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	175348	A. BUILDING _____ B. WING _____	02/29/2024

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HILLTOP LODGE HEALTH AND REHABILITATION CENTER	815 N INDEPENDENCE AVENUE BELOIT, KS 67420

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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey. The 2567 was sent electronically on 03/14/24.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §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

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 had a census of 59 residents. The sample included 19 residents with one reviewed for dignity. Based on observation, record review, and interview the facility staff failed to treat Resident (R) 54 with dignity, when staff failed to cover his urinary catheter (insertion of a catheter into the bladder to drain the urine into a collection bag) urine collection bag with a privacy bag leaving the urine visible to other residents and guests in the facility. This placed the resident at risk for impaired dignity.

Findings included:

- R54's Electronic Medical Record (EMR) documented R54 had a diagnosis of urinary retention (lack of ability to urinate and empty the bladder).

R54's "Quarterly Minimum Data Set" (MDS), dated 01/18/24, documented R54 had a Brief Interview of Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS documented R54 was dependent on staff for toileting hygiene. R54 had an indwelling urinary catheter.

R54's "Care Plan," revised 01/18/24, documented

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F 550	Continued From page 2 R54 required partial, moderate assistance with toileting hygiene. The MDS documented R54 had an indwelling urinary catheter and instructed staff to provide good perineal (private area) care, anchor the catheter tubing to prevent injury, provide catheter care every shift and as needed (PRN), and monitor, record, and report to the physician if R54 had signs or symptoms of urinary tract infection (UTI-an infection in any part of the urinary system). On 02/27/24 at 11:10 AM, observation revealed R54 ambulated down the hall from his room to the dining room with his urinary catheter bag hanging on the right side of his walker without a privacy bag. R54 sat at the dining room table and ate lunch; R54's urine collection bag remained uncovered, with 12 other residents able to view it. On 02/28/24 at 03:28 PM, Administrative Nurse D stated she expected staff to make sure R54's urinary catheter bag was in a privacy bag. The facility's "Promoting/Maintaining Resident Dignity Policy," revised November 2017, documented it was the practice of the facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality. The facility staff failed to treat R54 with dignity when staff failed to cover his urinary catheter bag with a privacy cover. This placed R54 at risk for impaired dignity.	F 550		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment	F 584		

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F 584	Continued From page 3 CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. 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. The facility must provide- §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. (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. (ii) The facility shall exercise reasonable care for 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	F 584		

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§483.10(i)(7) For the maintenance of comfortable sound levels.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 59 residents. The sample included 19 residents. Based on observation, record review, and interview the facility failed to provide a safe environment in Resident (R) 37's room, when staff placed crinkled duct tape between the floor carpet seams. This placed the resident at risk of preventable accidents and an unhomelike environment.

Findings included:

- On 02/27/24 at 09:30 AM, observation revealed in R37's room between the carpet seam had gray duct tape running from the bed to the south wall. Observation revealed that the middle of the duct tape was crinkled up approximately one foot (ft).

On 02/28/24 at 10:57 AM, Maintenance Staff (MS) U verified the above finding and stated the flooring needed to be replaced. He said he planned on getting a requisition to the administrator but had not got around to it yet.

On 02/28/24 at 04:23 PM, Administrative Nurse D stated she was unaware of the issue with the duct tape on the carpet and said that she would look at it.

On 02/29/24 at 09:56 AM, Administrative Nurse D stated the flooring needed to be replaced and agreed the issue with the duct tape could be a trip hazard.

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F 584	Continued From page 5 The facility's "Resident Environmental Quality Policy," revised in November 2017, documented preventative maintenance schedules, for the maintenance of the building and equipment, should be followed to maintain a safe environment. The facility failed to provide a safe environment for R37 when staff placed duct tape between the seams of the carpeting in his room. This placed the resident at risk of preventable accidents and an unhomelike environment.	F 584		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: The facility had a census of 59 residents. The sample included 17 residents. Based on observation, interview, and record review, the facility failed to ensure Resident (R) 11 and R18 remained free of neglect and abuse. This deficient practice placed R11 and R18 at risk for	F 600		

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injury and impaired physical and psychological well-being due to abuse, neglect, and/or mistreatment.

Findings included:

- R11's Electronic Medical Record (EMR) had diagnoses of cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), chronic obstructive pulmonary disease (COPD-progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain) of the right and left shoulders, chronic kidney disease, congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), major depressive disorder (major mood disorder which causes persistent feelings pf sadness), fibromyalgia (condition of musculoskeletal pain, spasms, stiffness, fatigue and severe sleep disturbance), rheumatoid arthritis (chronic inflammatory disease that affected joints and other organ systems), dementia (progressive mental disorder characterized by failing memory, confusion), type two diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), unsteadiness on feet, bipolar disorder (major mental illness that caused people to have episodes of severe high and low moods), and a need for assistance with personal cares.

The "Quarterly Minimum Data Set" (MDS), dated 02/08/24, documented that R11 had intact

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cognition and no behavioral symptoms. R11 had a functional range of motion impairment of one side upper extremity, used a walker and a wheelchair, and required partial to moderate assistance with toileting, upper body dressing, and personal hygiene. The MDS further documented that R11 required substantial/maximal assistance with chair, bed, and toilet transfers. R11 had occasional incontinence of urine and was always continent of the bowel.

The "Functional Activities of Daily Living Care Area Assessment" (CAA), dated 08/16/23, documented R11 had deconditioned and was at risk for further decline in activities of daily living (ADL), falls, contractures (abnormal permanent fixation of a joint or muscle), isolation, 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), and incontinence.

R11's "Care Plan," dated 02/14/24, documented R11 needed assistance with ADLs and directed staff to provide substantial maximal assistance with toileting hygiene and partial moderate assistance with upper body dressing and toilet transfers.

The "Resident/Family Concern/Grievance Form" documented that the date of the concern was 01/16/24. The nature of concern documented R11 used the call light around 11:00 PM when she was in the bathroom without a shirt or pants on. She waited for assistance until almost midnight, then used her cell phone to call a family member to report her call light had not been

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answered. R11's family member reported they called the facility, but the call was not answered. The form documented Certified Nurse Aide (CNA) P was rude and being "snotty" and threw a shirt at R11 then left without helping the resident at all. The form further documented that Administrative Nurse D educated staff on 01/25/24 regarding answering the phones and staff attitude; CNA P would not assist R11, and another CNA would take care of R11. Staff were counseled.

On 02/27/24 at 12:10 PM, observation revealed R11 ate lunch in her room while she sat in her recliner.

On 02/28/24 at 09:13 AM, R11 reported she had been in the bathroom (unsure of the specific date) with the call light for approximately one hour when Certified Nurse Aide (CNA) P had been very rude to her and threw a shirt at her and left the room without assisting the resident. R11 stated she needed assistance due to shoulder pain. R11 stated she was not fearful of staff.

On 02/28/24 at 01:44 PM Administrative Nurse D stated she received the grievance on 01/16/24 and discussed the incident with the Interdisciplinary Team (IDT) but had not interviewed R11. Administrative Nurse D reported she instructed CNA P not to work with R11 due to their personality differences. Administrative Nurse D verified they did not get statements from the staff working the night of the incident or do any further investigation of the incident Administrative Staff A and Administrative Nurse D verified it was an incomplete investigation and confirmed the allegation listed on the concern form was not reported to the State Agency.

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The facility's "Freedom from Abuse, Neglect, and Exploitation Policy and Procedure", dated 11/06/17, documented to ensure the proper management of conduct between residents and the staff to facilitate the resident's right to be free from abuse, neglect, and misappropriation of resident's property, and to provide for the safety and dignity of all its residents by implementing proper procedures for enforcing the resident's right to be free from abuse, neglect, and misappropriation of resident property, and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.

The facility failed to ensure R11 remained free from neglect and abuse when staff failed to provide the necessary care and services required by R11 and threw a shirt at her. This placed the resident at risk for continued neglect and abuse.

- The Electronic Medical Record (EMR) for R18 documented diagnoses of dementia (progressive mental disorder characterized by failing memory, and confusion) without behavioral disturbance, depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), edema (swelling), chronic obstructive pulmonary disease (COPD-a group of lung diseases that block airflow and make it difficult to breath), and chronic kidney disease (the kidneys have mild to moderate damage).

The "Annual Minimum Data Set" (MDS), dated 05/17/23, documented R18 had severely impaired cognition. R18 required extensive

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assistance from two staff for transfers, toileting, dressing, personal hygiene, and bed mobility. R18 had lower functional impairment on both sides, unsteady balance, and did not ambulate.

The "Quarterly MDS," dated 02/22/24, documented R18 had severely impaired cognition. R18 was dependent on staff for transfers, toileting, dressing, and personal hygiene, and required substantial/maximum assistance for bed mobility. The MDS further documented that R18 had upper and lower functional impairment on both sides and did not ambulate.

R18's "Care Plan," dated 02/21/24, initiated on 04/15/21, directed staff to use a Hoyer (total body mechanical lift) and two staff for transfers. The plan directed R18 had fragile skin, staff were to educate her caregivers on causative factors and measures to prevent skin injury.

The "Weekly Wound Observation Tool," dated 01/28/24, documented a raised area of discoloration across the entire width of R18's chest including over her right breast, which measured approximately seven centimeters (cm) x 7.5 cm.

The "Nurse's Note," dated 01/29/24 at 04:36 PM, documented a large, raised hematoma (collection of blood trapped in the tissues of the skin or in an organ, resulting from trauma) was noted to R18's right chest area approximately 10 cm in diameter. There was some greenish-yellow resolution to the bruising around the hematoma. R18 also had dark purple bruising to the underside of her right breast extending into her sternum (the long flat bone located in the central part of the chest) and

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downward towards her diaphragm (the muscle that separates the chest cavity from the abdomen) across the whole girth of R18. The note further documented the injury was possibly consistent with a gait belt (an assistive device used to help safely transfer someone from a sitting to a standing position) used during transfers, and staff were educated on the proper transfer technique for this resident to prevent injury.

R18's EMR lacked documentation that an investigation was completed related to the bruising's origin, or to the use of a gait belt on a resident who required a Hoyer lift.

The "Nurse's Note," dated 01/30/24 at 09:50 AM, documented R18 had bruising to her chest under her breast, likely from the use of a gait belt. Staff were educated on proper technique and would monitor the bruise until healed and update the physician as needed.

The "Weekly Skin Check," dated 02/07/24, documented the bruising to R18's chest and upper abdomen continued to show improvement.

R18's EMR lacked documentation that an investigation was completed related to the bruising's origin, or to the use of a gait belt on a resident who required a Hoyer lift.

On 02/28/24 at 08:47 AM, observation revealed R18 sat in a Broda chair (specialized wheelchair with the ability to tilt and recline). Certified Nurse Aide (CNA) M lifted R18's sweatshirt to display where the bruising was and that the bruising had resolved. CNA M stated she was unsure how R18 received the large bruise but said she thought

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someone transferred R18 with a gait belt. CNA M and CNA N placed a blue sling under the resident, attached it to the Hoyer lift, raised R18 into the air, and transferred R18 to her bed. Further observation revealed CNA M rolled R18 to her right side to remove the sling. CNA M told R18 she was going to check to see if the resident's incontinence brief was wet. CNA M pulled down R18's pants. Continued observation revealed a dark purple bruise on R18's right hand, multiple bruised areas of varying colors on her left leg, and a large wet area on the back of her sweatshirt from ointment that had been administered to a reddened area on her back. CNA M and CNA M placed a dry brief on R18, and covered her up, but did not change the wet, soiled shirt.

On 02/28/24 at 9:33 AM, Licensed Nurse (LN) G stated that the staff thought the bruised area was from an improper transfer with a gait belt. LN G said R18 always required a lift transfer and LN G did not know about the bruises on R18's leg and hand.

On 02/28/24 at 03:30 PM, Administrative Nurse D stated the facility did not complete an investigation, nor report to the State Agency, about the large, bruised area on R18. Administrative Nurse D said she thought that an agency staff transferred R18 with a gait belt instead of the Hoyer. Administrative Nurse D also stated she was unable to find documentation that education regarding safe, appropriate transfers was provided to the staff.

