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| F 000 | INITIAL COMMENTS<br><br>The following citations represent the findings of a Health Resurvey.<br><br>The 2567 was sent electronically on 01/18/24. | F 000 | | |
| F 550 SS=D | Resident Rights/Exercise of Rights<br>CFR(s): 483.10(a)(1)(2)(b)(1)(2)<br><br>§483.10(a) Resident Rights.<br>The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.<br><br>§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.<br><br>§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.<br><br>§483.10(b) Exercise of Rights.<br>The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.<br><br>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without | F 550 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 01/18/2024

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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interference, coercion, discrimination, or reprisal from the facility.

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 67 residents. The sample included 17 residents with two reviewed for dignity. Based on observation, record review, and interviews, the facility failed to ensure Residents (R) R13 and R24 were treated in a dignified manner. This deficient practice placed the residents at risk for decreased psychosocial well-being.

Findings included:

- On 01/02/24 at 10:22 AM, observation revealed R13 laid on her back, in her bed, on top of her blankets. R13 wore a top that did not fully cover her abdomen and she wore an adult incontinence brief. R13 was uncovered and her brief and bare legs were exposed and visible from the hallway. R13 stared off to her right and did not respond to questions.

On 01/02/24 at 12:12 PM, an observation revealed the door to R24's room was open, and a strong urine odor was detected in her room. R24 was observed in bed, uncovered, with her pants down around her knees and she wore an adult incontinence brief. R24 was visible from the hallway.

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On 01/04/24 at 11:36 Certified Nurse Aide (CNA) M stated if a resident was in a brief, uncovered, with the door open, he would go into the room to help them cover up. He stated R13 was dependent on staff and would not have been able to cover herself back up if her covers were removed. CNA M stated R24 was a fall risk and staff left her door open to monitor her for falls.

On 01/04/24 at 12:55 Licensed Nurse (LN) H stated R13 was dependent on staff and would have needed staff assistance to cover her if her blankets were removed. LN H stated if R13 was uncovered with her door open he would have expected staff to cover her up. LN H further stated R24 would use the bathroom on her own at times and lay in bed without pulling her pants up. LN H stated he expected staff to have gone into R24's room to help pull her pants up and cover her up.

On 01/04/24 at 01:22 PM Administrative Nurse D stated she expected staff to provide privacy and ensure residents were decent if a resident was uncovered while they wore a brief, and their door was open. Administrative Nurse D further stated it was not appropriate to have left residents exposed.

The facility's "dignity" policy with a reviewed date of 09/25/23, documented each resident has the right to be treated with dignity and respect. Interactions and activities with residents by staff, temporary agency staff, or volunteers must focus on maintaining and enhancing the resident's self-esteem, and self-worth, and incorporating the resident's goals, preferences, and choices.

The facility failed to ensure R13 and R24 were

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| F 550 | Continued From page 3<br>treated in a dignified manner. This deficient practice placed the residents at risk for decreased psychosocial well-being. | F 550 | | |
| F 558 SS=D | Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3)<br><br>§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.<br>This REQUIREMENT is not met as evidenced by:<br>The facility identified a census of 67 residents. The sample included 17 residents with two reviewed for accommodation of needs-related activities of daily living (ADLs). Based on record review, interviews, and observations, the facility failed to identify and correct environmental challenges to Resident (R) 42's mobility. The facility additionally failed to provide R65 a call light in his room. This deficient practice placed both residents at risk for a decline in ADLs.<br><br>Findings included:<br><br>- The "Medical Diagnosis" section within R42's Electronic Medical Records (EMR) included diagnoses of multiple sclerosis (MS- a progressive disease of the nerve fibers of the brain and spinal cord), major depressive disorder (major mood disorder), morbid obesity (severely overweight), sleep apnea (a disorder of sleep characterized by periods without respirations), and coronary atherosclerosis (mineral build-up on the walls of the heart's blood vessels). | F 558 | | |

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R42's "Quarterly Minimum Data Set (MDS)" completed 12/14/23 noted a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. The MDS noted he was independent with bed mobility, toileting, dressing, personal hygiene, bathing, and transfers. The MDS indicated he used a crutch to assist his mobility.

R42's "Falls Care Area Assessment (CAA)" completed 04/10/23 indicated he was at risk for falls. The CAA noted he had problems with transitioning from sitting to standing, surface-to-surface transfers, and walking. The CAA noted his multiple sclerosis increased his risk for falls. The CAA indicated he used dual canes to ambulate himself but had a left-side weakness. The CAA instructed staff to encourage him to use his call light to minimize the risks of falls.

R42's "Activities of Daily Living (ADLs) CAA" completed 04/10/23 indicated he had problems with transitioning from sitting to standing, surface-to-surface transfers, and walking. The CAA noted his multiple sclerosis increased his risk for falls. The CAA indicated he used dual canes to ambulate himself but had a left-side weakness.

R42's "Care Plan" initiated 03/31/23 indicated he was at risk for decreased self-care performances related to his ADLs. The plan noted he was able to transfer and ambulate himself using his own canes. The plan noted he was weight-bearing. The plan noted he had multiple sclerosis limiting his ability to complete ADLs. The plan noted he would use his canes to assist with his bed mobility. His care plan lacked documentation related to his left-side weakness.

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| F 558 | Continued From page 5<br><br>On 01/02/24 at 02:00 PM, R42 stated he had a difficult time exiting his room due to his roommate's bed blocking the right side of his bed. R42 stated he was right-side dominant and had to exit his bed using the left side of the bed. R42 reported he is weak on his left side and had difficulty maneuvering around with his dual support canes. An inspection of R42's side of the room revealed his roommate's bed was slanted inward with the foot of the bed two feet from R42's bed. R42 stood up on the left side of his bed but had difficulty maneuvering his left side to exit the bed area with his support canes. R42 had difficulty positioning his support canes due to the lack of room while exiting his bed area.<br><br>01/03/24 at 08:20 AM R42's roommate's bed was moved back towards the center of the room. R42 stated he could not exit through his right side due to the curtain next to his bed.<br><br>On 01/04/24 at 11:30 AM Certified Nurses Aid (CNA) M stated R42 never reported concerns with his room size or getting out of his bed. She stated R42 was more independent than other residents and would come and go without staff assistance.<br><br>On 01/04/24 at 12:03 PM, Licensed Nurse (LN) G stated she was unaware that R42 had difficulty getting in and out of his bed.<br><br>ON 01/04/24 at 01:23 PM Administrative Nurse D stated all residents were screened upon admission and quarterly based on their needs and preferences. She stated R42 didn't alert the facility that he had difficulty in his room. | F 558 | | |

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A review of the facility's "Activities of Daily Living" policy revised 08/2023 stated the facility will ensure an environment that assists with providing care and maintaining independence. The policy indicated each resident will be comprehensively assessed for their specific individualized care needs and provided a therapeutic environment.

The facility failed to identify and correct environmental challenges to R42's mobility. This deficient practice placed the resident at risk for a decline in ADLs and impaired mobility.

- The "Medical Diagnosis" section within R65's Electronic Medical Records (EMR) included diagnoses of dysphagia (difficulty swallowing), cerebral infarction (sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), history of falling, hemiparesis (muscular weakness of one half of the body), hemiplegia (paralysis of one side of the body), and Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, mask-like faces, shuffling gait, muscle rigidity and weakness).

R65's "Quarterly MDS" completed 12/14/23 noted a Brief Interview for Mental Status (BIMS) score of six indicating severe cognitive impairment. The MDS noted he was independent for oral hygiene, meals, toileting, dressing, and bed mobility. The MDS indicated he weighed 138 lbs. but had no weight loss. The MDS failed to identify he was edentulous or his choking concerns.

R65's "Activities of Daily Living (ADLs) CAA" completed 09/13/23 identified he was at risk for an ADL decline related to his severe cognitive

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impairment and medical diagnoses. The CAA instructed staff to provide ADL care assistance when needed and ensure his call light remained within reach to prevent falls or injuries.

R65's "Care Plan" initiated on 09/08/23 indicated he was at risk for nutritional impairment related to his severe cognitive impairment, physical limitations, difficulty chewing/swallowing, and Parkinson's disease. The plan instructed staff to provide his diet as ordered, weigh him as ordered, provide mouth care daily, and ensure his call light remained within reach (09/11/23). The plan noted he required set-up and supervision assistance during meals.

On 01/02/24 at 02:30 PM, R65 reported his call light button was removed from his room on Friday and never returned. An inspection of the room revealed no call light button installed on his side of the room. At 02:45 PM staff were alerted that R65's call light was not in his room. At 02:47 PM Licensed Nurse (LN) H light and Maintenance Staff U were notified of the call missing for R65. Maintenance Staff U replaced the light immediately. LN H stated the light may have been broken and removed by the weekend staff.

On 01/04/24 at 11:33 AM, Administrative Nurse D stated staff should be checking to ensure the call lights were within reach and functioning during each interaction. She stated if a call light was out or not functioning the resident should be checked on in frequent intervals until it could be replaced.

The facility's "Resident Call System" policy revised 01/2022 indicated the communication system will be maintained and function accordingly to ensure resident safety and needs

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| F 558 | Continued From page 8<br>are met. The policy indicated call light buttons should be always positioned within reach of the resident.<br><br>The facility failed to ensure R65 had a functioning call light button installed in his room. This deficient practice placed R65 at risk for preventable accidents and delayed care needs. | F 558 | | |
| F 580 SS=D | Notify of Changes (Injury/Decline/Room, etc.)<br>CFR(s): 483.10(g)(14)(i)-(iv)(15)<br><br>§483.10(g)(14) Notification of Changes.<br>(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-<br>(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;<br>(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);<br>(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or<br>(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).<br>(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.<br>(iii) The facility must also promptly notify the resident and the resident representative, if any, | F 580 | | |

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when there is-
(A) A change in room or roommate assignment as specified in §483.10(e)(6); or
(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 67 residents. The sample included 17 residents with five residents reviewed for nutrition. Based on record review, interviews, and observations, the facility failed to notify Resident (R)13's physician and representative regarding a weight loss and/or change in health condition. This placed R13 at risk for continued weight loss and malnutrition due to delayed physician and representative involvement.

Findings included:

- R13's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of legal blindness, and cognitive communication deficit (an impairment in organization,

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sequencing, attention, memory, planning, problem-solving, and safety awareness).

The "Admission Minimum Data Set" (MDS) dated 11/23/23 documented the Brief Interview for Mental Status (BIMS) assessment was unable to be completed. The MDS documented R13 had problems with recall ability and short-term and long-term memory. The MDS further documented R13 had severely impaired decision-making ability and never/rarely made decisions. The MDS documented R13 was dependent on staff for all activities of daily living (ADL) including repositioning and transfers.

R13's "Cognitive Loss / Dementia Care Area Assessment" (CAA) dated 11/23/23 documented R13 was alert to name and had difficulty following commands. The CAA further documented R13 required total care with ADL and was unable to answer questions during BIMS assessment.

R13's "Nutritional Status CAA" dated 11/23/23 documented R13 required staff to feed her due to being legally blind.

R13's "Care Plan" with an initiated date of 11/20/23, documented R13 had a nutrition risk. R13's "Care Plan" with a goal initiated on 11/20/23, documented R13 would consume greater than 75% of meals and would maintain weight without significant weight changes through the review date. R13's "Care Plan" with an intervention initiated on 11/20/23, directed staff to weigh R13 monthly and record the results.

A review of the EMR under the "Weights/Vitals" tab revealed an admission weight of 236.0 pounds (lbs.) on 11/16/23, a second weight of

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232.0 lbs. taken on 12/02/23 and a third weight of 213.9 taken on 01/01/24 which indicated a loss of 9.36% in less than 90 days for R13.

R13's EMR lacked evidence that she was weighed more than three times since her admission date on 11/16/23 or that her weight, taken on 01/01/23, of 213.9 lbs. was re-checked or addressed by the facility. R13's EMR lacked evidence that she refused to have her weight obtained.

R13's EMR lacked evidence the physician or R13's representative was notified regarding the change in her health status and weight loss.

On 01/03/24 at 12:27 PM R13 laid in in her room in bed.

On 01/04/24 at 11:36 AM Certified Nurse Aide (CNA) M stated the CNAs obtained the weights and took the information back to the nurses. He stated the nurses would then review and compare them to what was done previously. CNA M stated the nurses provided a list of the residents who needed a weight for the CNAs to use so they would know who needed one.

On 01/04/24 at 12:55 PM, LN H stated if there was a change in weight after a re-weigh, then he would notify the physician, Administrative Nurse D, and the dietitian for it to be addressed. LN H stated the nurse would have entered a progress note in the resident's EMR after notifying the physician, Administrative Nurse D, and the dietitian. LN H stated R13 was unable to refuse and depended on staff to provide for all her needs.

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| F 580 | Continued From page 12<br>On 01/04/24 at 01:22 PM Administrative Nurse D stated new admissions were weighed weekly for at least four weeks and then, if they were consistent in their weights, changed to monthly weights. Administrative Nurse D further stated if the resident lost weight, the physician and dietitian would be notified, and any recommendations given by the dietician would be followed.<br><br>The facility did not provide a policy for notification of changes.<br><br>The facility failed to notify R13's physician and representative regarding weight loss and/or change in health condition. This placed R13 at risk for continued weight loss and malnutrition due to delayed physician and representative involvement. | F 580 | | |
| F 584 SS=E | Safe/Clean/Comfortable/Homelike Environment<br>CFR(s): 483.10(i)(1)-(7)<br><br>§483.10(i) Safe Environment.<br>The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>The facility must provide-<br>§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.<br>(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.<br>(ii) The facility shall exercise reasonable care for | F 584 | | |

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the protection of the resident's property from loss or theft.

§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;

§483.10(i)(3) Clean bed and bath linens that are in good condition;

§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);

§483.10(i)(5) Adequate and comfortable lighting levels in all areas;

§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and

§483.10(i)(7) For the maintenance of comfortable sound levels.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 67 residents. The sample included 17 residents. Based on observation, record review, and interview, the facility failed to ensure the residents were provided a safe, clean, comfortable, and homelike environment. This placed the residents at risk for decreased psychosocial well-being and impaired safety and comfort for the affected residents.

Findings included:

- Upon the initial tour of the building on 01/02/24 at 07:05 AM and walkthrough of the facility

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revealed a heavy urine smell throughout the facility.

On 01/02/24 at 12:44 PM room 111 bathroom had no mirror on the wall and the paper towel dispenser was missing a cover.

On 01/02/24 at 12:47 PM, the wall behind bed A in room 116 was torn up and missing paint.

On 01/02/24 at 12:50 PM, room 120 was missing a plaque on the wall that showed the room number.

On 01/02/24 at 01:00 PM the couch in the 100 hall tv area had an unattended cup with clear liquid in it sitting on the cushion.

On 01/03/24 at 11:00 AM there was a strong urine odor noted in R24's room that could be smelled from the hallway.

On 01/03/24 at 11:45 AM, a very strong urine odor was prevalent throughout the hallways on both sides, and common areas.

On 01/03/24 at 11:48 AM Administrative Nurse D stated she was infomred by several staff members of the strong scent of urine throughout the building. Administrative Nurse D stated staff were directed to clean numerous residents' rooms and provide baths to the residents in those rooms noted to have a heavy urine smell.

