and asked him to come in and complete the required education. On 12/12/23 at 02:41 PM Administrative Nurse D stated Consultant II oversaw and tracked the compliance and education requirements/hours for the employees at the facility. Administrative Nurse D stated it was also her responsibility to make sure employees were up to date on required training. Administrative Nurse D stated dementia training was done annually through an online learning center and the facility offered hands on/in-person training as well.	F 947			

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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - OLATHE			STREET ADDRESS, CITY, STATE, ZIP CODE 20705 W 151ST STREET OLATHE, KS 66061		
(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 947	Continued From page 86 An education policy was not provided by the facility. The facility failed to ensure two of the five CNA staff reviewed had the required 12 hours of in-service education and dementia care training. This placed the residents at risk for decreased quality of life and/or inadequate care.	F 947			