The facility's "Residents Right to Freedom from Abuse, Neglect, and Exploitation" policy, undated, documented the facility should develop and

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(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 600	Continued From page 13 implement written policies and procedures that prohibit and prevent abuse, neglect, and exploitation of residents and establish policies and procedures to investigate any such allegations, Training must include education on those activities which constitute abuse and neglect, procedures for reporting relevant incidents, dementia management, and resident abuse prevention. The facility must prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. The facility must report the results of all investigations to the administrator or his or her designated representative and other officials in accordance with State law, within five working days of the incident. The facility failed to ensure R18 remained free from abuse and/or neglect when staff failed to provide the necessary care and services during a transfer which caused injury. This placed the resident at risk for further injury and unidentified abuse and neglect.	F 600		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if	F 609		

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the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 59 residents. The sample included 17 residents. Based on observation, interview, and record review, the facility failed to report to the State Agency (SA) allegations of verbal and physical abuse and neglect for Resident (R) 11 and R18. This placed the residents at risk for ongoing abuse, neglect and mistreatment.

Findings included:

- R11's Electronic Medical Record (EMR) had diagnoses of cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), chronic obstructive pulmonary disease (COPD-progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), osteoarthritis (degenerative changes to one or many joints

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characterized by swelling and pain) of the right and left shoulders, chronic kidney disease, congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), major depressive disorder (major mood disorder which causes persistent feelings pf sadness), fibromyalgia (condition of musculoskeletal pain, spasms, stiffness, fatigue and severe sleep disturbance), rheumatoid arthritis (chronic inflammatory disease that affected joints and other organ systems), dementia (progressive mental disorder characterized by failing memory, confusion), type two diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), unsteadiness on feet, bipolar disorder (major mental illness that caused people to have episodes of severe high and low moods), and a need for assistance with personal cares.

The "Quarterly Minimum Data Set" (MDS), dated 02/08/24, documented that R11 had intact cognition and no behavioral symptoms. R11 had a functional range of motion impairment of one side upper extremity, used a walker and a wheelchair, and required partial to moderate assistance with toileting, upper body dressing, and personal hygiene. The MDS further documented that R11 required substantial/maximal assistance with chair, bed, and toilet transfers. R11 had occasional incontinence of urine and was always continent of the bowel.

The "Functional Activities of Daily Living Care Area Assessment" (CAA), dated 08/16/23, documented R11 had deconditioned and was at risk for further decline in activities of daily living

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(ADL), falls, contractures (abnormal permanent fixation of a joint or muscle), isolation, 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), and incontinence.

R11's "Care Plan," dated 02/14/24, documented R11 needed assistance with ADLs and directed staff to provide substantial maximal assistance with toileting hygiene and partial moderate assistance with upper body dressing and toilet transfers.

The "Resident/Family Concern/Grievance Form" documented that the date of the concern was 01/16/24. The nature of concern documented R11 used the call light around 11:00 PM when she was in the bathroom without a shirt or pants on. She waited for assistance until almost midnight, then used her cell phone to call a family member to report her call light had not been answered. R11's family member reported they called the facility, but the call was not answered. The form documented Certified Nurse Aide (CNA) P was rude and being "snotty" and threw a shirt at R11 then left without helping the resident at all. The form further documented that Administrative Nurse D educated staff on 01/25/24 regarding answering the phones and staff attitude; CNA P would not assist R11, and another CNA would take care of R11. Staff were counseled.

On 02/27/24 at 12:10 PM, observation revealed R11 ate lunch in her room while she sat in her recliner.

On 02/28/24 at 09:13 AM, R11 reported she had

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been in the bathroom (unsure of the specific date) with the call light for approximately one hour when Certified Nurse Aide (CNA) P had been very rude to her and threw a shirt at her and left the room without assisting the resident. R11 stated she needed assistance due to shoulder pain. R11 stated she was not fearful of staff.

On 02/28/24 at 01:44 PM Administrative Nurse D stated she received the grievance on 01/16/24 and discussed the incident with the Interdisciplinary Team (IDT) but had not interviewed R11. Administrative Nurse D reported she instructed CNA P not to work with R11 due to their personality differences. Administrative Nurse D verified they did not get statements from the staff working the night of the incident or do any further investigation of the incident Administrative Staff A and Administrative Nurse D verified it was an incomplete investigation and confirmed the allegation listed on the concern form was not reported to the State Agency.

The facility's "Freedom from Abuse, Neglect, and Exploitation Policy and Procedure", dated 11/06/17, documented to ensure the proper management of conduct between residents and the staff to facilitate the resident's right to be free from abuse, neglect, and misappropriation of resident's property, and to provide for the safety and dignity of all its residents by implementing proper procedures for enforcing the resident's right to be free from abuse, neglect, and misappropriation of resident property, and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical

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symptoms.

The facility failed to report R11's allegations of abuse, neglect and mistreatment to the SA as required. This placed the residents at risk for ongoing abuse, neglect and mistreatment.

- The Electronic Medical Record (EMR) for R18 documented diagnoses of dementia (progressive mental disorder characterized by failing memory, and confusion) without behavioral disturbance, depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), edema (swelling), chronic obstructive pulmonary disease (COPD-a group of lung diseases that block airflow and make it difficult to breath), and chronic kidney disease (the kidneys have mild to moderate damage).

The "Annual Minimum Data Set" (MDS), dated 05/17/23, documented R18 had severely impaired cognition. R18 required extensive assistance from two staff for transfers, toileting, dressing, personal hygiene, and bed mobility. R18 had lower functional impairment on both sides, unsteady balance, and did not ambulate.

The "Quarterly MDS," dated 02/22/24, documented R18 had severely impaired cognition. R18 was dependent on staff for transfers, toileting, dressing, and personal hygiene, and required substantial/maximum assistance for bed mobility. The MDS further documented that R18 had upper and lower functional impairment on both sides and did not ambulate.

R18's "Care Plan," dated 02/21/24, initiated on

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04/15/21, directed staff to use a Hoyer (total body mechanical lift) and two staff for transfers. The plan directed R18 had fragile skin, staff were to educate her caregivers on causative factors and measures to prevent skin injury.

The "Weekly Wound Observation Tool," dated 01/28/24, documented a raised area of discoloration across the entire width of R18's chest including over her right breast, which measured approximately seven centimeters (cm) x 7.5 cm.

The "Nurse's Note," dated 01/29/24 at 04:36 PM, documented a large, raised hematoma (collection of blood trapped in the tissues of the skin or in an organ, resulting from trauma) was noted to R18's right chest area approximately 10 cm in diameter. There was some greenish-yellow resolution to the bruising around the hematoma. R18 also had dark purple bruising to the underside of her right breast extending into her sternum (the long flat bone located in the central part of the chest) and downward towards her diaphragm (the muscle that separates the chest cavity from the abdomen) across the whole girth of R18. The note further documented the injury was possibly consistent with a gait belt (an assistive device used to help safely transfer someone from a sitting to a standing position) used during transfers, and staff were educated on the proper transfer technique for this resident to prevent injury.

R18's EMR lacked documentation that an investigation was completed related to the bruising's origin, or to the use of a gait belt on a resident who required a Hoyer lift.

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The "Nurse's Note," dated 01/30/24 at 09:50 AM, documented R18 had bruising to her chest under her breast, likely from the use of a gait belt. Staff were educated on proper technique and would monitor the bruise until healed and update the physician as needed.

The "Weekly Skin Check," dated 02/07/24, documented the bruising to R18's chest and upper abdomen continued to show improvement.

R18's EMR lacked documentation that an investigation was completed related to the bruising's origin, or to the use of a gait belt on a resident who required a Hoyer lift.

On 02/28/24 at 08:47 AM, observation revealed R18 sat in a Broda chair (specialized wheelchair with the ability to tilt and recline). Certified Nurse Aide (CNA) M lifted R18's sweatshirt to display where the bruising was and that the bruising had resolved. CNA M stated she was unsure how R18 received the large bruise but said she thought someone transferred R18 with a gait belt. CNA M and CNA N placed a blue sling under the resident, attached it to the Hoyer lift, raised R18 into the air, and transferred R18 to her bed. Further observation revealed CNA M rolled R18 to her right side to remove the sling. CNA M told R18 she was going to check to see if the resident's incontinence brief was wet. CNA M pulled down R18's pants. Continued observation revealed a dark purple bruise on R18's right hand, multiple bruised areas of varying colors on her left leg, and a large wet area on the back of her sweatshirt from ointment that had been administered to a reddened area on her back. CNA M and CNA M placed a dry brief on R18, and covered her up, but did not change the wet,

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soiled shirt.

On 02/28/24 at 9:33 AM, Licensed Nurse (LN) G stated that the staff thought the bruised area was from an improper transfer with a gait belt. LN G said R18 always required a lift transfer and LN G did not know about the bruises on R18's leg and hand.

On 02/28/24 at 03:30 PM, Administrative Nurse D stated the facility did not complete an investigation, nor report to the State Agency, about the large, bruised area on R18. Administrative Nurse D said she thought that an agency staff transferred R18 with a gait belt instead of the Hoyer. Administrative Nurse D also stated she was unable to find documentation that education regarding safe, appropriate transfers was provided to the staff.

The facility's "Residents Right to Freedom from Abuse, Neglect, and Exploitation" policy, undated, documented the facility should develop and implement written policies and procedures that prohibit and prevent abuse, neglect, and exploitation of residents and establish policies and procedures to investigate any such allegations, Training must include education on those activities which constitute abuse and neglect, procedures for reporting relevant incidents, dementia management, and resident abuse prevention. The facility must prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. The facility must report the results of all investigations to the administrator or his or her designated representative and other officials in accordance with State law, within five working days of the incident.

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F 609	Continued From page 22 The facility failed to identify an injury of unknown origin as an allegation of potential abuse or report to the SA as required. This placed the resident at risk for unidentified abuse or mistreatment.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: The facility had a census of 59 residents. The sample included 17 residents. Based on observation, interview, and record review, the facility failed to fully investigate allegations of abuse, neglect and injuries of unknown origin for Resident (R) 11 and R18. This placed the residents at risk of ongoing abuse, neglect and mistreatment. Findings included:	F 610		

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- R11's Electronic Medical Record (EMR) had diagnoses of cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), chronic obstructive pulmonary disease (COPD-progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain) of the right and left shoulders, chronic kidney disease, congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), major depressive disorder (major mood disorder which causes persistent feelings pf sadness), fibromyalgia (condition of musculoskeletal pain, spasms, stiffness, fatigue and severe sleep disturbance), rheumatoid arthritis (chronic inflammatory disease that affected joints and other organ systems), dementia (progressive mental disorder characterized by failing memory, confusion), type two diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), unsteadiness on feet, bipolar disorder (major mental illness that caused people to have episodes of severe high and low moods), and a need for assistance with personal cares.

The "Quarterly Minimum Data Set" (MDS), dated 02/08/24, documented that R11 had intact cognition and no behavioral symptoms. R11 had a functional range of motion impairment of one side upper extremity, used a walker and a wheelchair, and required partial to moderate assistance with toileting, upper body dressing,

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and personal hygiene. The MDS further documented that R11 required substantial/maximal assistance with chair, bed, and toilet transfers. R11 had occasional incontinence of urine and was always continent of the bowel.

The "Functional Activities of Daily Living Care Area Assessment" (CAA), dated 08/16/23, documented R11 had deconditioned and was at risk for further decline in activities of daily living (ADL), falls, contractures (abnormal permanent fixation of a joint or muscle), isolation, 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), and incontinence.

R11's "Care Plan," dated 02/14/24, documented R11 needed assistance with ADLs and directed staff to provide substantial maximal assistance with toileting hygiene and partial moderate assistance with upper body dressing and toilet transfers.

The "Resident/Family Concern/Grievance Form" documented that the date of the concern was 01/16/24. The nature of concern documented R11 used the call light around 11:00 PM when she was in the bathroom without a shirt or pants on. She waited for assistance until almost midnight, then used her cell phone to call a family member to report her call light had not been answered. R11's family member reported they called the facility, but the call was not answered. The form documented Certified Nurse Aide (CNA) P was rude and being "snotty" and threw a shirt at R11 then left without helping the resident at all.

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The form further documented that Administrative Nurse D educated staff on 01/25/24 regarding answering the phones and staff attitude; CNA P would not assist R11, and another CNA would take care of R11. Staff were counseled.

On 02/27/24 at 12:10 PM, observation revealed R11 ate lunch in her room while she sat in her recliner.

On 02/28/24 at 09:13 AM, R11 reported she had been in the bathroom (unsure of the specific date) with the call light for approximately one hour when Certified Nurse Aide (CNA) P had been very rude to her and threw a shirt at her and left the room without assisting the resident. R11 stated she needed assistance due to shoulder pain. R11 stated she was not fearful of staff.