On 01/04/24 at 01:22 PM Administrative Nurse D stated there was a bath aide that was here during the week and would get as many baths done during the day as she could. Administrative Nurse D stated some of the residents in the 200-hall

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| F 584 | Continued From page 15<br>urinated frequently during the night and staff did their best to clean the room and bathe the residents if the resident allowed it. Administrative Nurse D stated she was unaware of issues in some of the rooms until informed by the surveyors. Administrative Nurse D stated she would meet with staff about ensuring the building and rooms were cleaned sufficiently.<br><br>The facility policy "Resident Belongings and Home Like Environment" reviewed 07/17/23 documented: The facility would provide a safe, clean, comfortable, and homelike environment, which allowed the resident to use his or her personal belongings to the extent possible. The resident has a right to a safe, clean, comfortable, and homelike environment, including but not limited to receiving treatment and support for daily living safely. It was the responsibility of all facility staff to create a "homelike" environment and promptly address any cleaning needs. The resident room should be uncluttered and orderly, to ensure the resident could receive care and services safely, without the risk of falling or injury, while maximizing resident independence.<br><br>The facility failed to ensure residents were provided a safe, clean, comfortable, and homelike environment. This placed the residents at risk of had the potential for decreased psychosocial well-being and impaired safety and comfort for the affected residents. | F 584 | | |
| F 623 SS=D | Notice Requirements Before Transfer/Discharge<br>CFR(s): 483.15(c)(3)-(6)(8)<br><br>§483.15(c)(3) Notice before transfer.<br>Before a facility transfers or discharges a resident, the facility must- | F 623 | | |

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(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.
(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written

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notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information

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becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 67 residents. The sample included 17 residents. Based on observation, record review, and interview, the facility failed to provide written notification to the long-term care ombudsman (LTCO) for Resident (R) 28 and R6. The facility failed to provide notice of transfer as soon as practicable to R6 or their representative. This deficient practice had the risk of miscommunication between the facility and resident/family and possible missed opportunities for healthcare service for R28 and R6.

Findings included:

- The electronic medical record (EMR) for R28 documented diagnosis of hypertension (elevated blood pressure), chronic respiratory failure (when not enough oxygen passes from the lungs to the blood), and bradycardia (low heart rate, less than 60 beats per minute).

The "Annual Minimum Data Set (MDS)" for R28 dated 07/03/23 documented a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. R28 was independent to limited

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assistance for activities of daily living (ADLs).

The "Quarterly MDS" dated 10/03/23 documented R28 had a BIMS score of 15 which indicated intact cognition. R28 was independent with functional abilities.

The "ADLs Care Area Assessment (CAA)" dated 07/03/23 documented R28 had a functional deficit due to a history of stroke and required supervision. R28 was alert and oriented and was encouraged by staff to participate in self-care to promote quality of life.

R28's "Discharge Status Care Plan" last revised on 06/15/23 directed staff that R28's guardian wished for the resident to remain in the facility long term. Staff was to encourage the resident's guardian to discuss feelings and concerns with impending discharge.

R28's "Kansas Nursing Home Transfer and Discharge Notice" dated 11/28/23 documented R28 was sent out to the hospital for further evaluation required by the emergency department as her needs could not be met in the facility. This notification was given to the resident as she was her own responsible party.

R28's "Kansas Nursing Home Transfer and Discharge Notice" dated 12/14/23 documented R28 was sent out to the hospital for further evaluation required by the emergency department as her needs could not be met in the facility. This notification was given to the resident as she was her own responsible party.

Upon request, the facility was unable to provide evidence the facility notified the LTCO of the

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facility-initiated discharges.

On 01/03/24 at 08:23 AM R28 sat in her wheelchair and propelled herself down the hall to the dining area for breakfast.

On 01/04/23 at 11:05 AM Administrative Staff A stated she did not believe that notification was emailed or sent to the ombudsman. Administrative Staff A stated either she or Administrative Nurse D would call to notify the ombudsman of discharges and/or transfers.

On 01/04/23 at 1:22 PM Administrative Nurse D stated that family representatives and the ombudsman were called by herself or Administrative Staff A when a resident transferred and/or discharged.

The "Notice of Transfers and Discharges" policy reviewed 08/10/23 documented that when a resident was temporarily transferred on an emergency basis to an acute care facility, notice of transfer may be provided to the resident and the resident representative as soon as practicable before the transfer. Copies of notices for emergency transfers must also still be sent to the ombudsman but they may be sent when practicable, such as in a list of residents on a monthly basis, as long as the lists meet all the requirements for content.

The facility failed to provide written notification of transfer with the required information to the LTCO for R28 in a practicable amount of time, or at least monthly. This deficient practice had the risk of miscommunication between the facility and resident/family and possible missed opportunities for healthcare service for R28.

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- R6's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of asthma (a disorder of narrowed airways that causes wheezing and shortness of breath) and chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing).

The "Annual Minimum Data Set" (MDS) dated 11/13/23 documented a Brief Interview of Mental Status (BIMS) score of 13 which indicated intact cognition.

The "Quarterly MDS" dated 12/27/23 documented a BIMS score of 15 which indicated intact cognition.

R6's "Activities of Daily Living (ADL) Functional/Rehabilitation Potential Care Area Assessment" (CAA) dated 11/24/23 documented R6 was able to communicate her needs and was independent with ADLs.

R6's "Care Plan" dated 11/15/21 documented that staff would allow R6 to make decisions about her treatment regime.

A review of the EMR under the "Progress Notes" tab documented a "Transfer to Hospital Summary Note" dated 01/05/23 at 09:32 AM R6 was transferred to the hospital for evaluation. The facility was unable to provide written notification of the transfer and admission to the hospital.

On 05/31/23 at 03:30 AM a "Health Status Note" documented R6 was transferred to the hospital for evaluation. The facility was unable to provide

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written notification of transfer and admission to the hospital.

On 6/20/23 at 06:05 AM an "Alert Note" documented R6 was transferred to the hospital for evaluation. The facility was unable to provide written notification of transfer and admission to the hospital.

The facility was also unable to provide evidence the LTCO was notified of the transfers.

Observation on 01/03/24 at 09:38 AM R21 sat on the couch in the common area and watched TV.

On 01/04/24 at 09:13 AM Administrative Staff A stated she was unable to locate written notification of transfer and admission to the hospital to the resident or her legal representative. Administrative Staff A stated the social service department was responsible for sending the written notification of transfer to the legal representatives.

On 01/04/24 at 01:22 PM Administrative Nurse D stated the nurse would notify the legal representatives by phone after the resident was sent to the hospital and documented in the resident's clinical record.

The facility's "Notice of Transfers and Discharges" policy last reviewed on 08/10/23 documented that the facility ensured that systems are implemented to provide written notification to the resident and resident representative. This written notification was provided on the Notice of Resident Discharge or Transfer Form. This information would be presented in a language and manner that the resident /resident

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| F 623 | Continued From page 23<br>representative could understand.<br><br>The facility failed to provide written notification of the reason and location for the transfer to the hospital to R6 or her representative. This deficient practice placed R6 at risk of miscommunication and uninformed decisions. | F 623 | | |
| F 657 SS=D | Care Plan Timing and Revision<br>CFR(s): 483.21(b)(2)(i)-(iii)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(2) A comprehensive care plan must be-<br>(i) Developed within 7 days after completion of the comprehensive assessment.<br>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--<br>(A) The attending physician.<br>(B) A registered nurse with responsibility for the resident.<br>(C) A nurse aide with responsibility for the resident.<br>(D) A member of food and nutrition services staff.<br>(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.<br>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.<br>(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.<br>This REQUIREMENT is not met as evidenced | F 657 | | |

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by:
The facility identified a census of 67 residents. The sample included 17 residents with 17 reviewed for care plan revisions. Based on observation, record review, and interviews, the facility failed to revise Resident (R)42's care plan to reflect the use of his personal knee braces. This deficient practice placed R42 at risk for impaired care due to uncommunicated care needs.

Findings Included:

- The "Medical Diagnosis" section within R42's Electronic Medical Records (EMR) included diagnoses of multiple sclerosis (MS- a progressive disease of the nerve fibers of the brain and spinal cord), major depressive disorder (major mood disorder), morbid obesity (severely overweight), sleep apnea (a disorder of sleep characterized by periods without respirations), and coronary atherosclerosis (mineral build-up on the walls of the heart's blood vessels).

R42's "Quarterly Minimum Data Set (MDS)" completed 12/14/23 noted a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. The MDS noted he was independent with bed mobility, toileting, dressing, personal hygiene, bathing, and transfers. The MDS indicated he used a crutch to assist his mobility.

R42's "Falls Care Area Assessment (CAA)" completed 04/10/23 indicated he was at risk for falls. The CAA noted he had problems with transitioning from sitting to standing, surface-to-surface transfers, and walking. The CAA noted his multiple sclerosis increased his risk for falls. The CAA indicated he used dual

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canes to ambulate himself but had a left-side weakness. The CAA instructed staff to encourage him to use his call light to minimize the risks of falls.

R42's "Activities of Daily Living (ADLs) CAA" completed 04/10/23 indicated he had problems with transitioning from sitting to standing, surface-to-surface transfers, and walking. The CAA noted his multiple sclerosis increased his risk for falls. The CAA indicated he used dual canes to ambulate himself but had a left-side weakness.

R42's "Care Plan" initiated 03/31/23 indicated he was at risk for decreased self-care performances related to his ADLs. The plan noted he was able to transfer and ambulate himself using his own canes. The plan noted he was weight-bearing. R42's plan lacked documentation related to bilateral knee braces he applies himself daily.

A review of R42's EMR revealed no assessments, physician's orders, or progress notes indicating he wore knee braces.

On 01/02/24 at 01:34 PM, R42 walked down the main hall to his room. R42 had knee braces on both knees.

On 01/02/24 at 02:00 PM, R42 stated he wore knee braces on both his knees to help him support his positioning. R42 stated that he puts the braces on himself and takes them off when not ambulating. R42 stated he was not sure if the facility had informed staff that he wears the braces or needs staff assistance to apply them correctly.

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| F 657 | Continued From page 26<br>On 01/03/24 at 12:45 PM, Consultant HH stated she was not sure if the knee braces were care planned but would notify the nursing department for assessment.<br><br>On 01/04/24 at 11:30 AM Certified Nurses Aid (CNA) M stated R42 often dressed himself and ambulated without staff assistance. He was not sure if R42's knee braces required staff assistance to put on.<br><br>On 01/04/24 at 12:03 PM, Licensed Nurse (LN) G stated she was aware R42 wore braces but she did not think they were medically necessary. She stated he always put them on himself and never voiced concerns about needing staff help.<br><br>ON 01/04/24 at 01:23 PM Administrative Nurse D stated the care plans should reflect the resident's current treatments, interventions, and preferences related to daily care. She stated R42 has been set up with a therapy evaluation for the braces.<br><br>The facility's "Care planning" policy revised 12/2022 indicated the facility will be updated showing the residents' individualized care needs and the level of assistance required to achieve the highest practicable level of function. The policy noted the facility will provide ongoing assessment and updated interventions to meet the needs of the residents.<br><br>The facility failed to revise R42's care plan to reflect the use of his personal knee braces. This deficient practice placed R42 at risk for impaired care due to uncommunicated care needs. | F 657 | | |
| F 676 SS=D | Activities Daily Living (ADLs)/Mntn Abilities | F 676 | | |

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| F 676 | Continued From page 27<br>CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii)<br><br>§483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that:<br><br>§483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ...<br><br>§483.24(b) Activities of daily living.<br>The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living:<br><br>§483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care,<br><br>§483.24(b)(2) Mobility-transfer and ambulation, including walking,<br><br>§483.24(b)(3) Elimination-toileting,<br><br>§483.24(b)(4) Dining-eating, including meals and snacks,<br><br>§483.24(b)(5) Communication, including<br>(i) Speech,<br>(ii) Language,<br>(iii) Other functional communication systems. | F 676 | | |

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This REQUIREMENT is not met as evidenced by:
The facility identified a census of 67 residents. The sample included 17 residents with four reviewed for maintaining activities of daily living (ADL). Based on observation, record review, and interviews, the facility failed to provide the necessary level of assistance for Resident (R)65 during mealtime to maintain his abilities. This deficient practice placed R65 at risk for impaired nutrition and a decline in his ADL.

Findings Included:

- The "Medical Diagnosis" section within R65's Electronic Medical Records (EMR) included diagnoses of dysphagia (difficulty swallowing), cerebral infarction (sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), history of falling, hemiparesis (muscular weakness of one half of the body), hemiplegia (paralysis of one side of the body), and Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, mask-like faces, shuffling gait, muscle rigidity and weakness).

R65's "Admission Minimum Data Set (MDS)" completed 09/13/23 noted he weighed 142 pounds (lbs.) and was edentulous ( no natural teeth). The MDS indicated he was at risk for coughing or choking during meals or when swallowing.

R65's "Quarterly MDS" completed 12/14/23 noted a Brief Interview for Mental Status (BIMS) score of six indicating severe cognitive impairment. The MDS noted he was independent for oral hygiene,

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meals, toileting, dressing, and bed mobility. The MDS indicated he weighed 138 lbs. but had no weight loss. The MDS failed to identify he was edentulous or his choking concerns.

R65's "Nutrition Care Area Assessment (CAA)" completed 09/13/23 indicated he was at risk for malnutrition and on a mechanically altered diet. The CAA identified he had swallowing concerns related to his medical diagnoses.

R65's "Activities of Daily Living (ADLs) CAA" completed 09/13/23 identified he was at risk for an ADL decline related to his severe cognitive impairment and medical diagnoses. The CAA instructed staff to provide ADL care assistance when needed and ensure his call light remained within reach to prevent falls or injuries.

R65's "Dental CAA" completed 09/13/23 indicated he was edentulous and had difficulty chewing his food. The CAA identified he was at risk for poor nutrition.

R65's "Care Plan" initiated on 09/08/23 indicated he was at risk for nutritional impairment related to his severe cognitive impairment, physical limitations, difficulty chewing/swallowing, and Parkinson's disease. The plan instructed staff to provide his diet as ordered, weigh him as ordered, provide mouth care daily, and ensure his call light remained within reach (09/11/23). The plan noted he required set-up and supervision assistance during meals.

On 01/02/24 at 08:22 AM R65 sat in his room and ate his breakfast. R65 had scrambled eggs and sausage patties. Staff were not present in his room during meal service. R65 had no call light

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mounted on his side of the room. R65 reported that sometimes the kitchen served meals he could not eat due to him not having teeth. He stated the kitchen usually sent sausage links that were difficult to chew. Staff were not present to monitor R65 during his meal.

On 01/03/24 at 01:05 PM, R65 sat off the side of his bed and had his lunch on the bedside table. R65 coughed several times then spit out apple slices from his mouth. R65 attempted to eat another slice of apple pie and spit it out. He stated he could not eat the pie because the slices were rubber and hard to chew. An inspection of the slices revealed them to be hard to cut with silverware. Staff were not present with R65 during his meal.

On 01/04/24 at 11:33 AM, Certified Nurses Aid (CNA) M stated R65 usually ate independently in his room without issues. He stated R65 did have a soft chew diet due to him being edentulous but was not sure if he required supervision during meals. He stated that R65 could express his needs if needed. He stated if a plan required supervision of a resident during meals, staff should be present during the meal.

On 01/04/24 at 11:33 AM, Administrative Nurse D stated staff were expected to ensure each resident's orders and planned interventions were being followed. She stated if the care plan stated R65 required supervision during mealtimes staff should either be checking on him frequently or with him.

A review of the facility's "Activities of Daily Living" policy revised 08/2023 stated the facility will ensure an environment that assists with providing

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| F 676 | Continued From page 31<br>care and maintaining independence. The policy indicated each resident will be comprehensively assessed for their specific individualized care needs and provided a therapeutic environment.<br><br>The facility failed to provide the necessary level of assistance for R65 during mealtime to maintain his abilities. This deficient practice placed R65 at risk for impaired nutrition and a decline in his ADL. | F 676 | | |
| F 677 SS=D | ADL Care Provided for Dependent Residents<br>CFR(s): 483.24(a)(2)<br><br>§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;<br>This REQUIREMENT is not met as evidenced by:<br>The facility identified a census of 67 residents. The sample included 17 residents with seven residents reviewed for activities of daily living (ADLs). Based on observations, record reviews, and interviews, the facility failed to provide consistent bathing opportunities for Residents (R)53 and R46. The facility additionally failed to provide ADL assistance to R13, a resident totally dependent on staff assistance for all ADL. These deficient practices placed the residents at risk of decreased psycho-social well-being and impaired ADL.<br><br>Findings Included:<br><br>- The "Medical Diagnosis" section within R53's Electronic Medical Records (EMR) included diagnoses of vitamin B insufficiency, anemia (an inadequate number of healthy red blood cells to | F 677 | | |

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carry adequate oxygen to body tissues), hemiplegia (paralysis of one side of the body), hemiparesis (weakness and paralysis on one side of the body), muscle weakness, abnormalities of gait and mobility.

A review of R53's "Quarterly Minimum Data Set (MDS)" completed 10/10/23 noted a Brief Interview for Mental Status (BIMS) score of 10 indicating moderate cognitive impairment. The MDS indicated he required supervision or touch assistance during personal hygiene, toileting, and bathing. The MDS indicated he was occasionally incontinent of bowel and bladder but had no toileting program in place. The MDS indicated no falls.

R53's "Urinary Incontinence Care Area Assessment (CAA)" completed 04/12/23 indicated he had occasional urinary incontinence. The CAA indicated he used a portable urinal and staff were to provide checks and changes to prevent skin breakdown.

R53's "Falls CAA" completed 04/12/23 noted he had bilateral lower extremity weakness with impaired balance. The CAA noted he was a fall risk and instructed staff to keep his bed in the lowest position and ensure his call light was within reach. The CAA noted he used a wheelchair for locomotion and required assistance from staff for his activities of daily living.

R53's "Care Plan" initiated 03/31/23 indicated he was at risk for skin impairment, ADL self-care deficits, and falls related to his medical diagnoses. The plan noted he required limited assistance from staff for bathing, bed mobility,

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personal hygiene, and transfers. The plan indicated he preferred to be bathed twice weekly. The plan indicated he was incontinent and used a urinal and staff were to provide peri-care as needed. The plan indicated he used a portable urine and sometimes emptied it in the trash can (04/04/23). The plan also indicated he would place his urine-soaked incontinence briefs on the floor or trash can. The plan indicated

R53 had a fall on 12/04/23 attempting to reach for his portable urinal. The plan instructed staff to keep his urinal within reach and use his call light (12/04/23). The plan lacked individualized interventions to maintain and promote R44's highest level of functioning related to incontinence. The plan failed to address his bowel incontinence.

A review of R53's "Documented Survey Report" for December 2023 indicated he did not receive bathing opportunities from 12/20/23 through 01/01/24. The report lacked refusal entries.

On 01/02/24 at 07:14 R53's room smelled heavily of urine.

On 01/02/24 at 09:42 AM R53 reported the facility was not consistently offering bathing to him. He stated the facility assisted him during bathing due to his history of falls. He stated he had not received bathing the previous week. R53's hair was uncombed and greasy. He stated he showered last night but went over a week without one.

On 01/04/24 at 11:33 AM Certified Nurses Aid (CNA) M stated R53 required limited assistance during bathing due to his balance issues. He

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stated each resident received two showers per week based on their preferred days. He stated bathing was documented on the shower sheet and put into the EMR system under tasks. He stated bathing refusals should also be documented after multiple attempts to complete the task. CNA M said R53 rarely refused bathing but should be documented in the EMR.

On 01/04/24 at 12:30 PM, Licensed Nurse (LN) G stated bathing should be documented as completed, refused, or not available. She stated that missed bathing opportunities should be rescheduled to the next available time slot.

On 01/04/24 at 01:34 PM Administrative Nurse D stated staff were expected to ensure each resident's bathing preferences were followed. She stated she expected staff to offer bathing opportunities multiple times and reschedule them if the resident was not available or preferred a different time. She stated documentation should not be left blank or incomplete and should always indicate if a bath occurred or was rescheduled.

A review of the facility's "Activities of Daily Living" policy revised 08/2023 stated that bathing opportunities provided to the residents promote cleanliness, comfort, and provide observations of the resident's skin. The policy noted that all bathing should be documented in the resident's EMR. The policy noted that if a resident refuses to bath the staff will notify the nurse.

The facility failed to provide consistent bathing opportunities for R53. This deficient practice placed him at risk for infections, decreased psycho-social well-being, and impaired ADLs.

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- R46's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of dementia (a progressive mental disorder characterized by failing memory, and confusion), chronic pain, and muscle weakness.

The "Admission Minimum Data Set" (MDS) dated 09/20/23 documented a Brief Interview of Mental Status (BIMS) score of five which indicated severely impaired cognition. The MDS documented that R46 required extensive assistance from one staff member for activities of daily living (ADLs). The MDS documented R46 required supervision for bathing during the observation period.

The "Quarterly MDS" dated 12/08/23 documented a BIMS score of zero which indicated severely impaired cognition. The MDS documented that R46 required partial/moderate assistance with bathing during the observation period.

R46's "ADL Functional/Rehabilitation Potential Care Area Assessment" (CAA) dated 09/21/23 documented R46 had generalized weakness and required assistance with ADLs.

R46's "Care Plan" dated 09/14/23 documented that staff would provide a sponge bath when R46 was unable to tolerate a full bath/shower. R46's "Care Plan" dated 09/15/23 documented R46 required maximum assistance from staff for bathing/showering at least twice weekly and as needed.

Review of the EMR under "Documentation Survey Reports" tab for bathing reviewed for the following dates for R37 from 10/01/23 to 01/01/24 (93 days) documented "Not Applicable" (NA) on

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37 days on 10/01/23, 10/02/23, 10/04/23, 10/07/23, 10/08/23, 10/11/23, 10/18/23, 10/20/23, 10/21/23, 10/22/23, 10/31/23, 11/01/23,11/04/23, 11/05/23, 11/10/23, 11/14/23, 11/17/23, 11/18/23, 11/19/23, 11/22/23, 11/26/23, 11/28/23, 12/01/23, 12/02/23, 12/04/23, 12/06/23, 12/08/23, 12/11/23, 12/12/23, 12/15/23, 12/18/23, 12/21/23, 12/22/23, 12/25/23, 12/26/23, 12/29/23, and 01/01/23. The clinical record lacked evidence of R46's refusals for bathing or a bed bath was given.

Observation on 01/03/24 at 09:42 AM R46 lay on his right side in bed. R46's room smelled of urine.

On 01/04/24 at 12:08 PM Certified Nurse Aide (CNA) N stated R46 never refused his bath. CNA N stated R46 was given a bed bath frequently since his return from the hospital. CNA N stated the bath or the refusal to bath would be charted in the residents' EMR.

On 01/04/24 at 12:19 PM, Licensed Nurse (LN) G stated she was not aware of R46's refusal to bathe. LN G stated since R46's return from a recent hospital stay he was assisted by staff with bed baths.

On 01/04/24 at 01:22 PM Administrative Nurse D stated she expected staff to document the resident's EMR what care was provided or the refusal of care. Administrative Nurse D stated she would expect staff to report refusal of care such as bathing to the charge nurse, so the cause of refusal was investigated.

The facility's "Activities of Daily Living (ADLs)" policy last reviewed on 08/2/23 documented the resident would receive assistance as needed to complete activities of daily living (ADLs). Any

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change in the ability to perform ADLs would be documented and reported to the licensed nurse. A resident who was unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

The facility failed to provide consistent bathing for R46 who required assistance with bathing. This deficient practice placed R46 at risk for complications related to poor hygiene and impaired dignity.

- R13's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of legal blindness, and cognitive communication deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness).

The "Admission Minimum Data Set" (MDS) dated 11/23/23 documented the Brief Interview for Mental Status (BIMS) assessment was unable to be completed. The MDS documented R13 had problems with recall ability and short-term and long-term memory. The MDS further documented R13 had severely impaired decision-making ability and never/rarely made decisions. The MDS documented R13 was dependent on staff for all activities of daily living (ADL) including repositioning and transfers.

R13's "Cognitive Loss / Dementia Care Area Assessment" (CAA) dated 11/23/23 documented R13 was alert to name and had difficulty following commands. The CAA further documented R13 required total care with ADL and was unable to answer questions during the BIMS assessment.

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R13's "Care Plan" with an initiated date of 11/2/23, documented R13 had a self-care deficit due to limited mobility. R13's "Care Plan" documented an intervention dated 11/24/23 which directed staff R13 was totally dependent on two staff for repositioning and turning in bed and was dependent upon staff for all ADLs.

On 01/02/24 at 10:22 AM, observation revealed R13 laid on her back, in her bed, on top of her blankets. R13 wore a top that did not fully cover her abdomen and she wore an adult incontinence brief. R13 was uncovered and her brief and bare legs were exposed and visible from the hallway. R13 stared off to her right and did not respond to questions.

On 01/04/24 at 11:36 Certified Nurse Aide (CNA) M stated if a resident was in a brief, uncovered, with the door open, he would go into the room to help them cover up. He stated R13 was dependent on staff and would not have been able to cover herself back up if her covers were removed and staff should have assisted her with her covers.

On 01/04/24 at 12:55 Licensed Nurse (LN) H stated R13 was dependent on staff and would have needed staff assistance to cover her if her blankets were removed. LN H stated if R13 was uncovered with her door open he would have expected staff to cover her up.

On 01/04/24 at 01:22 PM Administrative Nurse D stated she expected staff to provide each resident with the care and assistance they required.

The facility's "Activities of Daily Living (ADLs)" policy last reviewed on 08/2/23 documented the

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| F 677 | Continued From page 39<br>resident would receive assistance as needed to complete activities of daily living (ADLs).<br><br>The facility failed to provide R13 with the necessary ADL care and assistance she required. This placed the resident at risk for impaired quality of life and decreased dignity and comfort. | F 677 | | |
| F 679 SS=E | Activities Meet Interest/Needs Each Resident<br>CFR(s): 483.24(c)(1)<br><br>§483.24(c) Activities.<br>§483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community.<br>This REQUIREMENT is not met as evidenced by:<br>The facility identified a census of 67 residents. The sample included 17 residents. Based on observation, record review, and interviews, the facility failed to provide consistent weekend activities. This deficient practice placed the affected residents at risk for decreased psychosocial well-being and boredom.<br><br>Findings included:<br><br>- A review of the facility's "Activity Calendars" for October, November, and December of 2023 was completed. The review revealed "Resident's Choice" was the only facility-led activity on the weekends for all three months. A review of the | F 679 | | |

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weekday activity calendar revealed Bingo, games time, social events, manicures, and sports events.

On 01/03/24 at 02:00 PM, the facility held a staff-led Bingo game in the main dining area. The game included resident involvement from both (South and North) halls. The game included snacks and prizes provided to the residents.

On 01/03/24 at 01:15 PM, Resident Council members reported the weekend lacked consistent activities since the facility's Activities Coordinator left in November 2023. The council reported some of the direct care staff tried to hold activities but activities often did not get completed on the weekends. The council reported the calendar indicated "Resident's Choice" meaning they were provided games and movies to play and/or watch on their own. The council reported that weekends were boring.

On 01/02/24 at 02:01 PM, R42 reported that residents were not made aware of the weekend activities when they occurred. He stated it often involved playing the same game over and over or watching a movie. He stated the weekend staff did their best but did not have the resources or time to do anything else.

On 01/04/24 at 11:30 AM Administrative Staff A reported the facility did not have an activity coordinator since November 2023. She stated she oversaw the activities program, but the facility did not have certified activity personnel.

On 01/04/23 Licensed Nurse (LN) H stated the direct care staff attempted to provide weekend activities when they could if they had time. He

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| F 679 | Continued From page 41<br>stated sometimes church groups would come in on Sundays and movies were played for the residents. He stated sometimes the residents arranged their own activities group. He stated the facility had not had an activity coordinator for two months, so the staff tried to keep the residents engaged.<br><br>A review of the facility's "Activities Program" policy revised 08/2023 indicated the facility will provide ongoing and consistent activities that meet each resident social, spiritual, physical, and emotional needs. The policy indicated the facility would utilize licensed staff.<br><br>The facility failed to provide consistent activities for the residents during weekends. This deficient practice placed the affected residents at risk for decreased psychosocial well-being and boredom. | F 679 | | |
| F 680 SS=E | Qualifications of Activity Professional<br>CFR(s): 483.24(c)(2)(i)(ii)(A)-(D)<br><br>§483.24(c)(2) The activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who-<br>(i) Is licensed or registered, if applicable, by the State in which practicing; and<br>(ii) Is:<br>(A) Eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or<br>(B) Has 2 years of experience in a social or recreational program within the last 5 years, one of which was full-time in a therapeutic activities program; or<br>(C) Is a qualified occupational therapist or | F 680 | | |

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occupational therapy assistant; or
(D) Has completed a training course approved by the State.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 67 residents. The sample included 17 residents. Based on observation, record review, and interviews, the facility failed to provide a certified activity professional. This placed the affected residents at risk for decreased quality of life.

Findings included:

- A review of the facility's "Activity Calendars" for October, November, and December of 2023 was completed. The review revealed "Resident's Choice" was the only facility-led activity on the weekends for all three months. A review of the weekday activity calendar revealed Bingo, games time, social events, manicures, and sports events.

On 01/03/24 at 02:00 PM, the facility held a staff-led Bingo game in the main dining area. The game included resident involvement from both (South and North) halls. The game included snacks and prizes provided to the residents.

On 01/03/24 at 01:15 PM, Resident Council members reported the weekend lacked consistent activities since the facility's Activities Coordinator left in November 2023. The council reported some of the direct care staff tried to hold activities, but activities often did not get completed on the weekends. The council reported the calendar indicated "Resident's Choice" meaning they were provided games and movies to play and/or watch on their own. The

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council reported that weekends were boring.

On 01/02/24 at 02:01 PM, R42 reported that residents were not made aware of the weekend activities when they occurred. He stated it often involved playing the same game over and over or watching a movie. He stated the weekend staff did their best but did not have the resources or time to do anything else.

On 01/04/24 at 11:30 AM Administrative Staff A reported the facility did not have an activity coordinator since November 2023. She stated she oversaw the activities program, but the facility did not have certified activity personnel.

On 01/04/23 Licensed Nurse (LN) H stated the direct care staff attempted to provide weekend activities when they could if they had time. He stated sometimes church groups would come in on Sundays and movies were played for the residents. He stated sometimes the residents arranged their own activities group. He stated the facility had not had an activity coordinator for two months, so the staff tried to keep the residents engaged.

A review of the facility's "Activities Program" policy revised 08/2023 indicated the facility will provide ongoing and consistent activities that meet each resident social, spiritual, physical, and emotional needs. The policy indicated the facility will utilize a licensed activity professional to oversee the program.

The facility failed to provide a certified activity professional. This placed the affected residents at risk for decreased quality of life.

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| F 686 | Continued From page 44 | F 686 | | |
| F 686 SS=D | Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)<br><br>§483.25(b) Skin Integrity<br>§483.25(b)(1) Pressure ulcers.<br>Based on the comprehensive assessment of a resident, the facility must ensure that-<br>(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and<br>(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.<br>This REQUIREMENT is not met as evidenced by:<br>The facility identified a census of 67 residents. The sample included 17 with two reviewed for pressure ulcers (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). Based on interviews, observations, and record reviews, the facility failed to ensure Resident (R)60's low air-loss mattress pump was set up to his appropriate weight requirements and failed to provide wound care per R60's ordered treatment. The facility additionally failed to assess R8's pressure wounds upon admission. This deficient practice placed R60 and R8 at risk for complications related to skin breakdown and pressure ulcers.<br><br>Findings Included:<br><br>- The "Medical Diagnosis" section within R60's | F 686 | | |

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Electronic Medical Records (EMR) included diagnoses of hemiplegia (paralysis of one side of the body), hemiparesis (muscular weakness of one half of the body), and osteomyelitis (local or generalized infection of the bone and bone marrow).

A review of R60's "Admission Minimum Data Set (MDS)" completed on 12/08/23 noted a Brief Interview for Mental Status (BIMS) score of 12 indicating moderate cognitive impairment. The MDS indicated he was dependent on staff assistance for bed mobility, bathing, toileting, and transfers. The MDS indicated he had a stage four pressure ulcer (a deep wound that reaches the muscles, ligaments, or even bone). The MDS noted treatments of pressure-reducing devices, nutrition management, wound care, and non-surgical dressings were in place to treat his pressure ulcer.