On 02/28/24 at 01:44 PM Administrative Nurse D stated she received the grievance on 01/16/24 and discussed the incident with the Interdisciplinary Team (IDT) but had not interviewed R11. Administrative Nurse D reported she instructed CNA P not to work with R11 due to their personality differences. Administrative Nurse D verified they did not get statements from the staff working the night of the incident or do any further investigation of the incident Administrative Staff A and Administrative Nurse D verified it was an incomplete investigation and confirmed the allegation listed on the concern form was not reported to the State Agency.

The facility's "Freedom from Abuse, Neglect, and Exploitation Policy and Procedure", dated 11/06/17, documented to ensure the proper management of conduct between residents and

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the staff to facilitate the resident's right to be free from abuse, neglect, and misappropriation of resident's property, and to provide for the safety and dignity of all its residents by implementing proper procedures for enforcing the resident's right to be free from abuse, neglect, and misappropriation of resident property, and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.

The facility failed to investigate R11's allegation of abuse and neglect which placed the resident at risk of ongoing abuse and neglect.

- The Electronic Medical Record (EMR) for R18 documented diagnoses of dementia (progressive mental disorder characterized by failing memory, and confusion) without behavioral disturbance, depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), edema (swelling), chronic obstructive pulmonary disease (COPD-a group of lung diseases that block airflow and make it difficult to breath), and chronic kidney disease (the kidneys have mild to moderate damage).

The "Annual Minimum Data Set" (MDS), dated 05/17/23, documented R18 had severely impaired cognition. R18 required extensive assistance from two staff for transfers, toileting, dressing, personal hygiene, and bed mobility. R18 had lower functional impairment on both sides, unsteady balance, and did not ambulate.

The "Quarterly MDS," dated 02/22/24, documented R18 had severely impaired

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cognition. R18 was dependent on staff for transfers, toileting, dressing, and personal hygiene, and required substantial/maximum assistance for bed mobility. The MDS further documented that R18 had upper and lower functional impairment on both sides and did not ambulate.

R18's "Care Plan," dated 02/21/24, initiated on 04/15/21, directed staff to use a Hoyer (total body mechanical lift) and two staff for transfers. The plan directed R18 had fragile skin, staff were to educate her caregivers on causative factors and measures to prevent skin injury.

The "Weekly Wound Observation Tool," dated 01/28/24, documented a raised area of discoloration across the entire width of R18's chest including over her right breast, which measured approximately seven centimeters (cm) x 7.5 cm.

The "Nurse's Note," dated 01/29/24 at 04:36 PM, documented a large, raised hematoma (collection of blood trapped in the tissues of the skin or in an organ, resulting from trauma) was noted to R18's right chest area approximately 10 cm in diameter. There was some greenish-yellow resolution to the bruising around the hematoma. R18 also had dark purple bruising to the underside of her right breast extending into her sternum (the long flat bone located in the central part of the chest) and downward towards her diaphragm (the muscle that separates the chest cavity from the abdomen) across the whole girth of R18. The note further documented the injury was possibly consistent with a gait belt (an assistive device used to help safely transfer someone from a sitting to a standing position) used during

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transfers, and staff were educated on the proper transfer technique for this resident to prevent injury.

R18's EMR lacked documentation that an investigation was completed related to the bruising's origin, or to the use of a gait belt on a resident who required a Hoyer lift.

The "Nurse's Note," dated 01/30/24 at 09:50 AM, documented R18 had bruising to her chest under her breast, likely from the use of a gait belt. Staff were educated on proper technique and would monitor the bruise until healed and update the physician as needed.

The "Weekly Skin Check," dated 02/07/24, documented the bruising to R18's chest and upper abdomen continued to show improvement.

R18's EMR lacked documentation that an investigation was completed related to the bruising's origin, or to the use of a gait belt on a resident who required a Hoyer lift.

On 02/28/24 at 08:47 AM, observation revealed R18 sat in a Broda chair (specialized wheelchair with the ability to tilt and recline). Certified Nurse Aide (CNA) M lifted R18's sweatshirt to display where the bruising was and that the bruising had resolved. CNA M stated she was unsure how R18 received the large bruise but said she thought someone transferred R18 with a gait belt. CNA M and CNA N placed a blue sling under the resident, attached it to the Hoyer lift, raised R18 into the air, and transferred R18 to her bed. Further observation revealed CNA M rolled R18 to her right side to remove the sling. CNA M told R18 she was going to check to see if the

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resident's incontinence brief was wet. CNA M pulled down R18's pants. Continued observation revealed a dark purple bruise on R18's right hand, multiple bruised areas of varying colors on her left leg, and a large wet area on the back of her sweatshirt from ointment that had been administered to a reddened area on her back. CNA M and CNA M placed a dry brief on R18, and covered her up, but did not change the wet, soiled shirt.

On 02/28/24 at 9:33 AM, Licensed Nurse (LN) G stated that the staff thought the bruised area was from an improper transfer with a gait belt. LN G said R18 always required a lift transfer and LN G did not know about the bruises on R18's leg and hand.

On 02/28/24 at 03:30 PM, Administrative Nurse D stated the facility did not complete an investigation, nor report to the State Agency, about the large, bruised area on R18. Administrative Nurse D said she thought that an agency staff transferred R18 with a gait belt instead of the Hoyer. Administrative Nurse D also stated she was unable to find documentation that education regarding safe, appropriate transfers was provided to the staff.

The facility's "Residents Right to Freedom from Abuse, Neglect, and Exploitation" policy, undated, documented the facility should develop and implement written policies and procedures that prohibit and prevent abuse, neglect, and exploitation of residents and establish policies and procedures to investigate any such allegations, Training must include education on those activities which constitute abuse and neglect, procedures for reporting relevant

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F 610	Continued From page 30 incidents, dementia management, and resident abuse prevention. The facility must prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. The facility must report the results of all investigations to the administrator or his or her designated representative and other officials in accordance with State law, within five working days of the incident. The facility failed to investigate the origin of a large bruise on R18's chest, in order to rule out abuse and/or neglect. This placed the resident at risk for unidentified abuse, neglect or mistreatment.	F 610		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).	F 656		

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F 656	Continued From page 31 (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: The facility had a census of 59 residents. The sample included 17 residents. Based on observation, record review, and interview, the facility failed to develop a comprehensive care plan for Resident (R) 55 who had an indwelling urinary catheter (tube placed in the bladder to drain urine into a collection bag) and use of psychotropic (alters mood or thought) medication, and for R17 and R20's indwelling urinary catheter. This placed the residents at risk for impaired care due to uncommunicated care needs.	F 656		

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Findings included:

- R55's Electronic Medical Record (EMR) documented diagnoses of type two diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), post hemorrhagic (loss of a large amount of blood in a short period of time) anemia (inadequate number of healthy red blood cells to carry adequate oxygen to body tissues), muscle weakness, heart failure, dementia (progressive mental disorder characterized by failing memory, confusion), age related cognitive decline, pain, and the need of assistance with personal cares.

The "Quarterly Minimum Data Set" (MDS), dated 01/24/24, documented R55 had intact cognition and verbal behavioral symptoms directed toward others which occurred one to three days of the observation period. R55 had had functional range of motion to one side upper extremity and both lower extremities and required partial/moderate assistance with toileting and dressing. The MDS further documented R55 had an indwelling catheter and was occasionally incontinent of bowel. R55 received scheduled pain medication, insulin (a hormone that lowers the level of glucose in the blood), and high-risk medication of a hypnotic (a class of medications used to induce sleep) class.

The "Urinary Incontinence and Indwelling Catheter Care Area Assessment" (CAA), dated 10/31/23, documented R55 had an indwelling urinary catheter. R55 received diuretic (medication to promote the formation and excretion of urine) therapy and required assistance with toilet transfers and hygiene.

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The "Dehydration Fluid Maintenance CAA", dated 10/31/23, documented the CAA triggered due to admission diagnoses of pneumonia (inflammation of the lungs) and urinary tract infection (UTI).

The "Psychotropic Drug Use CAA" did not trigger further information.

R55's "Care Plan" dated 02/07/24 lacked interventions or direction related to R55's indwelling catheter and psychotropic medication use.

The "Physician Order" dated 10/25/25 directed staff to change the indwelling catheter every 30 days.

The "Physician Order" dated 10/25/23, directed staff to administer alprazolam 0.25 milligrams (mg) every eight hours as needed (PRN) for anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). The order lacked a stop date.

The "Physician Order", dated 12/12/23, directed staff to administer alprazolam 0.25 mg twice a day for anxiety.

The "Physician Order" dated 01/22/24 directed staff to anchor the catheter tubing to prevent injury, provide catheter care, and measure output every shift.

R55's clinical record revealed R55 received antibiotics to treat a UTI on 12/15/23, 12/29/23, and 01/30/24.

R55's EMR revealed that alprazolam was

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administered nine times in the month of December 2023, four times in January 2024, and once in February 2024.

The "Progress Note" dated 01/30/24 at 07:40 AM documented staff initiated a standing order to collect a urine analysis (UA) for a suspected UTI due to R55 had increased confusion, behaviors, and a general complaint of not feeling well.

The "Progress Note" dated 02/20/24 at 10:09 AM, documented the Interdisciplinary Team (IDT) met to discuss and review the resident's indwelling catheter, and the care plan was reviewed; the facility would continue the current plan of care.

R55's clinical record revealed R55 received antibiotics to treat a UTI on 12/15/23, 12/29/23, and 01/30/24.

R55's EMR revealed that alprazolam was administered nine times in the month of December 2023, four times in January 2024, and once in February 2024.

On 02/28/24 at 12:00 PM, observation revealed staff brought R55 to the dining room with the catheter drainage bag and tubing dragging on the floor under the wheelchair.

On 02/28/24 at 07:45 AM, observation revealed R55 in bed which was low to the floor; the catheter drainage bag rested on the floor mat next to the bed.

On 02/28/24 at 08:01 AM, Licensed Nurse (LN) H verified the catheter bag and tubing should not touch the floor. LN H said they did not think R55 was prone to UTIs. LN H also verified the care

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plan lacked information related to R55's catheter or psychotropic medication use.

On 02/28/24 at 01:30 PM, Administrative Nurse D verified the PRN alprazolam and indwelling catheter use should be included in R55's care plan.

The facility's "Comprehensive Care Plans", dated 02/01/20, documented it was the facility's policy to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that include measurable objective and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that identified in the resident's comprehensive assessment. The comprehensive care plan will be reviewed and revised by the IDT team after each comprehensive and quarterly assessment.

The facility failed to complete a comprehensive care plan related to R55's indwelling urinary catheter and use of psychotropic medication placing the resident at risk for impaired care due to uncommunicated care needs.

- R17's Electronic Medical Record (EMR) included diagnoses of a personal history of urinary tract infections (UTI), chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), neuralgia (intermittent along the course of a nerve) and neuritis (inflammation of nerves causing pain), unspecified disorders of the bladder, type two diabetes mellitus (DM-when the body cannot use glucose, not enough insulin

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made or the body cannot respond to the insulin), chronic respiratory failure with hypoxia (inadequate supply of oxygen), benign prostatic hyperplasia (BPH-non-cancerous enlargement of the prostate which can lead to interference with urine flow, urinary frequency, and urinary tract infections) with lower urinary tract symptoms, low back pain, unspecified cirrhosis (chronic degenerative disease of the liver), obesity (excessive body fat) and a need for assistance with personal cares.

The "Quarterly Minimum Data Set" (MDS), dated 01/03/24, documented R17 had intact cognition. R17 had a functional range of motion impairment of both lower extremities and was dependent on staff for toileting, bathing, dressing of the lower and upper body, personal hygiene, and transfers. The MDS further documented R17 had an indwelling urinary catheter (tube placed in the bladder to drain urine into a collection bag) and was frequently incontinent of bowel. R17 had macerated (softening and breaking down of skin as a result of prolonged exposure to moisture, such as sweat, urine, feces, or wounds for extended periods) associated skin damage. R17 had shortness of breath with exertion, sitting, resting, and lying flat. The MDS further documented R17 received medication for pain, an antidepressant (a class of medications used to treat mood disorders), a hypnotic (a class of medications used to induce sleep), a diuretic (medication to promote the formation and excretion of urine) and used oxygen during the observation period.

The "Urinary Incontinence and Indwelling Catheter Care Area Assessment" (CAA), dated 06/01/23, documented R17 was frequently

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incontinent of urine, required extensive assistance with toileting, and was at risk for skin rashes, breakdown, falls, isolation, and UTIs. The CAA further documented the resident was working with physical and occupational therapies.