R60's "Pressure Ulcer Care Area Assessment (CAA)" completed 12/18/23 indicated he was at risk for skin breakdown and admitted to the facility with a pressure injury to his coccyx (area at the base of the spine). The CAA noted he required assistance with mobility, repositioning, and toileting. The CAA noted he was frequently incontinent of bowel and bladder related to his medical diagnoses. The CAA noted he used a pressure-reducing mattress while in bed.

R60's "Activities of Daily Living (ADLs) CAA" completed 12/18/23 indicated he had moderate cognitive impairment but was able to understand others and express his needs. The CAA noted he required assistance with ADLs and mobility.

R60's "Nutritional CAA" completed 12/18/23

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indicated he was at risk for impairment related to his stage four pressure ulcer, cognitive loss, poor memory, and limited mobility. The CAA noted he was at risk for malnutrition.

R60's "Care Plan" initiated on 12/01/23 indicated he was at risk for malnutrition, ADL self-care deficits, skin breakdown, and pressure ulcer development. The plan noted he had a pressure injury on his coccyx upon admission. The plan instructed staff to provide treatment as ordered, complete weekly skin checks, and ensure peri-care was provided related to incontinence. The plan instructed staff to weigh R60 per his orders due to the risk of malnutrition. The plan indicated he had a pressure-reducing mattress but did not provide guidance for the low air-loss mattress settings.

R60's EMR revealed an "Admission Wound" assessment completed 12/02/23 indicating he had a stage four pressure ulcer upon admission on his coccyx measuring 1.0 centimeters (cm) in length, 1.5cm in width, and no depth (1.0cm x 1.5cm x 0cm).

R60's EMR revealed a "Weekly Wound Observation" completed on 12/29/23 that indicated the coccyx wound measured 1.9cm in length, 2.0cm in width, and 0.4cm in depth. The observation revealed he was seen by a plastic surgeon and would continue wound care. The observation noted he had a low air-loss mattress and wheelchair cushion in place.

R60's EMR under "Physician's Orders" noted on the order dated 12/01/23 for a low air-loss mattress for skin integrity. The order did not identify R60's low-air-loss mattress pump

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settings.

R60's EMR under "Physician's Orders" noted a wound care order dated 12/29/23 for staff to apply calcium alginate (dressing which forms a soft, gel that absorbs when it comes into contact with wound exudate) to his coccyx one time daily and cover with a foam dressing.

A review of R60's "Medication Administration Record (MAR)" indicated the dressing was not completed on 01/01/24. A review of the EMR revealed no notes indicating the status of the treatment on 01/01/24.

R60's EMR indicated he weighed 239 pounds (lbs.) on 01/01/24.

A review of R60's low air-loss mattress manufacturer operation (Drive Model 14030) recommendations indicated the mattress accommodated residents up to 600 lbs. in weight. The operation manual indicated the air mattress inflated based on the resident's weight. The manual indicated the mattress pressure increased based on the heavier the weight settings.

On 01/02/24 at 10:02 AM R60 rested in his bed. R60's low air-loss mattress was set to 500 lbs. with 30-minute air inflation intervals. R60 reported the facility weighed him but not every week. He stated the facility sometimes missed his daily wound care.

On 01/04/24 at 07:45 AM Licensed Nurse (LN) G stated the air mattress settings were based upon the weight of R60. She stated the settings should either be listed on the care plan or in the order.

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She stated she was not sure why the machine was set to 500 lbs. She stated all wound treatment should be documented in the MAR after completion and was not sure why R60's treatment was not completed on 01/01/24.

On 01/04/24 at 08:05 AM Administrative Nurse E stated the low air-loss mattresses with weight settings should be set according to the resident's weight and should be noted in the care plans for each resident if they preferred the mattress firmer or softer. Administrative Nurse E stated R60 preferred the setting of the bed to be firmer.

On 01/04/24 at 01:30 PM Administrative Nurse D said the mattress setting should be based on R60's weight and comfort levels. She stated she was not sure why R60's calcium alginate treatment was not completed on 01/01/24.

A review of the facility's "Wound Prevention Policy" revised 03/2023 noted the facility would ensure effective treatment to prevent and manage pressure ulcers. The policy indicated staff will closely monitor residents at risk for skin breakdown and pressure injury to ensure appropriate interventions are placed. The policy noted the facility will implement interventions to include routine skin assessments/care, proper positioning, heel protection, adequate nutrition/hydration, and pressure redistribution devices.

The facility failed to ensure R60's low air-loss mattress pump was set up to his appropriate weight requirements and failed to provide wound care per R60's ordered treatment. This deficient practice placed R60 at risk for complications related to skin breakdown and pressure ulcers.

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- The electronic medical record (EMR) for R8 documented diagnoses of pressure ulcer of the buttock, altered mental status, and severe malnutrition (when the body does not get enough nutrients).

The "Admission Minimum Data Set (MDS)" dated 11/10/23 for R8 documented R8 had both short and long-term memory problems. R8 had severely impaired cognitive skills for daily decision-making. R8 displayed inattention and disorganized thinking. R8 was dependent on staff for all functional abilities. R8 had unhealed pressure ulcers on admission; one stage 3 (full thickness pressure injury extending through the skin into the tissue below) and two unstageable (depth of the wound is unknown due to the wound bed being covered by a thick layer of other tissue and pus) deep tissue injury (DTI- purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear).

The "Pressure Ulcer Care Area Assessment (CAA)" dated 11/15/23 for R8 documented she had long-standing urinary incontinence and had unhealed pressure wounds. R8 was dependent on all care and bed/chair bound. Staff anticipated with all care, wound treatment was in place, low air mattress was in place.

The "Pressure Ulcers Care Plan" initiated on 11/06/23 and revised on 11/08/23 for R8 directed staff to do weekly skin checks. Staff was to do treatments as ordered. Staff was to ensure R8

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had a pressure-reducing mattress.

R8's 10/31/23 hospital paperwork found in the paper chart documented R8 had a pressure injury of the right and left buttock stage three, and unstageable pressure ulcers to the right and left buttocks.

Under the "Assessments" tab of R8's EMR documented a "Braden Scale-For Predicting Pressure Sore Risk and Risk Factors" assessment dated 11/04/23. R8 was at high risk for pressure sores. R8 had risk factors that included decreased or impaired bed/chair mobility, an existing pressure ulcer, and urinary or bowel incontinence.

The "Order Summary Report" for R8 documented a physician's order dated 11/06/23 to cleanse the coccyx (area at the base of the spine) and buttock open area and apply a foam dressing daily and as needed.

A "Weekly Skin Integrity Data Collection" dated 11/13/23 documented an open area and treatment in place for a wound to the right buttock and sacrum (large triangular bone/area between the two hip bones).

A "Wound Observation Tool" dated 11/14/23 for R8 documented a pressure wound on her right buttock that measured four centimeters (cm) in length, two cm with, and a depth of one cm.

A "Recommended Plan of Treatment" by hospice dated 11/17/23 for R8 documented: Consult received for evaluation and treatment recommendations for multiple wounds to the sacrum, buttocks, and bilateral hips. R8 was

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recently admitted to hospice on 11/09/23.

R8's EMR and paper chart lacked documentation of weekly skin/wound assessments and measurements from admission on 11/03/23 to 11/13/23. On 01/03/24 at 12:55 PM, R8 reclined in her Broda chair (specialized wheelchair with the ability to tilt and recline) in the unit's TV area, her daughter and grandson was visiting her. R8 was noted to be smacking her lips and constantly moving her jaw.

On 01/04/23 at 10:43 AM Licensed Nurse (LN) H stated upon admission all residents should have a baseline skin assessment completed. LN H stated skin assessments should be done weekly by the nurse and documented in the EMR under assessments. LN H stated if a resident had pressure ulcers present on admission those should be noted when the skin assessment was done. LN H stated R8 was receiving wound care treatments from hospice currently.

On 01/04/23 at 1:22 PM Administrative Nurse D stated skin assessments should be performed by the admitting nurse on admission and weekly thereafter. Administrative Nurse D was unaware that R8's skin/wounds had not been assessed on admission. Administrative Nurse D stated she was aware R8 was on hospice and that hospice was providing the wound care treatment for R8.

The "Skin Integrity & Pressure Ulcer/Injury Prevention and Management" policy reviewed 03/31/23 documented: A comprehensive skin inspection/assessment on admission and re-admission to the center may identify pre-existing signs of possible deep tissue damage already present. A skin

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| F 686 | Continued From page 52<br>assessment/inspection occurred on admission/re-admission. Skin observations also occurred throughout points of care provided by the certified nurse aides (CNA) during daily care. CNAs would report to the nurse any changes or open areas identified. The nurse would complete further inspection/assessment and provide treatment if needed. A risk assessment tool (Braden Scale) determined the resident's risk for pressure injury development. A skin assessment/inspection should be performed weekly by a licensed nurse.<br><br>The facility failed to ensure R8, who was admitted with pressure ulcers received the proper care to avoid the decline of a deep tissue injury and new development of a pressure injury/ulcer. This deficient practice placed R8 at risk for further skin breakdown and possible infection development. | F 686 | | |
| F 689 SS=E | Free of Accident Hazards/Supervision/Devices<br>CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>The facility had a census of 67 residents. The sample included 17 residents with one resident reviewed for accidents and/or hazards. Based on observation, record review, and interview, the facility failed to secure hazardous materials when the facility failed to ensure a Sharps container | F 689 | | |

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(bin to place used needles and lancets) mounted on the side of a cart and stored in the hallway had a lid to prevent residents from reaching into the container. This deficient practice placed the 19 cognitively impaired independently mobile residents at risk for preventable injuries and accidents. The facility additionally failed to ensure R53's portable urinal was within reach resulting in a non-injury fall. This deficient practice placed R53 at risk for preventable falls and injuries.

Findings Included:

- On 01/02/24 at 07:30 AM a walkthrough of the facility's 200 Hallway revealed a treatment cart next to the nurse's station. An inspection of the cart revealed a mounted Sharps container on the side of the cart. The Sharps container lacked a safety cover to prevent exposure to the used lancets and hazardous materials within the container. At 07:38 AM Licensed Nurse (LN) G reported that the container should have had a safety cover on top. LN G replaced the Sharps container at 07:40 AM.

On 01/04/24 at 01:10 PM Administrative Nurse D stated the nurses were responsible for ensuring the carts were secured and changed out the Sharps bin when needed. She stated the residents should not have access to the carts or the Sharps bins.

The facility's "Waste Management" policy revised 08/2023 indicated all Sharps containers supplied to the facility were to be inspected daily for safety and removed when 3/4 full. The policy indicated the containers must be puncture-resistant to eliminate potential hazards or physical injury.

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The facility failed to secure hazardous materials in a defective Sharps container. This deficient practice placed the 19 cognitively impaired independently mobile residents at risk for preventable injuries and accidents.

- The "Medical Diagnosis" section within R53's Electronic Medical Records (EMR) included diagnoses of vitamin B insufficiency, anemia (an inadequate number of healthy red blood cells to carry adequate oxygen to body tissues), hemiplegia (paralysis of one side of the body), hemiparesis (weakness and paralysis on one side of the body), muscle weakness, abnormalities of gait and mobility.
A review of R53's "Quarterly Minimum Data Set (MDS)" completed 10/10/23 noted a Brief Interview for Mental Status (BIMS) score of 10 indicating moderate cognitive impairment. The MDS indicated he required supervision or touch assistance during personal hygiene, toileting, and bathing. The MDS indicated he was occasionally incontinent of bowel and bladder but had no toileting program in place. The MDS indicated no falls.

R53's "Urinary Incontinence Care Area Assessment (CAA)" completed 04/12/23 indicated he had occasional urinary incontinence. The CAA indicated he used a portable urinal and staff were to provide checks and changes to prevent skin breakdown.

R53's "Falls CAA" completed 04/12/23 noted he had bilateral lower extremity weakness with impaired balance. The CAA noted he was a fall risk and instructed staff to keep his bed in the lowest position and ensure his call light was within reach. The CAA noted he used a

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wheelchair for locomotion and required assistance from staff for his activities of daily living (ADLs).

R53's "Care Plan" initiated 03/31/23 indicated he was at risk for skin impairment, ADL self-care deficits, and falls related to his medical diagnoses. The plan noted he required limited assistance from staff for bathing, bed mobility, personal hygiene, and transfers. The plan indicated he was incontinent, used a portable urinal, and provided peri-care as needed. The plan indicated he sometimes emptied his portable urinal out in the trash can (04/04/23). The plan also indicated he would place his urine-soaked incontinence briefs on the floor or trash can (04/04/23). The plan indicated R53 fell on 12/04/23 attempting to reach for his portable urinal. The plan instructed staff to keep his urinal within reach and use his call light (12/04/23). The plan lacked individualized interventions to maintain and promote R44's highest level of functioning related to incontinence. The plan failed to address his bowel incontinence. The plan failed to address the fall mat next to his bed.

A "Progress Note" dated 12/04/23 indicated staff found R53 on his knee attempting to pull himself up from the floor. The note indicated he reached for his urinal and fell out of bed. The note indicated R53 reported knee and shoulder pain, but no injuries were found. The note indicated a fall mat was added next to his bed but not added to his care plan.

The facility failed to provide an investigation or evidence the facility evaluated causative factors related to R53's fall.

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On 01/02/24 at 09:42 AM R53 reported that he had issues with incontinence and used a portable urinal. He reported that the facility did not have individualized toileting interventions for him. He stated he fell on 12/04/23 because his portable toilet was left out of reach, and he attempted to reach for it. He stated staff do not provide restroom breaks or ask him in the evening for assistance.

On 01/04/24 at 11:30 PM, Certified Nurse Aid (CNA) M stated R53 would usually take himself to the bathroom or use his portable urinal. CNA M stated staff were to ensure his urinal and call light were within reach and provide him assistance as needed. He stated residents with incontinence issues should also be provided opportunities to use the restroom during the night to prevent them from falling out of bed.

On 01/04/24 at 12:05 PM Licensed Nurse (LN) G stated residents with incontinence should be provided frequent toileting opportunities to prevent possible falls. She stated the care plan should be updated each time a fall occurs with interventions to prevent the falls from reoccurring. She stated R53 often will take himself to the toilet. She was not sure if R53 had any falls. She stated staff should ensure R53's call light and portable are within reach before he goes to bed.

On 01/04/24 at 01:30 PM Administrative Nurse D stated each resident's care plan was reviewed after falls occurred and updated according to the needed interventions. She stated the interdisciplinary team reviewed the factors related to the fall to ensure appropriate interventions were put in place. She stated staff were expected to follow the interventions based on what caused

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| F 689 | Continued From page 57<br>the fall. She stated residents with incontinence should be provided frequent opportunities for restroom usage.<br><br>The facility's "Fall Management" policy revised 12/2023 indicated the facility will assess and provide intervention for residents at risk for falls. The policy noted the facility will identify potential risks and ensure environmental, physical, and psychological are addressed by the care plan and interdisciplinary team.<br><br>The facility failed to ensure R53's portable urinal was within reach resulting in a non-injury fall. This deficient practice placed R53 at risk for preventable falls and injuries. | F 689 | | |
| F 690 SS=D | Bowel/Bladder Incontinence, Catheter, UTI<br>CFR(s): 483.25(e)(1)-(3)<br><br>§483.25(e) Incontinence.<br>§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.<br><br>§483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-<br>(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;<br>(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon | F 690 | | |

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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 67 residents. The sample included 17 residents with one reviewed for bowel and bladder management. Based on observation, record review, and interviews, the facility failed to assess ongoing patterns of incontinence to establish bowel and bladder patterns in order to identify measures to maintain or improve Resident (R)53's incontinence. This deficient practice placed R53 at risk for complications related to incontinence.

Findings included:

- The "Medical Diagnosis" section within R53's Electronic Medical Records (EMR) included diagnoses of vitamin B insufficiency, anemia (an inadequate number of healthy red blood cells to carry adequate oxygen to body tissues), hemiplegia (paralysis of one side of the body), hemiparesis (weakness and paralysis on one side of the body), muscle weakness, and abnormalities of gait and mobility.

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A review of R53's "Quarterly Minimum Data Set (MDS)" completed 10/10/23 noted a Brief Interview for Mental Status (BIMS) score of 10 indicating moderate cognitive impairment. The MDS indicated he required supervision or touch assistance during personal hygiene, toileting, and bathing. The MDS indicated he was occasionally incontinent of bowel and bladder but had no toileting program in place.

R53's "Urinary Incontinence Care Area Assessment (CAA)" completed 04/12/23 indicated he had occasional urinary incontinence. The CAA indicated he used a portable urinal and staff were to provide checks and changes to prevent skin breakdown.

R53's "Falls CAA" completed 04/12/23 noted he had bilateral lower extremity weakness with impaired balance. The CAA noted he was a fall risk and instructed staff to keep his bed in the lowest position and ensure his call light was within reach. The CAA noted he used a wheelchair for locomotion and required assistance from staff for his activities of daily living (ADLs).

R53's "Care Plan" initiated 03/31/23 indicated he was at risk for skin impairment, ADL self-care deficits, and falls related to his medical diagnoses. The plan noted he required limited assistance from staff for bathing, bed mobility, personal hygiene, and transfers. The plan indicated he was incontinent, used a portable urinal, and provided peri-care as needed. The plan indicated he sometimes emptied his portable urinal out in the trash can (04/04/23). The plan also indicated he would place his urine-soaked

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incontinence briefs on the floor or trash can (04/04/23). The plan instructed staff to keep his urinal within reach and use his call light (12/04/23). The plan lacked individualized interventions to maintain and promote R44's highest level of functioning related to incontinence. The plan failed to address his bowel incontinence needs.

A review of R53 EMR indicated no bowel and bladder incontinence-related assessments were completed since admission to establish toileting patterns for increased incontinence.

A review of R53's EMR under "Documentation Survey Report" between 11/01/23 and 01/04/24 indicated ongoing incontinence episodes of bowel and bladder.

On 01/02/24 at 07:14 R53's room smelled heavily of urine. R53 rested asleep in his wheelchair next to the door.

On 01/02/24 at 09:42 AM R53 reported that he had issues with both bowel and bladder incontinence. He reported that the facility did not have individualized toileting interventions for him. He stated staff will not offer restroom breaks in the evening or wake him up at night.

On 01/04/24 at 11:30 PM, Certified Nurse Aid (CNA) M stated R53 would usually take himself to the bathroom or use his portable urinal. CNA M stated staff were to ensure his urinal and call light were within reach and provide him assistance as needed. He stated residents with incontinence issues should also be provided opportunities to use the restroom during the night to prevent them from falling out of bed. He stated residents were

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offered every two hours and provided care if needed.

On 01/04/24 at 12:05 PM Licensed Nurse (LN) G stated residents with incontinence should be provided frequent toileting opportunities. She stated R53 often will take himself to the toilet. She stated staff should ensure R53's call light and portable urinal are within reach before he goes to bed. She stated the residents are assessed upon admission and provided interventions to maintain their ADLs.

On 01/04/24 at 01:30 PM Administrative Nurse D stated each resident was assessed upon admission for the type and level of incontinence and provided interventions to maintain or improve their incontinence. She stated interventions should include frequent checks and toileting, dietary review, and interventions to prevent skin breakdown.

The facility's "Urinary Incontinence Management" policy dated 08/2023 indicated all residents will be evaluated for bowel and bladder incontinence. The policy noted that pattern evaluations will be provided to residents for individualized continence management programs. The facility indicated the facility will identify factors related to incontinence including patterns, incontinence type, risk factors, and medically relevant diagnoses to provide effective treatment.

The facility failed to assess ongoing patterns of incontinence to establish bowel and bladder patterns to maintain or improve R53's incontinence. This deficient practice placed R53 at risk for complications related to incontinence

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| F 692 | Continued From page 62 | F 692 | | |
| F 692 SS=D | Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3)<br><br>§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-<br><br>§483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;<br><br>§483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;<br><br>§483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.<br>This REQUIREMENT is not met as evidenced by:<br>The facility identified a census of 67 residents. The sample included 17 residents. Based on observation, record review, and interviews, the facility failed to complete weekly weight monitoring as ordered by the physician for Resident (R)60 and failed to weigh R13 weekly upon admission per acceptable standards of practice. This deficient practice placed both residents at risk for complications related to weight loss.<br><br>Findings Included: | F 692 | | |

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- The "Medical Diagnosis" section within R60's Electronic Medical Records (EMR) included diagnoses of hemiplegia (paralysis of one side of the body), hemiparesis (muscular weakness of one half of the body), and osteomyelitis (local or generalized infection of the bone and bone marrow).

A review of R60's "Admission Minimum Data Set (MDS)" completed on 12/08/23 noted a Brief Interview for Mental Status (BIMS) score of 12 indicating moderate cognitive impairment. The MDS indicated he was dependent on staff assistance for bed mobility, bathing, toileting, and transfers. The MDS noted he weighed 241 pounds (lbs.) upon admission with no swallowing concerns.

R60's "Activities of Daily Living (ADLs) CAA" completed 12/18/23 indicated he had moderate cognitive impairment but was able to understand others and express his needs. The CAA noted he required assistance with ADLs and mobility.

R60's "Nutritional CAA" completed 12/18/23 indicated he was at risk for impairment related to his stage four pressure ulcer, cognitive loss, poor memory, and limited mobility. The CAA noted he was at risk for malnutrition.

R60's "Care Plan" initiated on 12/01/23 indicated he was at risk for malnutrition, ADL self-care deficits, skin breakdown, and pressure ulcer development. The plan instructed staff to provide treatment as ordered, complete weekly skin checks, and ensure peri-care was provided related to incontinence. The plan instructed staff to provide his diet and complete weighing him as ordered.

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R60's EMR indicated a "Physician's Order" date of 12/01/23 for staff to complete weekly weights every Sunday.

R60's EMR indicated he weighed 240.5 lbs. upon admission (12/01/23) and 239 lbs. on 01/01/24. No other weights were recorded in his EMR.

R60's EMR lacked evidence the resident refused to be weighed.

On 01/02/24 at 10:02 AM R60 rested in his bed. R60's low air-loss mattress was set to 500 lbs. with 30-minute air inflation intervals. R60 reported the facility weighed him but not every week. He stated the facility sometimes missed his daily wound care.

On 01/04/24 at 11:30 AM Certified Nurses Aid (CNA) M stated staff completed weights on the residents based on their physician's orders. He stated direct care staff weighed the residents and entered the weights in the EMR. He stated the nurses were alerted of any changes. He stated refusals should be documented in the EMR. He stated if R60 refused, it should have been documented in the EMR or a nursing progress note.

On 01/04/24 at 11:50 AM Licensed Nurse (LN) G stated each resident's weight was entered in the EMR and reviewed by the nursing staff. She stated if a resident was at risk, the facility completed more frequent weight checks and alerted the dietician for review. She stated if a resident refused weights the nurse would be alerted. She stated a progress note would be completed showing why the refusal occurred and

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the weights would be rescheduled.

On 01/04/24 at 01:30 PM Administrative Nurse D stated the direct care staff were expected to complete the weights assigned to them or notify the nurse if not completed. She stated the nurses' progress notes should identify when cares were not being completed and why. She stated attempts to reschedule the weighing to another time should be attempted.

A review of the facility's "Physician's Orders" policy revised 03/10/23 indicated the facility will ensure all physician's orders including medications, treatments, dietary, labs, and special procedures are followed based upon the physician's recommendations.

The facility failed to complete weekly weight checks per R60's physician's orders. This deficient practice placed R60 at risk for complications related to weight loss.

- R13's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of legal blindness, and cognitive communication deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness).

The "Admission Minimum Data Set" (MDS) dated 11/23/23 documented the Brief Interview for Mental Status (BIMS) assessment was unable to be completed. The MDS documented R13 had problems with recall ability and short-term and long-term memory. The MDS further documented R13 had severely impaired decision-making ability and never/rarely made decisions. The MDS documented R13 was dependent on staff for all

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activities of daily living (ADL) including repositioning and transfers.

R13's "Cognitive Loss / Dementia Care Area Assessment" (CAA) dated 11/23/23 documented R13 was alert to name and had difficulty following commands. The CAA further documented R13 required total care with ADL and was unable to answer questions during the BIMS assessment.

R13's "Nutritional Status CAA" dated 11/23/23 documented R13 required staff to feed her due to being legally blind.

R13's "Care Plan" with an initiated date of 11/20/23, documented R13 had a nutrition risk. R13's "Care Plan" with a goal initiated on 11/20/23, documented R13 would consume greater than 75% of meals and would maintain weight without significant weight changes through the review date. R13's "Care Plan" with an intervention initiated on 11/20/23, directed staff to weigh R13 monthly and record the results.

A review of the EMR under the "Weights/Vitals" tab revealed an admission weight of 236.0 pounds (lbs) on 11/16/23, a second weight of 232.0 lbs taken on 12/02/23 and a third weight of 213.9 taken on 01/01/24 which indicated a loss of 9.36% in less than 90 days for R13.

R13's EMR lacked evidence that she was weighed more than three times since her admission date on 11/16/23 or that her weight, taken on 01/01/23, of 213.9 lbs. was re-checked or addressed by the facility. R13's EMR lacked evidence that she refused to have her weight obtained.

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On 01/03/24 at 12:45 PM, an unidentified staff member attempted to feed R13 in her room. R13 was observed turning her head away when the unidentified staff member tried to give her a bite of food. The unidentified staff member brought in another staff and verified that R13 had refused to eat the offered meal before removing R13's food tray from the room.

On 01/04/24 at 11:36 AM Certified Nurse Aide (CNA) M stated the CNAs obtained the weights and took the information back to the nurses. He stated the nurses would then review and compare them to what was done previously. CNA M stated the nurses provided a list of the residents who needed a weight for the CNAs to use so they would know who needed one.

On 01/04/24 at 12:18 PM Licensed (LN) G stated Dietary BB would notify the registered dietitian (RD) of any weight loss and the RD would address the loss. LN G stated weights were typically done weekly or monthly; however, if a resident refused a weight, it would be documented in the resident's EMR.

On 01/04/24 at 12:55 PM LN H stated new admits were supposed to be weighed daily for three days then change to weekly weights and then change to monthly weights from there. He stated that he was unsure how long the resident would have been on weekly weights before they were changed to monthly. LN H stated nurses compared new weights to the previous ones documented and if there was a change, the resident would have been re-weighed. LN H further stated if there was still a change in weight after a re-weigh, then he would notify the physician, Administrative Nurse D, and the

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| F 692 | Continued From page 68<br>dietitian for it to be addressed. LN H stated the nurse would have entered a progress note in the resident's EMR after notifying the physician, Administrative Nurse D, and the dietitian. LN H stated R13 was unable to refuse and depended on staff to provide for all her needs.<br><br>On 01/04/24 at 01:22 PM Administrative Nurse D stated new admissions were weighed weekly for at least four weeks and then, if they were consistent in their weights, changed to monthly weights. Administrative Nurse D further stated if the resident lost weight, the physician and dietitian would be notified, and any recommendations given by the dietician would be followed.<br><br>The facility's "Resident at Risk" policy revised on 04/25/23, documented the facility would review weights of new admissions for a minimum of one week to determine residents' baseline weight and stability.<br><br>The facility failed to monitor R13's weights per acceptable standards of practice upon R13's admission. This deficient practice placed R13 at risk for continued weight loss and possible malnutrition. | F 692 | | |
| F 695 SS=D | Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)<br><br>§ 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning.<br>The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered | F 695 | | |

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care plan, the residents' goals and preferences, and 483.65 of this subpart.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 67 residents. The sample included 17 residents with two reviewed for respiratory care. Based on observation, record review, and interviews, the facility failed to maintain and store Resident (R)42's continuous positive airway pressure device (CPAP - ventilation device that blows a gentle stream of air into the nose to keep airway open during sleep) equipment in a sanitary manner. This deficient practice placed R42 at risk for complications related to respiratory infections.

Findings Included:

- The "Medical Diagnosis" section within R42's Electronic Medical Records (EMR) included diagnoses of multiple sclerosis (MS- a progressive disease of the nerve fibers of the brain and spinal cord), major depressive disorder (major mood disorder), morbid obesity (severely overweight), sleep apnea (a disorder of sleep characterized by periods without respirations), and coronary atherosclerosis (mineral build-up on the walls of the heart's blood vessels).

R42's "Quarterly Minimum Data Set (MDS)" completed 12/14/23 noted a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. The MDS noted he was independent with bed mobility, toileting, dressing, personal hygiene, bathing, and transfers. The MDS indicated he used a crutch to assist his mobility. The MDS indicated he used a continuous positive airway pressure device. The MDS noted he was on an antibiotic medication (medication used to

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treat bacterial infections).

R42's "Falls Care Area Assessment (CAA)" completed 04/10/23 indicated he was at risk for falls. The CAA noted he had problems with transitioning from sitting to standing, surface-to-surface transfers, and walking. The CAA noted his multiple sclerosis increased his risk for falls. The CAA indicated he used dual canes to ambulate himself but had a left-side weakness. The CAA instructed staff to encourage him to use his call light to minimize the risks of falls.

R42's "Activities of Daily Living (ADLs) CAA" completed 04/10/23 indicated he had problems with transitioning from sitting to standing, surface-to-surface transfers, and walking. The CAA noted his multiple sclerosis increased his risk for falls. The CAA indicated he used dual canes to ambulate himself but had a left-side weakness.

R42's "Care Plan" initiated 03/31/23 indicated he was at risk for decreased self-care performances related to his ADLs. The plan noted he was able to transfer and ambulate himself using his own canes. The plan noted he was weight-bearing and able to ambulate himself. The plan noted he used a CPAP device for his sleep apnea (04/04/23). The plan instructed staff to apply his mask while going to bed or napping. The plan noted he had pneumonia (inflammation of the lungs) (12/11/23). The plan instructed staff to complete good hand hygiene techniques during care and encourage R42 to use disposable tissue for sneezing. The plan instructed staff to monitor his breathing and lung sounds. The plan indicated he received antibiotic therapy for his

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pneumonia (12/11/23). The plan lacked instructions to clean or maintain his CPAP.

R42's EMR under "Physician's Orders" revealed he received Rocephin (antibiotic medication) ten-day treatment for pneumonia from 12/09/23 through 12/19/23.

R42's "Physician's Orders" indicated staff were to clean R42's CPAP water reservoir with warm soapy water weekly and fill the CPAP humidifier with distilled water every night before use.

R42's "Treatment Administration Record" reviewed from 10/01/23 to 01/04/23 indicated his CPAP and water reservoir were signed as being cleaned each night and refilled with distilled water.

On 01/02/24 at 01:10 PM, R42's CPAP and oxygen tubing were hung above his bed. No barrier bag was used to prevent contamination. R43 reported he was never offered a bag to put his respiratory equipment in when not in use. He stated the staff never cleaned his CPAP mask or the machine's reservoir. An inspection of the mask revealed it to be soiled with debris. The machine's water reservoir was empty with brown dust/stains on the inside of it. He stated staff had not filled the reservoir before offering it to him. He stated he recently got sick with pneumonia and believed it was caused by the lack of cleaning for his mask. From 01/02/23 through 01/04/23 R43's mask remained hung above his bed, unbagged and open to air, and the reservoir remained empty with debris inside it.