R17's "Care Plan" dated 02/08/24, lacked indwelling catheter use and directions for care.

The "Physician Order" dated 01/25/24 directed staff to change the catheter as needed (PRN).

R17's clinical record revealed R17 was treated for a UTI on 10/20/23, 11/05/23, 11/15/23, and 01/26/23.

On 02/27/24 at 01:47 PM, observation revealed R17 lay in bed and watched TV. The indwelling catheter drainage bag hung on the bedframe at the foot of the bed, without a privacy bag.

On 02/28/24 at 07:39 AM, observation revealed R17 lying on his back in the bed. His catheter drainage bag lay directly on the floor, not attached to the bed. Licensed Nurse (LN) H stated the catheter bag should not be lying on the floor and confirmed R17 had a history of UTIs. LN H drained the catheter bag and hooked it to the frame of the bed.

On 02/28/24 at 09:24 AM, Administrative Nurse E reported the Interdisciplinary Team (IDT), and nurses were responsible for updating the care plans. Administrative Nurse E verified R17's indwelling urinary should have been care planned.

On 02/28/24 at 01:30 PM, Administrative Nurse D verified the indwelling catheter use should be

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included in R17's care plan.

The facility's "Comprehensive Care Plans", dated 02/01/20, documented it was the facility's policy to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that include measurable objective and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that identified in the resident's comprehensive assessment. The comprehensive care plan will be reviewed and revised by the IDT team after each comprehensive and quarterly assessment.

The facility failed to complete a comprehensive care plan related to R17's indwelling urinary catheter placing the resident at risk for impaired care due to uncommunicated care needs.

- R20 's Electronic Medical Record documented diagnoses of cerebral palsy (a progressive disorder of movement, muscle tone, or posture caused by injury or abnormal development in the immature brain, most often before birth), neuromuscular dysfunction of bladder (dysfunction of the urinary bladder caused by a lesion of the nervous system), anxiety disorder (mental or emotional disorder characterized by apprehension, uncertainty and irrational fear), depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and insomnia (inability to sleep).

The "Quarterly Minimum Data Set" (MDS), dated 01/25/24, documented a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS documented R20 had no behaviors and received an antianxiety (a class

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of medications that calm and relax people), an antidepressant (a class of medications used to treat mood disorders), and a hypnotic (a class of medications used to induce sleep) medication. The MDS documented R20 was independent with eating and required moderate staff assistance with dressing and bed mobility. R20 was dependent on staff for toileting and transfers.

R20's "Care Plan," dated 02/07/24, lacked urinary catheter (a tube inserted into the bladder to drain the urine into a collection bag) interventions.

The "Physician Order," dated 10/15/23, directed staff to change the suprapubic catheter (urinary bladder catheter inserted through the abdomen into the bladder) every month.

The "Physician Order," dated 10/24/23, directed staff to flush the suprapubic catheter twice a week with 100 cubic centimeters (cc) of normal saline during the night shift every Tuesday and Friday.

The "Physician Order," dated 11/20/23, directed staff to cleanse the suprapubic site and cover it with a drain gauze dressing and tape daily at bedtime.

The "Physician Order," dated 01/22/24, directed staff to anchor the catheter tubing to prevent injury and provide catheter care every shift.

The "Physician Order," dated 01/23/24, directed staff to document catheter output every shift.

On 02/28/24 at 09:45 AM, observation revealed R20 lay in bed while Administrative Nurse E performed wound care. She ensured the catheter

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F 656	Continued From page 40 tubing was not "pinned" under the brief but did not ensure an anchor was present to prevent pulling or displacement of the catheter. On 02/29/24 at 07:55 AM, Administrative Nurse D verified staff should have ensured an anchor for the tubing was in place and said it should have been on R20's "Care Plan" so the nurse aides were aware of R20's needs. The facility's "Comprehensive Care Plans", dated 02/01/20, documented it was the facility's policy to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that include measurable objective and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that identified in the resident's comprehensive assessment. The comprehensive care plan will be reviewed and revised by the IDT team after each comprehensive and quarterly assessment. The facility failed to develop a care plan for R20's indwelling catheter. This placed the resident at risk for impaired care due to uncommunicated care needs.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician.	F 657		

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(B) A registered nurse with responsibility for the resident.
(C) A nurse aide with responsibility for the resident.
(D) A member of food and nutrition services staff.
(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.
(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.
(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 59 residents. The sample included 17 residents. Based on observation, interview, and record review the facility failed to revise Resident (R) 19's "Care Plan" to include interventions related to pressure ulcers (PU-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). This placed the resident at risk for impaired care due to uncommunicated care needs.

Findings included:

- R19's Electronic Medical Record (EMR) documented diagnoses of cerebrovascular accident (CVA-stroke), hemiplegia and hemiparesis ((weakness and paralysis on one

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side of the body), dysphagia (swallowing difficulty), and rheumatoid arthritis (chronic inflammatory disease that affected joints and other organ systems).

The "Quarterly Minimum Data Set" (MDS), dated 12/21/23, documented R19 had a Brief Interview for Mental Status (BIMS) score of zero with short- and long-term memory problems and moderately impaired decision-making skills. The MDS documented R19 had impaired range of motion (ROM) in all four extremities and was dependent on staff for all activities of daily living (ADLs) and mobility. R19 weighed 83 pounds and had one Stage 4 pressure ulcer (a deep pressure wound that reaches the muscles, ligaments, or even bone). R19 had pressure relief interventions to the chair and bed and received PU care.

R19's "Care Plan," dated 01/03/24, directed staff to administer treatments as ordered, monitor for effectiveness, and follow facility policies and protocols for the prevention and treatment of skin breakdown. The plan directed staff to inspect R19's skin weekly to observe for redness, open areas, scratches, cuts, or bruises and report changes to the nurse. The care plan stated R19 had an actual impairment to her skin and directed staff to identify and document potential causative factors and eliminate or resolve them where possible. The plan documented R19's left second toe wound treatment and directed staff to administer medications and treatments as ordered and monitor for effectiveness. A care plan update on 01/24/24 directed staff to place a foot cradle on the bed while R19 was in bed. A care plan update dated 02/06/24 directed staff to ensure an air overlay mattress was on the bed and to see current treatments on the "Treatment

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Administration Record" (TAR).

The "Progress Note," dated 10/17/23 at 06:39 PM, stated upon changing R19's preventative dressings, staff noted an open area to the right second toe along with redness and a scabbed area to the left second toe. Staff notified the wound nurse.

The "APRN Note," dated 11/27/23, stated the pressure ulcer on the toe of R19's right foot was unstageable. The pressure ulcer on the toe of the left foot was a Stage 4. The APRN recommended a foot cradle for R19's bed to keep linens off the feet.

R19's "Medication Administration Record" (MAR) and TAR lacked documentation for the foot cradle.

On 02/28/24 at 09:31 AM, observation revealed Administrative Nurse E used hand sanitizer then donned gloves and performed wound care for R19's right toe PU.

On 02/29/24 at 07:53 AM, Administrative Nurse D verified staff should have immediately care planned the ARNP recommendation for the foot cradle.

On 02/29/24 at 08:02 AM, Administrative Nurse E verified she missed seeing the foot cradle recommendation made on 11/27/23 and had not placed it on the care plan until 01/24/24.

The facility's "Care Plan Revision Upon Status Change" policy, dated 01/01/20, stated the interdisciplinary team would discuss and collaborate on intervention options and the care

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F 657	Continued From page 44 plan would be updated with new or modified interventions. The Unit Manager or other designated staff would communicate care plan interventions to all staff involved in the resident's care. The facility failed to revise R19's "Care Plan" to indicate she had a pressure ulcer and required a foot cradle to keep the covers from pressing down on her feet. This placed the resident at risk for impaired care due to uncommunicated care needs.	F 657		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: The facility had a census of 59 residents. The sample included 17 residents, with four reviewed for activities of daily living (ADLs). Based on observation, record review, and interview, the facility failed to provide consistent bathing for Resident (R) 38. This placed R38 at risk for complications related to poor hygiene. Findings included: - The Electronic Medical Record (EMR) for R38 documented diagnoses of vascular dementia (a progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain) with agitation (feeling of aggravation or restlessness brought on by a provocation or a medical condition),	F 677		

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posttraumatic stress disorder (PTSD- mental disorder characterized by an acute emotional response to a traumatic event or situation involving severe environmental stress), diabetes mellitus (DM-when the body cannot use glucose, not enough sepsis made or the body cannot respond to the insulin), and depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest).

The "Quarterly Minimum Data Set" (MDS), dated 11/09/23, documented that R38 had intact cognition and was independent with all ADLs except for bathing for which R38 required partial to moderate assistance.

The "Annual MDS," dated 02/01/24, documented the same information as the "Quarterly MDS," dated 11/09/23.

R38's "Care Plan," dated 02/07/24, initiated on 06/16/21, directed staff to offer R38 a choice of a whirlpool or shower based on his individualized preference on chosen bath days. The plan documented R38 refused at times and directed staff to notify the nurse if he refused. The care plan further directed staff to check R38's nail length and trim and clean his nails on bath days. The plan directed R38 required assistance from one staff with bathing, and directed staff to provide a sponge bath when a full bath or shower could not be tolerated.

R38's "January 2024 Bathing Report" documented R38 requested two showers per week on Sunday and Wednesday evenings and documented R38 had not received a bath or shower during the following days: 01/04/24-01/28/24 (25 days). R38's EMR lacked

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F 677	Continued From page 46 documentation R38 refused a bath or shower in that time frame. The "February 2024 Bathing Report" documented R38 requested two showers per week on Sunday and Wednesday evenings and documented R38 had not received a bath or shower during the following days: 2/15/24 - 02/28/24 (14 days). R38's EMR lacked documentation R38 refused a bath or shower in that time frame. On 02/28/24 at 08:17 AM, observation revealed R38 wore a stocking cap and a red sweatshirt that had multiple food stains on it. On 02/28/24 at 08:20 AM, Licensed Nurse (LN) G stated if R38 refused showers, the nurse aide informed her, and she talked to the resident. LN G stated if R38 still refused, she documented the refusal in the medical record and offered the bath at another time. On 02/28/24 at 03:30 PM, Administrative Nurse D stated R38 should receive his showers as requested and verified he had not refused any of his showers. The facility's "Bathing a Resident" policy, dated 2017, documented it was the practice of the facility to assist residents with bathing to maintain proper hygiene and help prevent skin issues. The facility failed to provide consistent bathing for R38. This placed the resident at risk for complications from poor hygiene.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25	F 684		

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§ 483.25 Quality of care
Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 59 residents. The sample included 17 residents, with five reviewed for non-pressure skin issues. Based on observation, record review, and interview, the facility failed to provide care and treatment in accordance with professional standards of practice for the care of non-pressure related skin injuries for Resident (R) 18 and R17. This placed the residents at risk for further skin injury and impaired healing.

Findings included:

- The Electronic Medical Record (EMR) for R18 documented diagnoses of dementia (progressive mental disorder characterized by failing memory, and confusion) without behavioral disturbance, depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), edema (swelling), chronic obstructive pulmonary disease (COPD-a group of lung diseases that block airflow and make it difficult to breath), and chronic kidney disease (the kidneys have mild to moderate damage).

The "Annual Minimum Data Set" (MDS), dated 05/17/23, documented R18 had severely

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impaired cognition. R18 required extensive assistance from two staff for transfers, toileting, dressing, personal hygiene, and bed mobility. R18 had lower functional impairment on both sides, unsteady balance, and did not ambulate.

The "Quarterly MDS," dated 02/22/24, documented R18 had severely impaired cognition. R18 was dependent on staff for transfers, toileting, dressing, and personal hygiene, and required substantial/maximum assistance for bed mobility. The MDS further documented R18 had upper and lower functional impairment on both sides and did not ambulate.

R18's "Care Plan," dated 02/21/24, initiated on 04/15/21, directed staff to use a Hoyer (total body mechanical lift) and two staff for transfers. The plan directed R18 had fragile skin, staff were to educate her caregivers on causative factors and measures to prevent skin injury. The care plan further directed staff to observe and assess R18's skin weekly. The plan instructed staff not to massage reddened bony prominence, and to administer medications and treatments as ordered. The plan directed staff to refer R18 to the dietician if any skin concerns and educate caregivers on causative factors and measures to prevent skin injury. The plan directed staff to use a commercial moisture barrier on R18's skin as indicated. The update, dated 09/23/23, directed staff to follow facility policies for the prevention and treatment of skin breakdown, monitor nutritional status; assess, record, and monitor wound healing weekly.