On 01/04/24 at 11:33 AM Certified Nurses Aid (CNA) M stated all respiratory equipment should

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| F 695 | Continued From page 72<br>be stored within a bag when not in use. She stated the CPAP machines should be cleaned frequently and charted in the EMR. She stated R43 was more independent and usually took care of his own equipment.<br><br>On 01/04/24 at 12:30 PM Licensed Nurse (LN) G stated R43's CPAP machine should be cleaned weekly and refilled with water every two/three days. She stated the masks should be stored in a bag when not in use to prevent contamination.<br><br>On 01/04/24 at 01:34 PM Administrative Nurse D stated she expected staff to ensure the proper storing and cleaning of oxygen equipment. She stated the CPAP mask should be stored in clean bags.<br><br>A review of the facility's "Oxygen Administration/Storage/Maintenance" policy reviewed 09/2023 indicated oxygen will be administered in accordance with the physician's orders and current standards of practice. The policy indicated oxygen supplies will be changed weekly and when visibly soiled with dates indicating placement. The policy indicated oxygen tubing and masks were to be stored in provided bags to prevent environmental contamination or infections.<br><br>The facility failed to maintain and store R42's CPAP equipment in a sanitary manner. This deficient practice placed R42 at risk for complications related to respiratory infections. | F 695 | | |
| F 698 SS=D | Dialysis<br>CFR(s): 483.25(l)<br><br>§483.25(l) Dialysis. | F 698 | | |

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The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 67 residents. The sample included 17 residents with two residents reviewed for hemodialysis (a procedure using a machine to remove excess water, solutes, and toxins from the blood in people whose kidneys can no longer perform these functions naturally). Based on observation, record review, and interviews, the facility failed to monitor Resident (R) 55's access site for signs of infection, and bleeding, and failed to obtain communication from the dialysis center and assess post-dialysis. These deficient practices placed R55 at risk of potential adverse outcomes and physical complications related to dialysis.

Findings included:

- R55's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of end-stage renal disease (ESRD-a terminal disease of the kidneys), dementia (progressive mental disorder characterized by failing memory, confusion), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), and Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure).

The "Significate Change Minimum Data Set" (MDS) dated 09/08/23 documented a Brief Interview of Mental Status (BIMS) score of zero

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which indicated severely impaired cognition. The MDS documented that R55 was dependent on two staff members' assistance for activities of daily living (ADLs). The MDS documented R55 received antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) medication during the observation period. The MDS documented R46 received dialysis during the observation period.

The "Quarterly MDS" dated 12/08/23 documented a BIMS score of zero which indicated severely impaired cognition. The MDS documented that R55 received antipsychotic medication during the observation period. The MDS documented R46 received dialysis during the observation period.

R55's "Urinary Incontinence and Indwelling Catheter Care Area Assessment" (CAA) dated 09/20/23 documented R55 was incontinent of bladder.

R55's "Care Plan" dated 11/11/22 documented staff would observe for bleeding at the dialysis access site.

A review of the EMR under the "Orders" tab revealed the following physician orders:
Emergency care- if bleeding from the shunt, apply pressure and call 911 as needed dated 04/12/23.
R55's clinical record lacked evidence of daily assessment for redness or signs of infection at the dialysis access site.
Dialysis patient: Receives dialysis on Tuesday, Thursday, and Saturday dated 05/17/23.

A review of R55's EMR clinical record from 12/01/23 to 12/31/23 revealed two dialysis communication sheets dated 12/05/23 and

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12/21/23, which lacked evidence of communication from the dialysis provider, and a post-dialysis was completed upon return from dialysis for R55. The facility was unable to provide dialysis communication sheets for the following dates 12/02/23, 12/07/23, 12/09/23, 12/12/23,12/14/23, 12/165/23,12/198/23,23/23/23,12/26/23, 12/28/23, and 12/30/23. R55's EMR lacked evidence the dialysis provider was contacted by the facility for a verbal report.

Observation on 01/03/24 at 09:37 AM R55 lay with his eyes closed on his bed. His bilateral lower extremities rested directly on the mattress.

On 01/04/23 at 12:19 PM, Licensed Nurse (LN) G stated the night nurse or the Certified Medication Aide would obtain R55's vital signs prior to leaving for dialysis. LN G stated night sift would fill out the dialysis communication sheet and place the sheet in R55's dialysis bag. LN G stated the nurse would contact the dialysis provider if the communication sheet did not return. LN G stated if a verbal report was given by the dialysis, the nurse would document the report in the EMR under the "Progress Notes" tab.

On 01/04/23 at 01:22 PM Administrative Nurse D stated R55's dialysis communication sheet was sent with him to dialysis and if the communications sheet was not returned or not filled out the nurse should contact the dialysis provider and receive a verbal report. Administrative Nurse D stated a post-assessment was to be completed upon R55's return from dialysis and documented on the dialysis communication sheet. Administrative Nurse D stated R55's dialysis access site should be

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| F 698 | Continued From page 76<br>assessed for infection every shift and documented on the "Treatment Administration Record" (TAR).<br><br>The facility's "Area of Focus: Dialysis" policy last revised on 11/23/23 documented that the facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. The facility would assess for any signs/symptoms of infection, such as redness or edema at the vascular access site. Document in the clinical nursing record: dialysis treatment completed, order changes, condition of shunt site, complaints from resident (if applicable), and whether physician and responsible party notification. Document any pertinent or relevant observations and information including compliance/non-compliance with food and fluid restrictions.<br><br>The facility failed to monitor R55's dialysis access site for signs of infection, bleeding, and the status of the dressing in place and failed to obtain communication from the dialysis center and assess post-dialysis. These deficient practices placed R55 at risk of potential adverse outcomes and physical complications related to dialysis. | F 698 | | |
| F 727 SS=F | RN 8 Hrs/7 days/Wk, Full Time DON<br>CFR(s): 483.35(b)(1)-(3)<br><br>§483.35(b) Registered nurse<br>§483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. | F 727 | | |

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§483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis.

§483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 67 residents. The sample included 17 residents. Based on record review and interview, the facility failed to provide a Registered Nurse (RN) for at least eight consecutive hours a day seven days a week. This placed the residents at risk for decreased quality of care.

Findings included:

- Review of the Payroll-Based Journal for Fiscal Year 2023 Quarters1 through 4 revealed the facility triggered for no RN hours on four or more weekend days during quarter one 10/15/22, 10/16/22, 10/22/22, 10/29/22, 10/30/22,11/05/22, 11/12/22, 11/13/22, 11/19/22, 11/26/22,12/03/22, 12/10/22, 12/11/22, and 12/24/22).

Review of the Payroll-Based Journal for Fiscal Year 2023 Quarter2 revealed the facility triggered for no RN hours on four or more weekend days during the quarter (01/01/23, 01/15/23, 01/21/23, 02/04/23, 02/05/23, 02/12/23, 02/18/23, 02/19/23, 02/26/23, 03/12/23, 03/18/23, and 03/26/23).

Upon request, the facility provided handwritten "Time Clock Adjustment" sheets for the dates listed above. The facility failed to provide proof of

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| F 727 | Continued From page 78<br>eight hours of consecutive RN coverage a day seven days a week as requested.<br><br>The facility also provided an "Earnings Statement" for RNs for the dates requested, but the statements lacked proof of the actual punch times to verify the dates and consecutiveness that the staff members worked.<br><br>On 01/04/24 at 11:30 AM Administrative Staff A stated the facility always had an RN on staff in the building every day. Administrative Nurse D stated on the weekends management staff covered the RN hours a lot of the time but she was unable to show verification or punch times for their hours worked since they were salaried employees and did not clock in/out like regular hourly staff.<br><br>The facility lacked a policy regarding staffing hours.<br><br>The facility failed to ensure there was RN coverage at least eight consecutive hours a day seven days a week. This placed all residents at risk of delayed care and the potential for physical or psychosocial harm. | F 727 | | |
| F 732 SS=C | Posted Nurse Staffing Information<br>CFR(s): 483.35(g)(1)-(4)<br><br>§483.35(g) Nurse Staffing Information.<br>§483.35(g)(1) Data requirements. The facility must post the following information on a daily basis:<br>(i) Facility name.<br>(ii) The current date.<br>(iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for | F 732 | | |

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resident care per shift:
(A) Registered nurses.
(B) Licensed practical nurses or licensed vocational nurses (as defined under State law).
(C) Certified nurse aides.
(iv) Resident census.

§483.35(g)(2) Posting requirements.
(i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift.
(ii) Data must be posted as follows:
(A) Clear and readable format.
(B) In a prominent place readily accessible to residents and visitors.

§483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.

§483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 67 residents. The sample included 17 residents. Based on observation, record review, and interview, the facility failed to ensure nurse staffing data was posted daily. The facility further failed to maintain the posted daily nurse staffing data for a minimum of 18 months.

Findings included:

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| F 732 | Continued From page 80<br>- On 01/02/24 at approximately 07:15 AM, the initial tour of the facility revealed the current daily posted nursing staff data was dated 12/29/23.<br><br>Review of the past 18 months of daily posted nurse staff data sheets lacked a daily posted nurse staff data on the following days: (09/20/23, 09/21/23, 09/23/23, 09/24/23, 09/25/23, 09/28/23, 09/29/23, 09/30/23, 10/01/23, and 10/02/23.<br><br>On 01/04/24 at 07:15 AM Administrative Staff A stated that the night nurse was responsible for posting the daily nurse staffing data daily. Administrative Staff A stated she expected the night staff nurse to post the sheet daily before shift change.<br><br>The facility lacked a policy regarding daily posted nurse staff data.<br><br>The facility failed to ensure the hours of nurse staff data was posted daily as required. The facility failed to maintain 18 months of posted daily nursing staff data. | F 732 | | |
| F 756 SS=D | Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5)<br><br>§483.45(c) Drug Regimen Review.<br>§483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.<br><br>§483.45(c)(2) This review must include a review of the resident's medical chart.<br><br>§483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, | F 756 | | |

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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 67 residents. The sample included 17 residents with five sampled for unnecessary medications. Based on observation, record review, and interview, the facility failed to ensure the Consultant Pharmacist (CP) identified and reported the lack of blood pressure and pulse monitoring for Resident (R)32 before administration of Cozaar (an antihypertensive medication used to treat high blood pressure and heart failure) as ordered by the physician. The facility failed to ensure the CP

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identified and reported R28's blood pressure and pulse lacked monitoring as the physician ordered. The CP did not identify and report R55 was on an antipsychotic (class of medications used to treat major mental conditions that cause a break from reality) medication which lacked an appropriate indication for use or the required physician documentation. This deficient practice placed R32, R28, and R55 at risk for unnecessary medications and possible adverse side effects.

Findings included:

- The electronic medical record (EMR) for R32 documented diagnosis of hypertension (elevated blood pressure), and congestive heart failure (CHF- a condition with low heart output and the body becomes congested with fluid).

The "Annual Minimum Data Set (MDS)" for R32 dated 11/24/23 documented a Brief Interview for Mental Status (BIMS) score of 14 which indicated intact cognition. R32 was independent to supervision for functional abilities. R32 utilized a manual wheelchair for mobility. R32 was administered an antiplatelet (a medication that prevents blood clots) medication.

The "Activities of Daily Living (ADLs) Functional Care Area Assessment (CAA)" dated 12/12/23 documented R32 had a BIMS score of 14 which indicated no cognitive impairment. R32 needed assistance from staff with ADLs and mobility.

R32's "Hypertension Care Plan" last revised 06/09/22 directed staff to administer medications as ordered. Staff was directed to obtain blood pressure readings as ordered and communicate noted abnormalities with the physician.

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The "Order Summary" for R32 documented a physician's order dated 06/07/22 for Cozaar 50 milligram (mg) tablet daily for hypertension. Hold for systolic blood pressure (SBP- top number, the force your heart exerts on the walls of your arteries each time it beats) less than 110 milliliters of mercury (mm Hg) and/or a pulse less than 60 and notify the physician.

The "Order Summary" for R32 documented a physician's order dated 06/07/23 for parameters to notify the physician if R32'sblood pressure was greater than 160/100 mm Hg or less than 90/60 mm Hg every day and evening shift.

R32's October 2023 "Medication Administration Record (MAR)" lacked evidence staff monitored the blood pressure and pulse before Cozaar administration on 28 of 31 opportunities and lacked an evening measurement before administration on 31 out of 31 opportunities.

R32's November 2023 MAR lacked physician-ordered blood pressure or pulse monitoring on 60 of 60 opportunities.

R32's December 2023 MAR lacked physician-ordered blood pressure or pulse monitoring on 62 of 62 opportunities.

R32's "Monthly Medication Regimen Review" (MRR) revealed the CP made no recommendations or identified any irregularities regarding the lack of monitoring of R32's blood pressure and pulse.

On 01/03/24 at 12:45 PM 32 sat in her wheelchair at the dining table and ate lunch.

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| F 756 | Continued From page 84<br><br>On 01/04/24 at 12:55 PM, Licensed Nurse (LN) H stated that he only received the pharmacy recommendations after they had been reviewed by the director of nursing and given to the nurses to make the changes as needed.<br><br>On 01/04/24 at 01:22 PM Administrative Nurse D stated that the CP did monthly MRRs and would send the recommendations to her and the physician. Administrative Nurse D stated when the responses were received back from the physician, she reviewed them and then sent them on to each unit for the nurses to address.<br><br>The facility "LTC Facility's Pharmacy Services and Procedures Manual" last revised 08/17/23 documented that the CP would conduct MRRs if required under a Pharmacy Consultant Agreement and would make recommendations based on the information available in the residents' health record. The facility and CP would follow guidance outlined in the CMS State Operations Manual Appendix PP and current practice guidelines, for the appropriate provision of pharmaceutical care. The attending physician should address the CP's recommendations no later than their next scheduled visit to the facility to assess the resident, either 30 or 60 days per applicable regulation.<br><br>The facility failed to ensure the CP identified and reported R32 lacked physician-ordered blood pressure and pulse readings before the administration of Cozaar. This deficient practice placed R32 at risk for unnecessary medications and possible adverse side effects. | F 756 | | |

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- The electronic medical record (EMR) for R28 documented diagnosis of hypertension (elevated blood pressure), chronic respiratory failure (when not enough oxygen passes from the lungs to the blood), and bradycardia (low heart rate, less than 60 beats per minute).

The "Annual Minimum Data Set (MDS)" for R28 dated 07/03/23 documented a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. R28 was independent to limited assistance for activities of daily living (ADLs).

The "Quarterly MDS" dated 10/03/23 documented R28 had a BIMS score of 15 which indicated intact cognition. R28 was independent with functional abilities.

The "ADLs Care Area Assessment (CAA)" dated 07/03/23 documented R28 had a functional deficit due to a history of stroke and required supervision. R28 was alert and oriented and was encouraged by staff to participate in self-care to promote quality of life.

R28's "Cardiovascular Status Care Plan" last revised 06/15/23 directed staff to administer medications as ordered. Staff was directed to obtain blood pressure readings as ordered and communicate noted abnormalities with the physician.

The "Order Summary" for R28 documented a physician's order dated 08/02/22 for blood pressure parameters. Notify the physician if blood pressure is more than 160/100 milliliters (mm) of mercury (Hg) or less than 90/60 mm/Hg every day and evening shift.

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The December 2023 "Medication Administration Record (MAR)" for R28 documented a physician's order dated 12/04/23 for Cozaar 25 milligrams (mg) tablet daily for hypertension. Hold for systolic blood pressure (SBP- top number, the force your heart exerts on the walls of your arteries each time it beats) less than 110 mm Hg and/or a pulse less than 60 and notify the physician.

The December 2023 MAR for R28 documented a physician's order dated 12/04/23 for Cardizem (a calcium channel blocker used to treat high blood pressure and chest pain)120 mg capsule daily for hypertension. Hold and notify the physician for SBP below 110 mm/Hg or pulse below 60.

R28's October 2023 "Treatment Administration Record (TAR)" lacked evidence staff monitored the blood pressure and pulse as the physician ordered on 31 out of 31 evening opportunities.

R28's November 2023 TAR lacked evidence of the physician-ordered blood pressure or pulse monitoring on 30 of 30 evening opportunities.

R28's December 2023 TAR lacked evidence of the physician-ordered blood pressure or pulse monitoring on 27 of 27 evening opportunities.

R28's "Monthly Medication Regimen reviews (MRRs) for the past year (December 2022 to December 2023) revealed the CP failed to identify and report that R28's blood pressure and pulse were not being monitored as ordered.

On 01/03/24 at 08:23 AM R28 sat in her wheelchair and propelled herself down the hall to the dining area for breakfast.