The "Nurse's Note," dated 02/19/24 at 11:17 AM, documented R18 had a reddened, abraded (worn away from friction) area on the bony prominence

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of her back and directed staff to reposition R18 every two hours and as needed to relieve areas of pressure.

The "Weekly Skin Check," dated 02/21/24, documented that the abrasion to R18's back was from a sling (used with the Hoyer lift) and the area continued to worsen.

The "Physician's Order," dated 02/27/24, directed staff to place a sacral (large triangular area between the two hip bones) border dressing (self-adherent, multilayer foam dressing designed to prevent pressure ulcers) to the abrasion on R18's mid-back. The order directed staff to change the dressing every three days and as needed. The dressing was discontinued on 02/27/24.

The "Physician's order," dated 02/27/24, directed staff to administer Diflucan (treats fungal infections), 200 milligrams (mg), by mouth, for three days for R18's back wound.

The "Physician's order," dated 02/27/24, directed staff to administer Keflex (an antibiotic), 500 mg, by mouth, for ten days, for R18's back wound.

The "Physician's order," dated 02/27/24, directed staff to apply DermaSeptin (a skin barrier cream to prevent irritation from moisture and to promote healing with zinc and menthol), twice a day, until healed for R18's back abrasion.

On 02/28/24 at 08:50 AM, observation during personal care revealed a large wet spot on R18's sweatshirt. Underneath the area R18 a reddened area, approximately four inches (in) x four in. in diameter, on her mid-back over her spine.

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Certified Nurse Aide (CNA) M stated R18 got the abrasion on her back from staff leaving the lift sling underneath the resident and the resident was so fragile the sling scraped her skin. CNA M said R18 had ointment that needed to be put on the area on her back which caused the wet spot on her sweatshirt. Further observation revealed multiple bruises of varying color on R18's left leg and a dark purple bruise on her right hand.

On 02/28/24 at 09:33 AM, Licensed Nurse (LN) G stated staff left the sling underneath the resident which caused an abrasion. LN G said facility staff put a dressing on the area, but the resident sweated a lot, and that caused moisture under the dressing which irritated the area and made it a lot worse. LN G further stated that because of the moisture, R18 was prescribed an antibiotic and an antifungal since the area was very red and irritated; it was also decided to leave any dressing off the area because R18's skin was fragile and any type of tape on the dressing could cause her to have open areas on her skin. LN G stated the ointment that staff were supposed to use had zinc and because there was no dressing, the ointment seeped through R18's clothes and made them wet. LN G said staff thought they would place an ABD pad (a highly absorbent dressing that provided padding and protection for large wounds) on the area after they applied the ointment, and it would stick in place without tape.

On 02/28/24 at 03:30 AM, Administrative Nurse D stated staff should not have left the sling underneath the resident as her skin was very fragile. Administrative Nurse D further stated she would talk with the nurse about the bruises on R18's leg and hand and start an investigation.

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The facility's "Unexplained Injuries" policy, dated 10/21/23, documented all unexplained injuries including bruises, abrasions, and injuries of unknown sources would be investigated, and an incident report would be completed. An injury should be classified as an injury of unknown source when both of the following conditions are met, the injury was not observed by any person, or the source of the injury could not be explained.

The facility failed to remove the Hoyer sling from underneath R18 which resulted in a skin abrasion on R18's back. This placed the resident at risk for further skin injury and infection.

- R17's Electronic Medical Record (EMR) included diagnoses of a personal history of urinary tract infections (UTI), chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), neuralgia (intermittent along the course of a nerve) and neuritis (inflammation of nerves causing pain), unspecified disorders of the bladder, type two diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), chronic respiratory failure with hypoxia (inadequate supply of oxygen), benign prostatic hyperplasia (BPH-non-cancerous enlargement of the prostate which can lead to interference with urine flow, urinary frequency, and urinary tract infections) with lower urinary tract symptoms, low back pain, unspecified cirrhosis (chronic degenerative disease of the liver), obesity (excessive body fat) and a need for assistance with personal cares.

The "Quarterly Minimum Data Set" (MDS), dated

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01/03/24, documented R17 had intact cognition. R17 had a functional range of motion impairment of both lower extremities and was dependent on staff for toileting, bathing, dressing of the lower and upper body, personal hygiene, and transfers. The MDS further documented R17 had an indwelling urinary catheter (tube placed in the bladder to drain urine into a collection bag) and was frequently incontinent of bowel. R17 had macerated (softening and breaking down of skin as a result of prolonged exposure to moisture, such as sweat, urine, feces, or wounds for extended periods) associated skin damage. R17 had shortness of breath with exertion, sitting, resting, and lying flat. The MDS further documented R17 received medication for pain, an antidepressant (a class of medications used to treat mood disorders), a hypnotic (a class of medications used to induce sleep), a diuretic (medication to promote the formation and excretion of urine) and used oxygen during the observation period.

R17's "Care Plan," dated 05/19/23, documented R17 required assistance with activities of daily living (ADL) and required two staff assistance with a mechanical lift for transfer.

R17's "Care Plan," revised on 07/12/23, documented R17 had the risk for alterations in skin integrity related to immobility. The care plan directed staff to educate the resident, family, and caregivers as to the causes of skin breakdown including transfers and positioning requirements, the importance of taking care during ambulation and mobility, good nutrition, and frequent repositioning. The care plan further documented to encourage the resident to report pain that may prevent repositioning.

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R17's clinical record lacked any documentation regarding a recent or current issue with R17's toe.

On 02/27/24 at 01:47 PM, during the initial survey interview, R17 reported he had pain in the right first toe which extended to the ankle area and felt as though the toe would fall off. R17 reported this area was painful for the past several days. The right first toe had a bandage covering the nail. R17 was uncertain of the date in which the pain started or the reason for the pain.

On 02/28/24 at 07:39 AM, observation revealed R17 reported toe pain from the toe to the ankle area. Licensed Nurse (LN) H stated she was not aware R17 had the bandage on his toe and said the pain could have been when staff used the lift to transfer R17 to a recliner.

On 02/28/24 at 09:13 AM LN H was unable to find the physician notification regarding an issue with R17's right great toe. LN H went to R17's room to assess the toe. Observation of R17's toe revealed the toe had dark red, dried blood diagonally across the nail. The base of the nail was red, and it had light yellow drainage when LN H applied pressure to cleanse the area. R17 reported it was very painful.

On 02/28/24 at 09:24 AM, Administrative Nurse E reported she was notified about skin conditions through the risk management report the staff entered in the EMR. Administrative Nurse E stated she was not aware of R17's toe bandage or pain.

On 02/08/24 at 01:54 PM, Administrative Nurse D

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F 684	Continued From page 54 was not aware of R17's toe injury. Administrative Nurse D verified staff should have notified the physician. The facility's "Notification of Changes" policy, dated 02/01/20, documented the policy to ensure the facility promptly informs the resident, consults the resident's physician, and notifies, consistent with his or her authority, the resident's representative when a change requires notification. Circumstances requiring notification include accidents resulting in injury and the potential to require physician intervention. The facility failed to ensure staff assessed, documented, and reported a toe condition to R17's physician and just applied a band-aid to R17's toe. This placed the resident at risk for increased pain, infection, and decreased mobility.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (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 (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. This REQUIREMENT is not met as evidenced by:	F 686		

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The facility had a census of 59 residents. The sample included 17 residents with seven reviewed for pressure injuries. Based on observation, record review, and interview, the facility failed to provide interventions to prevent the development of or promote healing 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) for Resident (R)11 and R19, who had or were at risk for pressure injuries. This placed R11 and R19 at risk for ongoing further pressure injury and related complications.

Findings included:

- R11's Electronic Medical Record (EMR) had diagnoses of cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), chronic obstructive pulmonary disease (COPD-progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain) of the right and left shoulders, chronic kidney disease, congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), major depressive disorder (major mood disorder which causes persistent feelings pf sadness), fibromyalgia (condition of musculoskeletal pain, spasms, stiffness, fatigue and severe sleep disturbance), rheumatoid arthritis (chronic inflammatory disease that affected joints and other organ systems), dementia (progressive mental disorder

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characterized by failing memory, confusion), type two diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), unsteadiness on feet, bipolar disorder (major mental illness that caused people to have episodes of severe high and low moods), and a need for assistance with personal cares.

The "Quarterly Minimum Data Set" (MDS), dated 02/08/24, documented R11 had intact cognition and no behavioral symptoms. R11 had a functional range of motion impairment of one side upper extremity, used a walker and a wheelchair, and required partial to moderate assistance with toileting, upper body dressing, and personal hygiene. The MDS further documented that R11 required substantial/maximal assistance with chair, bed, and toilet transfers. R11 had occasional incontinence of urine and was always continent of bowel.

The "Pressure Ulcer Injury Care Area Assessment" (CAA), dated 08/16/23, documented the CAA triggered for potential pressure due to R11's need for extensive assistance with bed mobility. R11 was continent of bowel and bladder and was at risk for impaired skin integrity. R11 had a venous wound to the right leg and no pressure ulcers.

R11's "Care Plan," initiated on 08/16/23, documented R11 was at risk for alteration in skin integrity related to decreased mobility and had a current venous wound to the right leg. The care plan directed staff to educate the resident, family, and caregivers on the causes of skin breakdown, including transfer, positioning requirements, the importance of taking care during ambulation,

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good nutrition, and frequent repositioning. The plan directed to report pain that may prevent repositioning and monitor nutrition intake. The plan documented to specify cushion used in chair and mattress but lacked the specific cushion and mattress used.

The "Weekly Skin Check", dated 02/15/24, documented R17's skin was intact with no new skin concerns identified.

The "Physician Order" dated 02/22/24, directed staff to clean the area with generic wound cleanser, apply hydrocolloid (opaque dressing for wounds that are biodegradable, non-breathable, and adheres to the skin) dressing, and change every other day in the morning to left buttock.

The "Skin and Wound" assessment, dated 02/22/24, recorded a Stage 1 (pressure wound which appears reddened, does not blanche, and may be painful but is not open) pressure ulcer, six days old and facility acquired. The assessment noted the wound measured 3.36 centimeters (cm) in length and 0.63 cm in width. The wound bed was bleeding and had light sanguineous (bloody) drainage. The surrounding tissue had erythema (redness or inflammation of the skin). The wound was cleansed with a generic wound cleaner, autolytic debridement (using the body's own defense mechanisms and fluids to liquefy dead tissue), dressed with a hydrocolloid and additional care included a turning/repositioning program.

The "Skin and Wound" assessment dated 02/29/24, recorded a Stage 2 (partial-thickness skin loss into but no deeper than the dermis including intact or ruptured blisters) pressure

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ulcer, 1.66 cm in length, 0.44 cm in width, and 0.1 cm deep. The wound had 100 percent (%) granulation tissue (new tissue formed during wound healing) and moderate serosanguineous drainage. The assessment recorded the treatment of wound cleanser, autolytic debridement, hydrophilic fiber, and a foam dressing every other day; additional care included nutritional dietary supplements.

R11's clinical record lacked evidence R11 received any nutritional supplements and further lacked evidence the registered dietician was notified of R11's pressure injury.

On 02/27/24 at 09:34 AM, R11 reported she had a sore on her bottom which was painful. She stated when she asked for a bandage for the sore, the staff told her the facility was out of bandages.

On 02/28/24 at 02:40 PM, observation revealed R11 in the bathroom. Licensed Nurse (LN) H assisted R11 with hygiene and changing her incontinent brief. R11 had a large dressing to the right and left buttock area. Further observation revealed R11 did not have pressure pressure-relieving cushion for her recliner. R11 stated she had not been offered a cushion for her chair. R11 said she slept in the chair and not the bed because the bed was "too tall," and she struggled to get in and out of it even at its lowest height.

On 02/28/24 at 09:24 AM, Administrative Nurse E reported skin conditions were reported to her through risk management alerts, and then she checked the area of concern and followed up on a weekly basis until healed.

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On 02/28/24 at 01:44 PM, Administrative Nurse D stated R11's buttock wound came and went. Administrative Nurse D stated R11 should have nutritional supplements to support wound healing if approved by her physician. Administrative Nurse D stated the resident's family brought R11 a new chair which was a bit larger than her first chair and as a result, R11 had increased shearing potential. Administrative Nurse D stated that R11 should have a pressure-reducing device in her chair.

The facility's "Pressure Injury Prevention and Management" policy, dated 01/01/20, documented the facility was committed to the prevention of avoidable pressure injuries and the promotion of healing of existing pressure injuries. The facility shall establish a systematic approach for pressure injury prevention and management, including prompt assessment and treatment, intervening to stabilize, reduce, or remove underlying risk factors, monitoring the impact of the interventions, and modifying the interventions as appropriate.

The facility failed to provide interventions including a pressure-reducing cushion to further pressure ulcers for R11 and failed to involve the registered dietician for nutritional support to aid in the healing of R11's existing pressure injuries. This placed the resident at risk for continued pressure ulcers and delayed healing.

- R19's Electronic Medical Record (EMR) documented diagnoses of cerebrovascular accident (CVA-stroke), hemiplegia and hemiparesis (weakness and paralysis on one side of the body), dysphagia (swallowing difficulty),

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and rheumatoid arthritis (chronic inflammatory disease that affected joints and other organ systems).

The "Quarterly Minimum Data Set" (MDS), dated 12/21/23, documented R19 had a Brief Interview for Mental Status (BIMS) score of zero with short- and long-term memory problems and moderately impaired decision-making skills. The MDS documented R19 had impaired range of motion (ROM) in all four extremities and was dependent on staff for all activities of daily living (ADLs) and mobility. R19 weighed 83 pounds and had one Stage 4 pressure ulcer (a deep pressure wound that reaches the muscles, ligaments, or even bone). R19 had pressure relief interventions to the chair and bed and received PU care.

R19's "Care Plan," dated 01/03/24, directed staff to administer treatments as ordered, monitor for effectiveness, and follow facility policies and protocols for the prevention and treatment of skin breakdown. The plan directed staff to encourage good nutrition and hydration in order to promote healthier skin. Staff were to monitor nutritional status, serve diet as ordered, and monitor and record intake. The plan directed staff to inspect R19's skin weekly to observe for redness, open areas, scratches, cuts, or bruises and report changes to the nurse. The care plan stated R19 had an actual impairment to her skin and directed staff to identify and document potential causative factors and eliminate or resolve them where possible. The plan documented R19's left second toe wound treatment and directed staff to administer medications and treatments as ordered and monitor for effectiveness. A care plan update dated 01/24/24 directed staff to place a foot cradle on the bed while R19 was in bed. A

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care plan update dated 02/06/24 directed staff to ensure an air overlay mattress was on the bed and to see current treatments on the "Treatment Administration Record" (TAR).

R19's "Care Plan" directed staff to provide and serve R19's diet as ordered with the assistance of one staff and monitor and record intake every meal. The care plan documented the Registered Dietician would evaluate and make diet change recommendations as needed. The care plan update dated 04/12/2023 directed staff to provide a regular diet, pureed texture with honey consistency, and supplements as ordered for unexpected weight loss.

The "Progress Note," dated 10/17/23 at 06:39 PM, stated upon changing R19's preventative dressings, staff noted an open area to the right second toe along with redness and a scabbed area to the left second toe. Staff notified the wound nurse.

The "Advanced Practice Registered Nurse (APRN) Note," dated 10/30/23, stated the left toe second digit recurring pressure ulcer was unstageable (depth of the wound is unknown due to the wound bed being covered by a thick layer of other tissue and pus) with minimal serosanguinous (semi-thick blood-tinged) drainage and no odor.

The "APRN Note," dated 11/27/23, stated the pressure injury on the toe of R19's right foot was unstageable. The pressure injury on the toe of the left foot was a Stage 4. The APRN recommended a foot cradle for R19's bed to keep linens off the feet.

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The "APRN Note," dated 12/18/23, stated R19 had a recurring pressure ulcer to her left second toe, which last resolved on 07/07/2023, and a new pressure ulcer to the right second toe. The note documented that R19 did not wear shoes and the APRN suspected that a weighted blanket used for anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear) contributed to the ulcers.

The "Progress Note," dated 01/24/24 at 09:49 PM, stated R19 continued with a wound to her left second toe which likely resulted from friction, shearing (the separation of skin layers caused by friction or trauma), and impaired mobility. The note recorded there were interventions in place which included a foot cradle and an air overlay to the mattress.

The "Registered Dietician (RD) Note," dated 02/05/24, stated R19 required total dependence on staff for feeding and drinking, shakes were to be offered as tolerated throughout the day and the RD recommended chocolate or strawberry fortified milk and juice with all meals, along with Pro stat (liquid protein supplement) 30 milliliters (ml) twice daily.

R19's Medication Administration Record (MAR) or TAR lacked documentation for the foot cradle and the Pro stat was not added until 02/29/24.

On 02/28/24 at 09:31 AM, observation revealed Administrative Nurse E used hand sanitizer then donned gloves and removed the soiled dressing from R19's right second toe. She cleaned the wound, changed gloves, and applied a Triad hydrophilic (a soft, moist dressing designed to help loosen and soften necrotic tissue while

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maintaining a moist wound) wound dressing and a two-by-two-inch bordered gauze.

On 02/28/24 at 09:31 AM, Administrative Nurse E stated staff provided R19 with a different chair, a blanket trough on the bed, and foam booties. Administrative Nurse E said R19 did not like the blue foam booties and kicked them off, so staff floated her feet in bed with pillows. Administrative Nurse E stated R19 was on hospice until October 2023 and still had an air mattress overlay on her bed. Administrative Nurse E stated R19 had osteomyelitis (local or generalized infection of the bone and bone marrow) at one point and was placed on Zyvox (an antibacterial drug) which helped.

On 02/29/24 at 07:53 AM, Administrative Nurse D verified staff should have immediately followed through with the RD recommendation for Prostat and the ARNP recommendation for the foot cradle.

On 02/29/24 at 08:02 AM, Administrative Nurse E verified she missed seeing the foot cradle recommendation. She stated the physician had not signed the order for the Prostat until 02/19/24 and she had not entered the order into the facility system yet (nine days later).

The facility's "Pressure Ulcer Prevention and Management" policy, dated 01/01/2020, stated the facility would establish and utilize a systematic approach for pressure ulcer prevention and management, including prompt assessment and treatment, intervening to stabilize, reduce or remove underlying risk factors, monitor the impact of interventions, and modify the interventions as appropriate. Evidenced-based

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F 686	Continued From page 64 interventions would be implemented for all residents who were assessed at risk or who had a pressure injury present. Interventions would be documented in the care plan and communicated to all relevant staff. The facility failed to provide recommended interventions for pressure ulcer prevention or treatment in a timely manner, placing R19 at risk for prolonged pressure ulcer risks and infection.	F 686		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: The facility had a census of 59 residents. The sample included 17 residents with one reviewed for range of motion (ROM) services. Based on observation, interview, and record review the facility failed to provide ROM services to prevent	F 688		

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further loss of mobility and function per the plan of care for Resident (R) 19. This placed the resident at risk for impaired mobility and decreased function.

Findings included:

- R19's Electronic Medical Record (EMR) documented diagnoses of cerebrovascular accident (CVA-stroke- sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), hemiplegia and hemiparesis (weakness and paralysis on one side of the body), dysphagia (swallowing difficulty), and rheumatoid arthritis (chronic inflammatory disease that affected joints and other organ systems).

The "Quarterly Minimum Data Set" (MDS), dated 12/21/23, documented R19 had a Brief Interview for Mental Status (BIMS) score of zero with short- and long-term memory problems and moderately impaired decision-making skills. The MDS documented R19 had impaired range of motion (ROM) in all four extremities and was dependent on staff for all activities of daily living (ADLs) and mobility.

R19's "Care Plan," dated 01/03/24, stated R19 had an ADL self-care performance deficit and required assistance with her care needs related to rheumatoid arthritis. The care plan directed staff to provide gentle range of motion (active or passive) with morning and evening care daily.

The facility lacked documentation that the range of motion services was provided as care planned.

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On 02/27/24 at 02:24 PM, observation revealed R19 lying in a low bed, on her right side. Her hands were clenched, and she did not have anything in her hand to pad or protect her palm or prevent contracture (abnormal fixation of a joint or muscle).

On 02/28/24 at 01:14 PM, observation revealed R19 sat in her Broda chair (specialized wheelchair with the ability to tilt and recline) in the living room. She held her left hand up to her mouth at times and appeared to chew on her thumbnail.

On 02/29/24 at 10:58 AM, Restorative Aide NN stated she had not provided ROM services to R19.

On 02/29/24 at 11:00 AM, Certified Nurse Aide (CNA) N stated she had not provided ROM services to R19. She stated the nurse aides provided what was specified for the resident on the task documentation in the resident's EMR.

On 02/29/24 at 11:20 AM, Administrative Nurse D verified staff should have provided ROM services to R19 as care planned.

The facility's "Prevention of Decline in Range of Motion" policy, dated 02/01/20, stated that based on the comprehensive assessment, the facility would provide interventions, exercises, or therapy to maintain or improve range of motion. Care plan interventions would be developed and delivered through the facility's restorative program and documented on the resident's care plan. The nurse responsible for the resident would monitor for consistent implementation of the care plan interventions.

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F 688	Continued From page 67 The facility failed to provide R19's ROM services per her plan of care. This placed the resident at risk for impaired mobility and decreased function.	F 688		
F 690 SS=E	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to 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	F 690		

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receives appropriate treatment and services to restore as much normal bowel function as possible.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 59 residents. The sample included 17 residents. Based on observation, record review, and interview, the facility failed to provide Resident (R) 55, R17, and R54 with sanitary indwelling urinary catheter (tube placed in the bladder to drain urine into a collection bag) care and R20 lacked an anchor for catheter tubing. These deficient practices placed the residents at risk for urinary tract infections and catheter related injury.

Findings included:

- R55's Electronic Medical Record (EMR) documented diagnoses of type two diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), post hemorrhagic (loss of a large amount of blood in a short period of time) anemia (inadequate number of healthy red blood cells to carry adequate oxygen to body tissues), muscle weakness, heart failure, dementia (progressive mental disorder characterized by failing memory, confusion), age related cognitive decline, pain, and the need of assistance with personal cares.

The "Quarterly Minimum Data Set" (MDS), dated 01/24/24, documented R55 had intact cognition and verbal behavioral symptoms directed toward others which occurred one to three days of the observation period. R55 had had functional range of motion to one side upper extremity and both lower extremities and required partial/moderate

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assistance with toileting and dressing. The MDS further documented R55 had an indwelling catheter and was occasionally incontinent of bowel. R55 received scheduled pain medication, insulin (a hormone that lowers the level of glucose in the blood), and high-risk medication of a hypnotic (a class of medications used to induce sleep) class.

The "Urinary Incontinence and Indwelling Catheter Care Area Assessment" (CAA), dated 10/31/23, documented R55 had an indwelling urinary catheter. R55 received diuretic (medication to promote the formation and excretion of urine) therapy and required assistance with toilet transfers and hygiene.

The "Dehydration Fluid Maintenance CAA", dated 10/31/23, documented the CAA triggered due to admission diagnoses of pneumonia (inflammation of the lungs) and urinary tract infection (UTI).

R55's "Care Plan" dated 02/07/24 lacked interventions or direction related to R55's indwelling catheter.

The "Physician Order" dated 10/25/25 directed staff to change the indwelling catheter every 30 days.

The "Physician Order" dated 01/22/24 directed staff to anchor the catheter tubing to prevent injury, provide catheter care, and measure output every shift.

The "Progress Note" dated 01/30/24 at 07:40 AM documented staff initiated a standing order to collect a urine analysis (UA) for a suspected UTI due to R55 had increased confusion, behaviors,

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and a general complaint of not feeling well.

The "Progress Note" dated 02/20/24 at 10:09 AM, documented the Interdisciplinary Team (IDT) met to discuss and review the resident's indwelling catheter, and the care plan was reviewed; the facility would continue the current plan of care.

R55's clinical record revealed R55 received antibiotics to treat a UTI on 12/15/23, 12/29/23, and 01/30/24.

On 02/28/24 at 12:00 PM, observation revealed staff brought R55 to the dining room with the catheter drainage bag and tubing dragging on the floor under the wheelchair.

On 02/28/24 at 07:45 AM, observation revealed R55 in bed which was low to the floor; the catheter drainage bag rested on the floor mat next to the bed.

The facility's "Catheter Care Policy", dated 01/09/24, documented it was the policy of the facility to provide catheter care to all residents that have an indwelling catheter to reduce bladder and kidney infections.