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On 01/04/24 at 12:55 PM, Licensed Nurse (LN) H stated that he only received the pharmacy recommendations after they had been reviewed by the director of nursing and given to the nurses to make the changes as needed.

On 01/04/24 at 01:22 PM Administrative Nurse D stated that the CP did monthly MRRs and would send the recommendations to her and the physician. Administrative Nurse D stated when the responses were received back from the physician she reviewed them and then sent them on to each unit for the nurses to address.

The facility "LTC Facility's Pharmacy Services and Procedures Manual" last revised 08/17/23 documented that the CP would conduct MRRs if required under a Pharmacy Consultant Agreement and would make recommendations based on the information available in the residents' health record. The facility and CP would follow guidance outlined in the CMS State Operations Manual Appendix PP and current practice guidelines, for the appropriate provision of pharmaceutical care. The attending physician should address the CP's recommendations no later than their next scheduled visit to the facility to assess the resident, either 30 or 60 days per applicable regulation.

The facility failed to ensure the CP identified and reported R28 lacked physician-ordered blood pressure and pulse monitoring before the administration of Cozaar. This deficient practice placed R28 at risk for unnecessary medications and possible adverse side effects.

- R55's Electronic Medical Record (EMR) from

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the "Diagnoses" tab documented diagnoses of end-stage renal disease (ESRD-a terminal disease of the kidneys), dementia (progressive mental disorder characterized by failing memory, confusion), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), and Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure).

The "Significate Change Minimum Data Set" (MDS) dated 09/08/23 documented a Brief Interview of Mental Status (BIMS) score of zero which indicated severely impaired cognition. The MDS documented that R55 was dependent on two staff members' assistance for activities of daily living (ADLs). The MDS documented R55 received antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) medication during the observation period.

The "Quarterly MDS" dated 12/08/23 documented a BIMS score of zero which indicated severely impaired cognition. The MDS documented that R55 received antipsychotic medication during the observation period.

R55's "Psychotropic Drug Use Care Area Assessment" (CAA) dated 09/20/23 documented R55 received psychotropic medication and was at risk for adverse side effects.

R55's "Care Plan" dated 11/18/22 documented the facility would consult with the pharmacist and physician to consider dose reduction of psychotropic medication when clinically indicated or at least quarterly.

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A review of the EMR under the "Orders" tab revealed the following physician orders: Risperidone (antipsychotic) oral tablet 0.25 milligrams (mg) give one tablet by mouth at bedtime related to dementia for four weeks dated 12/22/23.

A review of the "Monthly Medication Review" (MMR) from January 2023 to December 2023 lacked evidence of recommendations for physician documentation for risk versus benefits for the continued use of the antipsychotic medication for R37 with a diagnosis of dementia and Alzheimer's disease.

Observation on 01/03/24 at 09:37 AM R55 lay with eyes closed on his bed. His bilateral lower extremities rested directly on the mattress.

On 01/04/24 at 12:19 PM Licensed Nurse (LN) G stated antipsychotic medication was given to residents with dementia if they had behaviors and for yelling out. LN G stated she did not review the MMRs because the director of nursing usually handled them.

On 01/04/24 at 01:22 PM Administrative Nurse D stated a resident taking psychotropic medication would have a dose reduction and documentation for the continued use if the resident had a diagnosis of dementia.

The facility's "Medication Regimen review" policy last revised on 08/17/23 documented the Consultant Pharmacist would conduct MRRs if required under a Pharmacy Consultant Agreement and would make recommendations based on the information available in the

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| F 756 | Continued From page 90<br>residents' health records. The facility and Consultant Pharmacist would follow guidance outlined in the CMS State Operations Manual Appendix PP and current practice guidelines, for the appropriate provision of pharmaceutical care.<br><br>The facility failed to ensure the CP noted and recommended the need for a physician-documented rationale for the continued use of the antipsychotic medication for R55 who had a diagnosis of dementia. This deficient practice placed R55 at risk for unnecessary psychotropic medication and related complications. | F 756 | | |
| F 757 SS=D | Drug Regimen is Free from Unnecessary Drugs<br>CFR(s): 483.45(d)(1)-(6)<br><br>§483.45(d) Unnecessary Drugs-General.<br>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-<br><br>§483.45(d)(1) In excessive dose (including duplicate drug therapy); or<br><br>§483.45(d)(2) For excessive duration; or<br><br>§483.45(d)(3) Without adequate monitoring; or<br><br>§483.45(d)(4) Without adequate indications for its use; or<br><br>§483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or<br><br>§483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this | F 757 | | |

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section.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 67 residents. The sample included 17 residents with five sampled for unnecessary medications. Based on observation, record review, and interview, the facility failed to ensure that Resident (R) 32's physician-ordered blood pressure and pulse were monitored prior to the administration of Cozaar (an antihypertensive medication used to treat high blood pressure and heart failure). The facility failed to ensure R28's blood pressure and pulse were monitored as the physician ordered. This deficient practice placed R32 and R28 at risk for unnecessary medications and possible adverse side effects.

Findings included:

- The electronic medical record (EMR) for R32 documented diagnosis of hypertension (elevated blood pressure), and congestive heart failure (CHF- a condition with low heart output and the body becomes congested with fluid).

The "Annual Minimum Data Set (MDS)" for R32 dated 11/24/23 documented a Brief Interview for Mental Status (BIMS) score of 14 which indicated intact cognition. R32 was independent to supervision for functional abilities. R32 utilized a manual wheelchair for mobility. R32 was administered an antiplatelet (a medication that prevents blood clots) medication.

The "Activities of Daily Living (ADLs) Functional Care Area Assessment (CAA)" dated 12/12/23 documented R32 had a BIMS score of 14 which indicated no cognitive impairment. R32 needed

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assistance from staff with ADLs and mobility.

R32's "Hypertension Care Plan" last revised 06/09/22 directed staff to administer medications as ordered. Staff was directed to obtain blood pressure readings as ordered and communicate noted abnormalities with the physician.

The "Order Summary" for R32 documented a physician's order dated 06/07/22 for Cozaar 50 milligram (mg) tablet daily for hypertension. Hold for systolic blood pressure (SBP- top number, the force your heart exerts on the walls of your arteries each time it beats) less than 110 milliliters of mercury (mm Hg) and/or a pulse less than 60 and notify the physician.

The "Order Summary" for R32 documented a physician's order dated 06/07/23 for parameters to notify the physician if R32'sblood pressure was greater than 160/100 mm Hg or less than 90/60 mm Hg every day and evening shift.

A review of R32's October 2023 "Medication Administration Record (MAR)" lacked evidence staff monitored the blood pressure and pulse prior to Cozaar administration on 28 of 31 opportunities and lacked an evening measurement prior to administration on 31 out of 31 opportunities.

Review of R32's November 2023 MAR lacked the physician-ordered blood pressure or pulse monitoring on 60 of 60 opportunities.

Review of R32's December 2023 MAR lacked the physician-ordered blood pressure or pulse monitoring on 62 of 62 opportunities.

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On 01/03/24 at 12:45 PM R32 sat in her wheelchair at the dining table and ate lunch.

On 01/04/24 at 12:55 PM, Licensed Nurse (LN) H stated that R32's blood pressure and pulse should still be monitored. LN H stated at times R32 refused to get her blood pressure taken, but that should be documented by the nurse or whoever was obtaining the blood pressure and the physician should be notified as well. LN H could not say why R32's blood pressure was not monitored as it should have been.

On 01/04/24 at 01:22 PM Administrative Nurse D stated that R32's blood pressure and pulse should be monitored as ordered. Administrative Nurse D could not say why R32's blood pressure and pulse had not been monitored as ordered but said she would talk to her staff to make sure it was done now.

The facility's "Administration of Medications" policy revised on 02/13/23 documented the facility would ensure medication was administered safely and appropriately per physician order to address resident's diagnoses and signs and symptoms.

The facility failed to ensure that R32's physician ordered blood pressure and pulse was monitored prior to the administration of Cozaar. This deficient practice placed R32 at risk for unnecessary medications and possible adverse side effects.

- The electronic medical record (EMR) for R28 documented diagnosis of hypertension (elevated blood pressure), chronic respiratory failure (when not enough oxygen passes from the lungs to the

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blood), and bradycardia (low heart rate, less than 60 beats per minute).

The "Annual Minimum Data Set (MDS)" for R28 dated 07/03/23 documented a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. R28 was independent to limited assistance for activities of daily living (ADLs).

The "Quarterly MDS" dated 10/03/23 documented R28 had a BIMS score of 15 which indicated intact cognition. R28 was independent with functional abilities.

The "ADLs Care Area Assessment (CAA)" dated 07/03/23 documented R28 had a functional deficit due to a history of stroke and required supervision. R28 was alert and oriented and was encouraged by staff to participate in self-care to promote quality of life.

R28's "Cardiovascular Status Care Plan" last revised 06/15/23 directed staff to administer medications as ordered. Staff was directed to obtain blood pressure readings as ordered and communicate noted abnormalities with the physician.

The "Order Summary" for R28 documented a physician's order dated 08/02/22 for blood pressure parameters. Notify the physician if blood pressure is more than 160/100 milliliters of mercury (mm Hg) or less than 90/60 mm Hg every day and evening shift for blood pressure.

The December 2023 "Medication Administration Record (MAR)" for R28 documented a physician's order dated 12/04/23 for Cozaar 25 milligrams (mg) tablet daily for hypertension. Hold for

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systolic blood pressure (SBP- top number, the force your heart exerts on the walls of your arteries each time it beats) less than 110 mm Hg and/or a pulse less than 60 and notify the physician.

The December 2023 MAR for R28 documented a physician's order dated 12/04/23 for Cardizem (a calcium channel blocker used to treat high blood pressure and chest pain)120 mg capsule daily for hypertension. Hold and notify the physician for SBP below 110 mm Hg or pulse below 60.

R28's October 2023 "Treatment Administration Record (TAR)" lacked evidence staff monitored the blood pressure and pulse as the physician ordered on 62 out of 62 opportunities.

R28's November 2023 TAR lacked evidence of the physician-ordered blood pressure or pulse monitoring on 60 of 60 opportunities.

R28's December 2023 TAR lacked evidence of the physician-ordered blood pressure or pulse monitoring on 27 of 27 opportunities.

On 01/03/24 at 08:23 AM R28 sat in her wheelchair and propelled herself down the hall to the dining area for breakfast.

On 01/04/24 at 12:55 PM Licensed Nurse (LN) H stated he was not aware that R28's blood pressure and pulse should have been monitored prior to her hospitalization. LN H stated at times R28's blood pressure was obtained prior to the administration of her Cozaar and Cardizem since her return from the hospital in December. LN H could not say why R28's blood pressure was not monitored as it should have been.

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| F 757 | Continued From page 96<br><br>On 01/04/24 at 01:22 PM Administrative Nurse D stated that R28's blood pressure and pulse should be monitored as ordered. Administrative Nurse D could not say why R28's blood pressure and pulse were not monitored as ordered but said she would talk to her staff to make sure it was done now.<br><br>The facility's "Administration of Medications" policy revised on 02/13/23 documented the facility would ensure medication was administered safely and appropriately per physician order to address resident's diagnoses and signs and symptoms.<br><br>The facility failed to ensure that R28's blood pressure and pulse were monitored twice daily as ordered by the physician. This deficient practice placed R28 at risk for unnecessary medications and possible adverse side effects. | F 757 | | |
| F 758 SS=D | Free from Unnec Psychotropic Meds/PRN Use<br>CFR(s): 483.45(c)(3)(e)(1)-(5)<br><br>§483.45(e) Psychotropic Drugs.<br>§483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:<br>(i) Anti-psychotic;<br>(ii) Anti-depressant;<br>(iii) Anti-anxiety; and<br>(iv) Hypnotic<br><br>Based on a comprehensive assessment of a resident, the facility must ensure that---<br><br>§483.45(e)(1) Residents who have not used | F 758 | | |

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psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;

§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;

§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and

§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.

§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 67 residents. The sample included 17 residents with five reviewed for unnecessary medications. Based on observation, record review, and interview the facility failed to ensure an appropriate indication or a documented physician rationale which

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included the multiple unsuccessful attempts for nonpharmacological symptom management and risk versus benefits for the continued use of an antipsychotic (class of medications used to treat a mental disorder characterized by gross impairment in reality testing) for Resident (R)55, who had a diagnosis of Alzheimer's and dementia (progressive mental disorder characterized by failing memory, confusion). This placed the resident at risk for unnecessary psychotropic (alters perception, mood, consciousness, cognition, or behavior) medications and related complications.

Findings included:

- R55's Electronic Medical Record (EMR) documented the resident had diagnoses of dementia, Alzheimer's, and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear).

The "Significate Change Minimum Data Set" (MDS) dated 09/08/23 documented a Brief Interview of Mental Status (BIMS) score of zero which indicated severely impaired cognition. The MDS documented that R55 was dependent on two staff members' assistance for activities of daily living (ADLs). The MDS documented R55 received antipsychotic medication during the observation period.

R55's "Psychotropic Drug Use Care Area Assessment" (CAA) dated 09/20/23 documented R55 received psychotropic medication and was at risk for adverse side effects.

R55's "Care Plan" dated 11/18/22 documented the facility would consult with the pharmacist and

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physician to consider dose reduction of psychotropic medication when clinically indicated or at least quarterly.

R55's "Psychosocial Care Plan," revised 12/24/22, documented R55 received Risperdal (risperidone-antipsychotic medication) for targeted behavior and instructed staff to watch R55 for side effects of his medication.

The "Physician Order Sheet," dated 01/4/23, instructed staff to administer Risperidone 0.5mg before bed for a diagnosis of severe agitation for anxiety.

R55's EMR lacked a documented physician rationale which included the multiple unsuccessful attempts for nonpharmacological symptom management and risk versus benefits.

On 01/2/23 at 12:18 PM, observation revealed R55 sat in his room in a Broda chair (special wheelchair with tilt and recline capability) R55 visited politely with visitors and staff.

The facility's "Psychotropic Medications Policy," revised 10/24/22, documented that antipsychotic medications are indicated for the treatment of behaviors only if non-drug approaches and interventions were attempted prior to their use.

The facility's "Drug Regimen Review Policy," revised 8/17/23, documented the pharmacist would report any irregularities to the attending physician, the facility's medical director, and the director of nursing. The facility would act upon the pharmacist's recommendations and provide an explanation as to why the recommendation was rejected.

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| F 758 | Continued From page 100<br><br>The facility failed to ensure an appropriate indication or a documented physician rationale which included the multiple unsuccessful attempts for nonpharmacological symptom management and risk versus benefits for the continued use of R55's antipsychotic medication. This placed the resident at risk of receiving an unnecessary psychotropic medication. | F 758 | | |
| F 760 SS=D | Residents are Free of Significant Med Errors<br>CFR(s): 483.45(f)(2)<br><br>The facility must ensure that its-<br>§483.45(f)(2) Residents are free of any significant medication errors.<br>This REQUIREMENT is not met as evidenced by:<br>The facility identified a census of 67 residents. The sample included 17 residents with five reviewed for hospitalization. Based on observation, record review, and interviews, the facility failed to prevent a significant medication error when Resident (R) 24 received twice the physician-ordered dose of Eliquis (medication used to thin the blood) from 11/30/23 to 01/02/24. The deficient practice placed R24 at risk for adverse effects including bleeding related to the medication error.<br><br>Findings Included:<br><br>- R24's Electronic Medical Record (EMR) documented diagnosis of occlusion and stenosis of the left carotid artery (narrowing, constriction, or blockage of either of the two main arteries that supply blood to the head), peripheral vascular disease (PVD- slow and progressive circulation disorder causing narrowing, blockage, or spasms | F 760 | | |

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in a blood vessel), generalized muscle weakness and cognitive communication deficit.

The "Admission Minimum Data Set (MDS)" dated 11/16/23 documented a Brief Interview for Mental Status (BIMS) score of 12 which indicated moderate cognitive impairment. The MDS further documented R24 used a walker and wheelchair for mobility and required partial/moderate assistance for many of her activities of daily living (ADL).