The facility failed to provide R55 with sanitary indwelling catheter care by allowing the catheter drainage bag to touch the floor. This placed R55 at risk for ongoing complications of UTIs.

- R17's Electronic Medical Record (EMR) included diagnoses of a personal history of urinary tract infections (UTI), chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished

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lung capacity and difficulty or discomfort in breathing), neuralgia (intermittent along the course of a nerve) and neuritis (inflammation of nerves causing pain), unspecified disorders of the bladder, type two diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), chronic respiratory failure with hypoxia (inadequate supply of oxygen), benign prostatic hyperplasia (BPH-non-cancerous enlargement of the prostate which can lead to interference with urine flow, urinary frequency, and urinary tract infections) with lower urinary tract symptoms, low back pain, unspecified cirrhosis (chronic degenerative disease of the liver), obesity (excessive body fat) and a need for assistance with personal cares.

The "Quarterly Minimum Data Set" (MDS), dated 01/03/24, documented R17 had intact cognition. R17 had a functional range of motion impairment of both lower extremities and was dependent on staff for toileting, bathing, dressing of the lower and upper body, personal hygiene, and transfers. The MDS further documented R17 had an indwelling urinary catheter (tube placed in the bladder to drain urine into a collection bag) and was frequently incontinent of bowel. R17 had macerated (softening and breaking down of skin as a result of prolonged exposure to moisture, such as sweat, urine, feces, or wounds for extended periods) associated skin damage. R17 had shortness of breath with exertion, sitting, resting, and lying flat. The MDS further documented R17 received medication for pain, an antidepressant (a class of medications used to treat mood disorders), a hypnotic (a class of medications used to induce sleep), a diuretic (medication to promote the formation and

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excretion of urine) and used oxygen during the observation period.

The "Urinary Incontinence and Indwelling Catheter Care Area Assessment" (CAA), dated 06/01/23, documented R17 was frequently incontinent of urine, required extensive assistance with toileting, and was at risk for skin rashes, breakdown, falls, isolation, and UTIs. The CAA further documented the resident was working with physical and occupational therapies.

R17's "Care Plan" dated 02/08/24, lacked indwelling catheter use and directions for care.

The "Physician Order" dated 01/25/24 directed staff to change the catheter as needed (PRN).

R17's clinical record revealed R17 was treated for a UTI on 10/20/23, 11/05/23, 11/15/23, and 01/26/23.

On 02/27/24 at 01:47 PM, observation revealed R17 lay in bed and watched TV. The indwelling catheter drainage bag hung on the bedframe at the foot of the bed, without a privacy bag.

On 02/28/24 at 07:39 AM, observation revealed R17 lying on his back in the bed. His catheter drainage bag lay directly on the floor, not attached to the bed. Licensed Nurse (LN) H stated the catheter bag should not be lying on the floor and confirmed R17 had a history of UTIs. LN H drained the catheter bag and hooked it to the frame of the bed.

On 02/28/24 at 09:24 AM, Administrative Nurse E reported the Interdisciplinary Team (IDT), and nurses were responsible for updating the care

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plans. Administrative Nurse E verified R17's indwelling urinary should have been care planned.

On 02/28/24 at 01:30 PM, Administrative Nurse D verified the indwelling catheter use should be included in R17's "Care Plan."

The facility's "Catheter Care Policy", dated 01/09/24, documented it was the policy of the facility to provide catheter care to all residents that have an indwelling catheter to reduce bladder and kidney infections.

The facility failed to provide R17 with sanitary indwelling catheter care by allowing the catheter drainage bag to touch the floor, which placed the R17 at risk for ongoing complications of UTIs and infectious diseases.

- R54's Electronic Medical Record (EMR) documented R54 had a diagnosis of urinary retention (lack of ability to urinate and empty the bladder).

R54's "Quarterly Minimum Data Set" (MDS), dated 01/18/24, documented R54 had a Brief Interview of Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS documented R54 was dependent on staff for toileting hygiene. R54 had an indwelling urinary catheter.

R54's "Care Plan," revised 01/18/24, documented R54 required partial, moderate assistance with toileting hygiene. The plan documented R54 had an indwelling urinary catheter and instructed staff to provide good perineal (private area) care, anchor the catheter tubing to prevent injury,

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provide catheter care every shift and as needed (PRN), and monitor, record, and report to the physician if R54 had signs or symptoms of urinary tract infection (UTI-an infection in any part of the urinary system).

On 02/28/24 at 08:37 AM, R54 sat on the toilet. Certified Nurse Aide (CNA) N placed the uncovered urinary catheter bag on the floor in front of the toilet and placed a plastic container on the floor without a clean barrier. CNA N used an alcohol pad to wipe the tip of the drainage port, then picked up the catheter bag and opened the port. CNA N drained the clear yellow urine into the container. CNA N used an alcohol pad to wipe the drainage port tip again and reinserted the port into the holder then placed the catheter bag on the floor in front of R54. CNA N then applied gloves, stepped on the bag and tubing with her shoe, then used an alcohol wipe and wiped the catheter starting from the tubing insertion site, down to the connection site. R54 stood up and CNA N, with the same soiled gloves, pulled R54's cloth underwear and pants up, then removed and discarded the gloves. CNA N placed R54's catheter bag in her ungloved hand and followed the resident to his wheelchair. Further observation revealed CNA N placed the uncovered catheter bag on the floor, then picked it up with ungloved hands and fastened it to the right-hand side of R54's walker. CNA N left the room without washing her hands and went into another resident's room.

On 02/28/24 at 08:55 AM, CNA N verified she placed the urinary catheter bag on the floor and did not change her gloves or wash her hands after providing catheter care. CNA N stated she was going to hang the catheter on the walker but

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did not think she could. She said she should have changed her gloves and washed her hands after providing catheter care.

On 02/28/24 at 03:28 PM, Administrative Nurse D stated she expected staff to follow infection prevention protocols when providing urinary catheter care. Administrative Nurse D said staff should hang the urinary catheter bag below the level of the bladder and never place it on the floor. Administrative Nurse D stated she expected staff to change gloves between dirty and clean and wash hands immediately after removing gloves.

The facility's "Hand Hygiene Policy," revised 10/25/2002, documented that staff involved with direct resident contact would perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors.

The facility's "Catheter Care Policy," revised 01/09/24, instructed staff to apply gloves, provide catheter care to the perineal area, bag and gather all supplies used, discard disposable items in the trash can, assist resident to a comfortable, appropriate position, return room back to the original order and then perform hand hygiene.

The facility failed to appropriate catheter treatment and services for R54. This placed the resident at increased risk for UTI and catheter-related complications.

- R20 's Electronic Medical Record documented diagnoses of cerebral palsy (a progressive disorder of movement, muscle tone, or posture caused by injury or abnormal development in the

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immature brain, most often before birth), neuromuscular dysfunction of bladder (dysfunction of the urinary bladder caused by a lesion of the nervous system), anxiety disorder (mental or emotional disorder characterized by apprehension, uncertainty and irrational fear), depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and insomnia (inability to sleep).

The "Quarterly Minimum Data Set" (MDS), dated 01/25/24, documented a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS documented R20 had no behaviors and received an antianxiety (a class of medications that calm and relax people), an antidepressant (a class of medications used to treat mood disorders), and a hypnotic (a class of medications used to induce sleep) medication. The MDS documented R20 was independent with eating and required moderate staff assistance with dressing and bed mobility. R20 was dependent on staff for toileting and transfers.

R20's "Care Plan," dated 02/07/24, lacked information R20 had a urinary catheter and lacked interventions related to the care of it.

The "Physician Order," dated 10/15/23, directed staff to change the suprapubic catheter (urinary bladder catheter inserted through the abdomen into the bladder) every month.

The "Physician Order," dated 10/24/23, directed staff to flush the suprapubic catheter twice a week with 100 cubic centimeters (cc) of normal saline during the night shift every Tuesday and Friday.

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The "Physician Order," dated 11/20/23, directed staff to cleanse the suprapubic site and cover it with a drain gauze dressing and tape daily at bedtime.

The "Physician Order," dated 01/22/24, directed staff to anchor the catheter tubing to prevent injury and provide catheter care every shift.

The "Physician Order," dated 01/23/24, directed staff to document catheter output every shift.

A review of R20's catheter output documentation in the EMR lacked evidence staff measured and recorded R20's urine output on six shifts from 02/01/24 through 02/28/24.

On 02/28/24 at 09:45 AM, observation revealed R20 lay in bed while Administrative Nurse E performed wound care. She ensured the suprapubic catheter tubing was not "pinned" under the brief but did not ensure an anchor was present to prevent pulling or displacement of the catheter.

On 02/29/24 at 07:55 AM, Administrative Nurse D verified staff should have ensured an anchor for the tubing was in place and said it should have been on R20's "Care Plan."

On 02/29/24 at 08:05 AM, Administrative Nurse E verified a catheter tubing anchor should be in place to prevent R20's suprapubic catheter tubing from getting tugged and causing pain.

The facility's "Catheter Care" policy, dated 01/09/2024, stated the facility would provide catheter care to residents who have an indwelling catheter to reduce bladder and kidney infection.

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F 690	Continued From page 78 The facility failed to ensure staff measured and recorded R20's urinary output and failed to ensure R20's suprapubic catheter tubing was anchored to prevent pulling or dislodgement. This placed the resident at risk for complications related to an indwelling suprapubic catheter.	F 690		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: The facility had a census of 59 residents. The sample included 17 residents, with five reviewed for nutrition. Based on observation, record review, and interview, the facility failed to provide necessary nutritional assessments, notify and	F 692		

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seek the involvement of the Registered Dietician (RD), and implement interventions to prevent unintended weight loss for Resident (R) 59, who had known weight loss before admission and continued loss after admission. The facility further failed to ensure that R19, who was on a pureed diet received the full nutritional benefit of what was served during the noon meal. This placed the residents at risk for ongoing weight loss and decline.

Findings included:

- R59 admitted on 02/09/24.

The Electronic Medical Record (EMR) for R59 documented diagnoses of anoxic brain injury (brain injury that occurs when the brain is deprived of oxygen for too long), diabetes mellitus (DM-when the body cannot use glucose, not enough sepsis made or the body cannot respond to the insulin), and moderate protein calorie malnutrition (occurs when the supply of protein, calories, or both is inadequate).

The "Admission Minimum Data Set" (MDS), dated 02/15/24, documented R59 had severely impaired cognition. R59 was dependent upon staff for all activities of daily living (ADLs). The MDS documented R59 was 69 inches tall, weighed 196 pounds (lbs.), and had weight loss.

The "Nutrition Care Area Assessment." dated 02/15/24, documented that R59 required a mechanically altered diet, and had a 10 percent (%) weight loss before admission while in the hospital. The CAA documented that R59's weight was stable since admission.

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R59's "Care Plan," dated 02/19/24, directed staff to encourage R59 to attend meals in the dining area and seat her with other residents whom she could talk with. The plan directed staff to obtain a registered dietician consult as indicated. The care plan lacked documentation of diet orders and interventions to prevent weight loss.

A review of R59's weight record revealed the following weights:
02/10/24-198 lbs.
02/11/24-196 lbs.
02/18/24- 193.6 lbs.
02/28/24- 188.4 lbs.

The EMR for R59 lacked nutritional assessments from the RD and lacked documentation the staff had notified the physician of R59's weight loss.

On 02/27/24 at 11:11 AM, observation revealed R59 sat at a dining table and ate lunch. R59 was assisted by staff to eat turkey, dressing, and Brussels sprouts. R59 did not finish the meal.

On 02/28/24 at 09:33 AM, Licensed Nurse (LN) G stated R59 required total assistance with meals, and she usually ate well.

On 02/28/24 at 04:20 PM, Dietary BB stated she had not contacted the RD to let the RD know that the resident was admitted. Dietary BB stated she would tell the RD when the RD was in the building on 03/01/24. Dietary BB further stated that there had not been any nutritional assessments completed for R59 yet and confirmed it was her responsibility to contact the RD when a new resident was admitted. Dietary BB verified that R59 did not have any nutritional supplements.

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On 02/28/24 at 04:45 PM, Administrative Nurse D stated the RD should be contacted within three days of admission and should also have a nutritional assessment completed. Administrative Nurse D was unsure whether the physician was notified of R59's weight loss.

On 02/29/24 at 09:03 AM, Certified Nurse Aide (CNA) O stated that R59 required assistance with meals. CNA O went on to say R59 ate well and did not have any supplements.