The "Cognitive Loss / Dementia Care Area Assessment (CAA)" dated 11/16/2023, documented R24 was alert and oriented to self, place and was able to communicate basic needs. The CAA further documented R24 had weakness and a BIMS of 12.

R24's "Care Plan" with an initiated date of 11/13/2023, documented R24 had impaired cognitive ability.

An "Admission/Readmission Note," dated 11/29/23 at 08:14 PM, documented R24 was admitted to a hospital on 11/20/23 after a fall, and a change of condition was observed. The "Admission/Readmission Note" further documented that while R24 was in a hospital she had a hemoglobin (Hgb- measure of blood that carried oxygen to the cells from the lungs and carbon dioxide away from the cells to the lungs) of 6.8 and received three units of blood.

The "Discharge Medications List" R24 received from a hospital stay dated 11/29/23, directed R24 to continue Eliquis. The "Discharge Medications List" documented that the Eliquis dosage had been changed to 2.5 milligrams (mg), one tablet

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twice daily.

Review of R24's "Medication Administration Record" from 12/01/23 - 01/04/24, documented an order for Eliquis 5mg, one tablet twice a day with a start date of 11/30/23 and an end date of 01/04/24.

Review of R24's "Medication Administration Record" from 11/30/23 - 01/02/24, documented R24 received 5 mg (twice the ordered dosage) of Eliquis 67 out of 67 opportunities.

On 01/04/24 at 07:50 AM inspection of a medication cart revealed medication cards for R24's Eliquis. The cards contained 5 mg tablets and instructed to give one tablet twice a day with a start date of 11/30/23.

On 01/04/24 at 12:55 PM, Licensed Nurse (LN) H stated he was uncertain if R24 had a history of GI bleed. He said the nurse that did the resident's admission put in the ordered medications. LN H stated the nurse on the following shift should have audited the medications to make sure they were correct. LN H stated the nurse was supposed to clarify the ordered medications with the doctor. He further stated the pharmacy also checked ordered medications after the orders were faxed to them. LN H stated each time a resident left the facility and was readmitted, all the medications had to be re-ordered and re-entered by the nurses.

On 01/04/24 at 01:22 PM Administrative Nurse D stated the admission nurse should have faxed the medications ordered on R24's discharge medications list from the hospital to the pharmacy and should have compared them in R24's EMR to

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| F 760 | Continued From page 103<br>ensure accuracy. Administrative Nurse D further stated the nurse scheduled to work the following shift should have reviewed the ordered medications to further ensure accuracy. Administrative Nurse D stated when a resident was discharged and then readmitted, all of the previous medications were discontinued if the resident was out of the facility for more than 24 hours. Administrative Nurse D stated medications should have been sent to the pharmacy so they could compare them to what was ordered in R24's EMR. Administrative Nurse D stated if R24 received 5 mg of Eliquis when she discharged from a hospital with an order for 2.5 mg of Eliquis that would be a medication error. Administrative Nurse D stated she would investigate R24's medications or determine if an error occurred and said she could not comment on any outcome until the investigation was completed.<br><br>The facility provided an "Administration of Medications" policy with a reviewed date of 08/24/23, documenting that the facility will ensure medications are administered safely and appropriately per physician order to address residents' diagnoses and signs and symptoms. The policy further documented staff were to check the MAR and the doctor's order before medicating and if there was a question on the drug, stop and verify all information before administering.<br><br>The facility failed to prevent a significant medication error when R24. The deficient practice placed R24 at risk for other complications related to medication errors. | F 760 | | |
| F 761 SS=E | Label/Store Drugs and Biologicals<br>CFR(s): 483.45(g)(h)(1)(2) | F 761 | | |

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| F 761 | Continued From page 104<br><br>§483.45(g) Labeling of Drugs and Biologicals<br>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.<br><br>§483.45(h) Storage of Drugs and Biologicals<br><br>§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.<br><br>§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.<br>This REQUIREMENT is not met as evidenced by:<br>The facility reported a census of 67 residents. The Facility had four medication carts and two medication rooms. Based on observations, record reviews, and interviews, the facility failed to ensure the safe storage and handling of Resident (R)55's insulin medication (a hormone that lowers the level of glucose in the blood). This deficient practice placed the resident at risk for diversion and ineffective medication regimen.<br><br>Findings Included: | F 761 | | |

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| F 761 | Continued From page 105<br><br>- On 01/02/24 at 07:35 AM a walkthrough of the facility's South Hall revealed a treatment cart by the nurse's station. An inspection of the treatment cart revealed unsecured insulin medication stored in plastic bins on top of the cart. The plastic bins contained four insulin glargine (long-acting insulin medication) auto-injector pens that belonged to R55. At 07:38 AM Licensed Nurse (LN) G stated she just left the area briefly to put her coat up. LN G stated the insulin should be supervised or locked up when not in use. She secured the insulin in the third drawer of her treatment cart.<br><br>On 01/04/24 at 01:10 PM Administrative Nurse D stated medication should be locked in the treatment cart when staff step away from the carts. She stated medication should never be left unsecured or in reach of the residents.<br><br>The facility's "Medication Storage" policy revised 06/2021 indicated all medications provided to the facility will stored in a safe manner.<br><br>The policy indicated all medication rooms and carts containing medications will be secured and always supervised. The policy indicated that all drugs and biologicals were to be stored in locked compartments accessible only by licensed personnel. The policy indicated all medication rooms, carts, and supplies remain locked when not attended.<br><br>The facility failed to ensure safe storage and handling of R55's medications. This deficient practice placed the residents at risk for diversion and ineffective medication regimens. | F 761 | | |
| F 812 SS=F | Food Procurement,Store/Prepare/Serve-Sanitary | F 812 | | |

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| F 812 | Continued From page 106<br>CFR(s): 483.60(i)(1)(2)<br><br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br>(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.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br>This REQUIREMENT is not met as evidenced by:<br>The facility identified a census of 67 residents with one kitchen. Based on observation, record review, and interviews, the facility failed to maintain sanitary dietary standards related to the storage of food. This deficient practice placed the residents at risk related to food-borne illnesses and food safety concerns.<br><br>Findings included:<br><br>On 01/02/24 at 07:27 AM an observation in the main kitchen area revealed three plastic storage containers with cereal inside. The containers lacked labels and were undated.<br><br>On 01/02/24 at 07:35 AM an observation in the | F 812 | | |

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kitchen's meat freezer revealed two resealable plastic bags. One plastic bag contained ham and the other contained chicken patties. The plastic bags were not labeled and were undated.

On 01/02/24 at 07:36 AM, an observation in the kitchen's meat freezer revealed one opened box of frozen beef patties. The box was open to air and the patties were uncovered.

On 01/02/24 at 07:38 AM, an observation in the kitchen's dry storage area revealed one bag of dry noodles. The bag was opened and was undated.

On 01/02/24 at 07:39 AM, an observation in the kitchen's dry storage area revealed one opened box of graham cracker crumbs. The box was open and the crumbs were open to air.

On 01/02/24 at 07:40 AM an observation in the kitchen's dry storage area revealed one bag of tortilla chips. The bag was opened and was undated.

On 01/02/24 at 07:43 AM, an observation in the kitchen's A refrigerator revealed one package of cheese slices. The package was opened and was undated.

On 01/02/24 at 07:45 AM, an observation in the kitchen's A refrigerator revealed one gallon of whole milk. The gallon of milk was opened and was undated.

On 01/02/24 at 07:47 AM an observation in the kitchen's vegetable freezer revealed two bags of diced green peppers. The bags were opened and undated.

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On 01/02/24 at 07:48 AM an observation in the kitchen's vegetable freezer revealed one resealable bag of mixed peppers/onions. The bag was not labeled or dated.

On 01/02/24 at 07:49 AM, an observation in the kitchen's baking freezer revealed one bag of breadsticks. The bag was open to air and undated.

On 01/02/24 at 07:50 AM an observation in the kitchen's baking freezer revealed one resealable plastic bag of cookies. The bag did not have a label and was undated.

On 01/02/24 at 07:50 AM an observation in the kitchen's baking freezer revealed one plastic bag of French fries. The bag was opened and undated.

On 01/02/24 at 07:54 AM, an observation in the kitchen's main area revealed three bags of hot dog buns and one loaf of bread. The bags were opened and undated.

On 01/03/24 at 12:09 PM, Dietary BB stated after items were opened, staff were expected to add a date to the packaging, and any items placed into a resealable plastic bag should have been labeled and dated. Dietary BB further stated food items that were placed in a resealable bag that lacked a label and/or date should have been discarded when found.

The facility's "Food Safety" policy with a revised date of 04/26/23, documented that Pre-packaged food is placed in a leak-proof, non-absorbent, sanitary container with a tight-fitting lid. The

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| F 812 | Continued From page 109<br>container is labeled with the name of the contents and the date (when the item is transferred to the new container). Use by date is noted on the label or product when applicable. The policy further documented frozen, raw meat that is placed in a cooler in a pan and labeled with the pulled and use-by dates.<br><br>The facility failed to maintain sanitary dietary standards related to the storage of food. This deficient practice placed the residents at risk related to food-borne illnesses and food safety concerns. | F 812 | | |
| F 880 SS=F | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>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.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; | F 880 | | |

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| F 880 | Continued From page 110<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(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<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. | F 880 | | |

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§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 67 residents. Based on observation, record review, and interviews, the facility failed to ensure proper infection control standards were followed related to the implementation of procedures to monitor and prevent Legionella disease (Legionella is a bacterium that can cause pneumonia in vulnerable populations) or other opportunistic waterborne pathogens, failed to ensure sanitary storage of respiratory equipment, failed to ensure adequate laundry temperatures for laundry including laundry from residents with infectious disease and on transmission-based precautions and failed to ensure staff performed hand hygiene between resident car. The facility further failed to ensure appropriate disposal of filled red biohazard boxes and failed to ensure the Infection Preventionist tracked and trended infections within the facility. These deficient practices placed the residents at risk for complications related to infectious diseases.

Findings included:

- Observation on 01/02/24 at 07:05 AM a large bag of soiled linen rested on the floor in the 200 hallways.

On 01/02/24 at 07:14 AM an unlocked soiled utility room on the 200 hallway revealed a small refrigerator, which the thermometer registered a temperature of 18 degrees. The refrigerator had ice along the back of the refrigerator. Two large red biohazard boxes sat on a cart with six small

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red biohazard sharps containers on top of the two large red biohazard boxes. Four of the six red sharps containers were filled past the fill line on the box. A can with cat litter and a cigarette butt sat on the counter next to the sink.

On 01/02/24 at 07:21 AM the clean utility room on the 200 hall had an opened box of disposable gloves and a gait belt which partially rested on the floor. A blue hand splint rested directly on the floor as well.

On 01/02/24 at 07:48 AM Resident (R) 44's oxygen tubing rested on the floor next to the bed, unbagged.

On 01/02/23 at 11:35 AM R42's continuous positive airway pressure (CPAP- ventilation device that blows a gentle stream of air into the nose to keep the airway open during sleep) mask hung unbagged above his bed.

On 01/04/24 at 06:43 AM Certified Medication Aide (CMA) S failed to perform hand hygiene between administration of medication to R21 and administered medication and inhaler to R10.

The facility provided a policy related to Legionella testing but was unable to provide a plan, a risk assessment, or a procedure related to Legionella testing.

A review of the temperature logs provided by the facility water temperature logs documented temperatures below the recommended 160 degrees. The facility was unable to provide washing machine specifications upon request.

On 01/04/23 at 10:39 AM Administrative Nurse E,

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the facility Infection Preventionist stated she had a book that she did track the facility's infections "some place." Administrative Nurse E stated she completed Mcgeer's criteria after a urine analysis was obtained. Administrative Nurse E stated respiratory equipment should never touch the floor, should be dated, and changed weekly, and placed in a clean bag when not in use. Administrative Nurse E stated she was not sure how frequently a resident's CPAP mask should be replaced. Administrative Nurse E stated hand hygiene should be performed in between each resident.

On 01/04/24 at 12:08 PM Certified Nurse Aide (CNA) N stated soiled linen should never be placed on the floor. CNA N stated respiratory equipment should be stored in a clean bag when not in use.

On 01/04/24 at 01:22 PM Administrative Nurse D stated hand hygiene should be performed between administration of medication and any other resident care. Administrative Nurse D stated respiratory equipment should be stored in a clean bag when not in use. CPAP masks should be cleaned daily after use. Administrative Nurse D stated the Infection Preventionist, administrator, and maintenance director oversee the plan and procedure for testing for Legionella disease. Administrative Nurse D stated the nurses were responsible for ensuring red biohazard sharps containers were changed and placed in the large red biohazard container in the soiled utility rooms. Administrative Nurse D stated night shift was responsible for monitoring the specimen refrigerator in the utility room to ensure it was defrosted and at the appropriate temperature.

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| LIFE CARE CENTER OF KANSAS CITY | 3231 N 61ST STREET KANSAS CITY, KS 66104 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 880 | Continued From page 114 | F 880 | | |

The facility's "Hand Hygiene" policy last revised 06/13/23 documented that 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.

The facility's "Laundry Services" policy last reviewed on 06/04/23 documented that linens should be washed using the equipment manufacturer's recommendations for appropriate chemical mix and water temperature.

A review of the facility's "Oxygen Administration/Storage/Maintenance" policy reviewed 09/2023 indicated oxygen will be administered in accordance with the physician's orders and current standards of practice. The policy indicated oxygen supplies will be changed weekly and when visibly soiled with dates indicating placement. The policy indicated oxygen tubing and masks were to be stored in provided bags to prevent environmental contamination or infections.

The facility's "Antibiotic Stewardship" policy last reviewed on 05/19/23 documented that the antibiotic stewardship program promoted the appropriate use of antibiotics and included a system of monitoring to improve resident outcomes and reduce antibiotic resistance. This meant that the antibiotic was prescribed for the correct indication, dose, and duration to appropriately treat the resident while also attempting to reduce the development of antibiotic-resistant organisms and/or other adverse events. The program would be managed

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175281 | A. BUILDING _____ B. WING _____ | 01/04/2024 |

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|---|---|---|---|---|
| F 880 | Continued From page 115<br>and overseen by the Infection Preventionist.<br><br>The facility failed to implement appropriate infection control practices. This placed the residents at risk for transmission of infectious diseases. | F 880 | | |
| F 881 SS=F | Antibiotic Stewardship Program<br>CFR(s): 483.80(a)(3)<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use.<br>This REQUIREMENT is not met as evidenced by:<br>The facility identified a census of 67 residents. The sample included 17 residents. Based on observation, record review, and interviews, the facility failed to develop and implement the core elements of antibiotic stewardship to ensure an effective infection prevention and control program including antibiotic stewardship for the residents of the facility.<br><br>Findings included:<br><br>- Review of the "Infection Control Log" for tracking and trending infections from January 2023 through December 2023, lacked evidence of organism identifications, duration of antibiotic prescribed, and the infections treated. The facility was unable to provide evidence of tracking upon request. | F 881 | | |

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|---|---|---|---|---|
| F 881 | Continued From page 116<br><br>On 01/04/23 at 10:39 AM Administrative Nurse E, the facility Infection Preventionist stated she had a book that she did track the facility's infections "some place." Administrative Nurse E stated she completed Mcgeer's criteria after a urine analysis was obtained.<br><br>The facility's "Antibiotic Stewardship" policy last reviewed on 05/19/23 documented that the antibiotic stewardship program promoted the appropriate use of antibiotics and included a system of monitoring to improve resident outcomes and reduce antibiotic resistance. This meant that the antibiotic was prescribed for the correct indication, dose, and duration to appropriately treat the resident while also attempting to reduce the development of antibiotic-resistant organisms and/or other adverse events. The program would be managed and overseen by the Infection Preventionist.<br><br>The facility failed to proactively apply the principles of antibiotic stewardship, for the residents of the facility from January 2023 through December 2023 to ensure antibiotics were administered in a safe and effective manner to prevent unnecessary side effects of antibiotics and antibiotic resistance. | F 881 | | |