On 02/29/24 at 09:49 AM, the RD was unavailable for an interview.

The facility's "Interventions for Unintended Weight Loss" policy, dated 2021, documented unintended weight loss or gradual weight loss would be identified and monitored so that appropriate and individualized interventions could be implemented, the resident would be weighed upon admission or readmission weekly for the first four weeks after admission and at least monthly thereafter help identify and document weight trends, staff would follow a consistent approach to weighing and use an appropriate calibrated and functioning scale.

The facility's "Director of Food and Nutrition Services" policy, dated 2021, documented the food and nutrition services were responsible for all aspects of the food and nutrition services department including but not limited to food safety, staff safety, and meeting nutritional needs of residents. The Director of Food and Nutrition would cooperate with other department heads and other professionals including the RD, the dietary manager would participate in meetings with the administration, department head

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meetings, care plan meetings, and regular meetings with the RD.

The facility failed to implement immediate interventions to prevent weight loss for R59 and failed to involve the RD and physician regarding R59's weight loss. This placed the resident at risk for further weight loss and decline.

- R19's Electronic Medical Record (EMR) documented diagnoses of cerebrovascular accident (CVA-stroke), hemiplegia and hemiparesis ((weakness and paralysis on one side of the body), dysphagia (swallowing difficulty), and rheumatoid arthritis (chronic inflammatory disease that affected joints and other organ systems).

The "Quarterly Minimum Data Set" (MDS), dated 12/21/23, documented R19 had a Brief Interview for Mental Status (BIMS) score of zero with short- and long-term memory problems and moderately impaired decision-making skills. The MDS documented R19 had impaired range of motion (ROM) in all four extremities and was dependent on staff for all activities of daily living (ADLs) and mobility. R19 weighed 83 pounds and had one Stage 4 pressure ulcer (a deep pressure wound that reaches the muscles, ligaments, or even bone).

R19's "Care Plan," dated 01/03/24, directed staff to encourage good nutrition and hydration to promote healthier skin. Staff were to monitor nutritional status, serve diet, regular pureed texture, honey consistency, with supplements as ordered, and monitor and record intake. The Registered Dietician (RD) to evaluate and make diet change recommendations as needed. The

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care plan documented that R19 required the assistance of one staff for eating.

The "RD Note," dated 02/05/24, stated R19's weight of 81 pounds (lbs.) showed a 2.4 lb. weight loss from the last weight check on 12/11/23. R19 required total dependence on staff for eating and drinking. The note stated the RD recommended four-ounce chocolate or strawberry fortified milk and juice with all meals, along with Pro-stat (liquid protein supplement) 30 milliliters (ML) twice daily.

On 02/27/24 at 11:30 AM, observation revealed R19 sat in a Broda chair (specialized wheelchair with the ability to tilt and recline). Staff took R19 to the dining room where Certified Nurse Aide (CNA) MM fed her two pureed foods, a red beverage, and water. During the meal, the staff requested a chocolate shake for R19, but she received a strawberry shake. The menu stated the meal was turkey, dressing, Brussels sprouts, and dessert, but R19 only received pureed turkey, Brussels sprouts, and a dessert.

On 02/27/24 at 12:00 PM, Dietary Staff (DS) BB and CNA MM verified that R19 had not received the pureed stuffing as listed on the menu and that she should have.

On 02/29/24 at 07:53 AM, Administrative Nurse D verified staff should have provided the stuffing or an alternative.

The facility's "Interventions for Unintended Weight Loss" policy, dated 2021, stated unintended weight loss would be identified and monitored so appropriate and individualized intervention could be implemented.

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F 692	Continued From page 84 The facility failed to provide R19 a meal with the full nutritional value, placing R19 at risk for further weight loss.	F 692		
F 742 SS=D	Treatment/Srvcs Mental/Psychoscial Concerns CFR(s): 483.40(b)(1) §483.40(b) Based on the comprehensive assessment of a resident, the facility must ensure that- §483.40(b)(1) A resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being; This REQUIREMENT is not met as evidenced by: The facility had a census of 59 residents. The sample included 17 residents. Based on observation, interview, and record review, the facility failed to provide Resident (R) 11 with the appropriate treatment and services to attain the highest practicable mental and psychosocial (interrelation of social factors and individual thought and behavior) well-being. This placed the resident at risk for unmet mental health care needs. Findings included: - R11's Electronic Medical Record (EMR) had diagnoses of cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), chronic	F 742		

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obstructive pulmonary disease (COPD-progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain) of the right and left shoulders, chronic kidney disease, congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), major depressive disorder (major mood disorder which causes persistent feelings pf sadness), fibromyalgia (condition of musculoskeletal pain, spasms, stiffness, fatigue and severe sleep disturbance), rheumatoid arthritis (chronic inflammatory disease that affected joints and other organ systems), dementia (progressive mental disorder characterized by failing memory, confusion), type two diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), unsteadiness on feet, bipolar disorder (major mental illness that caused people to have episodes of severe high and low moods), and a need for assistance with personal cares.

The "Quarterly Minimum Data Set" (MDS), dated 02/08/24, documented R11 had intact cognition and no behavioral symptoms. R11 had a functional range of motion impairment of one side upper extremity, used a walker and a wheelchair, and required partial to moderate assistance with toileting, upper body dressing, and personal hygiene. The MDS further documented that R11 required substantial to maximal assistance with chair, bed, and toilet transfers. R11 had occasional incontinence of urine and was always continent of bowel. R11 took an antianxiety (class of medications that calm and relax people),

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antidepressant (class of medications used to treat mood disorders), diuretic (medication to promote the formation and excretion of urine), opioid (medication used to treat pain), and antiplatelet (medication that prevents blood clots).

The "Psychosocial Drug Use Care Area Assessment" (CAA), dated 08/16/23, documented R11 received an antidepressant and antianxiety medications and was at risk for adverse reactions to medications. The CAA noted R11's care plan goal to have no medication side effects.

R11's "Care Plan," initiated 08/18/23, documented R11 was dependent on staff for meeting her emotional, intellectual, physical, and social needs. The care plan directed staff to assist with arranging community activities; R11 needed one-to-one room visits and activities if unable to attend out-of-room events. The plan directed staff to provide activities of interest and empower R11 by encouraging and allowing choice, self-expression, and responsibility.

R11's "Care Plan," initiated on 08/18/23, documented R11 had a mood problem. The care plan directed staff to monitor, record, and report to the physician as needed any risk for harm, a sense of hopelessness, impaired judgment, or safety awareness. The care plan further directed staff to monitor, record, and report to the physician acute episodes or feelings of sadness, loss of pleasure or interest in activities, feelings of worthlessness or guilt, a change in appetite and eating habits, a change in sleep patterns, diminished ability to concentrate, patterns of depression, anxiety, or a sad mood.

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R11's clinical record lacked evidence she was offered or provided mental health services at the facility.

On 02/7/24 at 09:28 AM, during the initial interview, R11 reported feeling down for a while now and said she would like mental health help. R11 stated she did not get mental health help or services at the facility. R11 reported she was the resident council president and enjoyed the role due to other residents' ability to talk to her about concerns. R11 went on to say she no longer attended meals in the dining room due to another resident's behaviors toward her and others.

On 02/28/24 at 03:30 PM, Social Service X reported that R11 received mental health assistance while at another facility and R11 requested continued services. Social Service X stated the previous mental health provider contacted the facility for a smooth transition of care for R11 and had not started mental health services at this facility. Social Service X reached out to the facility's mental health provider and said R11 would be seen on the next visit to the facility.

On 02/28/24 at 01:44 PM, Administrative Nurse D verified that R11 had not been going to the dining room for meals, and her attendance to activities had decreased. Administrative Nurse D also said R11 was more irritable with staff, but Administrative Nurse F was unaware of the reason. Administrative Nurse D verified that R11 should receive mental health services if requested.

The facility's "Behavioral Health Services" policy, dated 10/21/23, documented all residents receive

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F 742	Continued From page 88 necessary behavioral health care and services to assist him or her in reaching and maintaining the highest level of mental and psychosocial functioning. Behavioral health care and services shall be provided in an environment that promotes emotional and psychosocial well-being, supports each resident's needs, and includes individualized approaches to care. The facility failed to provide R11 with the appropriate mental health treatment and services to attain her highest practicable mental and psychosocial well-being. This placed the resident at risk for unmet mental health care needs.	F 742		
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug,	F 756		

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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 had a census of 59 residents. The sample included 17 residents. Based on observation, record review, and interview, the facility failed to ensure the Consultant Pharmacist (CP) identified and reported Resident (R) 10's had multiple antidepressant (class of medications used to treat mood disorders) medications with a diagnosis of anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), R17 lacked blood sugar parameters, R55 lacked an end date for the use of an as needed (PRN) antianxiety (class of medications that calm and relax people), R20's recommended gradual dose reduction of psychotropic (alters mood or thought) medications lacked a physician response, and R38's use of antipsychotic (class of medications used to treat major mental conditions which cause a break from reality) for unapproved diagnosis. The facility also failed to ensure the physicians acknowledged and responded to the

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CP recommendations. This placed the residents at risk for inappropriate use of medication.

Findings included:

- R10's Electronic Medical Record (EMR) documented diagnoses of anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear) disorder, hypersomnia (excessive sleepiness or drowsiness), age related physical debility, communication deficit, bipolar disorder (major mental illness that caused people to have episodes of severe high and low moods), dementia, muscle weakness, and pain.

The "Quarterly Minimum Data Set" (MDS), dated 01/11/24, documented R10 had moderately impaired cognition, and had not exhibited behaviors. R10 required substantial to maximal assistance of staff for activities of daily living (ADL) and mobility. R10 took an antipsychotic (class of medications used to treat major mental conditions which cause a break from reality) and an antidepressant (class of medications used to treat mood disorders) with no gradual dose reduction (GDR) or physician documentation the GDR was clinically contraindicated.

The "Psychotropic Drug Use Care Area Assessment" (CAA), dated 10/24/23, documented R10 received antipsychotic and antidepressant medications. R10 was at risk for adverse reactions to medications and the pharmacist reviewed medication on admission and monthly thereafter.

R10's "Care Plan," revised 10/27/23, documented R10 was prescribed psychotropic medications

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and was at risk for complications. The care plan directed staff to administer medications as ordered by the physician, monitor for side effects and effectiveness each shift, consult with pharmacy and physician to consider dosage reduction when clinically appropriate at least quarterly. The care plan further directed staff to discuss with the physician and family regarding ongoing need for use of medication. Staff were to review behaviors, and alternate therapies attempted and their effectiveness, monitor, document, and report any adverse reactions.

The "Physician Order", dated 10/14/23, directed staff to administer:
Aripiprazole (antipsychotic) two milligrams (mg) by mouth in the morning related to bipolar disorder.
Duloxetine (antidepressant) 30 mg by mouth every morning related to anxiety disorder.
Mirtazapine (antidepressant) 15 mg by mouth at bedtime related to anxiety disorder.
Hydralazine (blood pressure medication) 50 mg by mouth two times a day with meals related to anxiety disorder.

The "Pharmacy Drug Regimen Review" dated 10/14/23, documented recommendation to R10's attending physician which noted R10 had an order of mirtazapine that did not have a Food and Drug Administration (FDA) labeled indication and to recommended to reassess the indication for use or a Risk versus Benefit assessment. An order of mirtazapine that was prescribed "Off-Label" could potentially be considered an unnecessary medication. R10's clinical record lacked evidence the of a physician response.

The "Pharmacy Drug Regimen Review" dated

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11/01/23, documented a recommendation to the attending physician that R10 had an order for hydralazine with an indication of anxiety, if applicable change the indication. Hydralazine was not FDA approved for anxiety but benefit to resident outweighs any potential adverse side effects. R10's clinical record lacked evidence the of a physician response.

On 02/27/24 at 01:39 PM, observation revealed R10 sat in a wheelchair in the hallway.

On 02/28/24 at 01:39 PM, Administrative Nurse D could not verify if the pharmacy recommendations were sent to the physician or if a response from the physician was received regarding R10's medication used for anxiety. Administrative Nurse D verified anxiety was not an approved use those medications.

The facility's "Medication Regimen Review", dated 01/01/20, documented the drug regimen of each resident is reviewed at least monthly by a licensed pharmacist and included a review of resident's medial chart. Review of the medical record in order to prevent, identify, report, and resolve medication -related problems, medication errors, or other irregularities. The pharmacist shall communicate any recommendations and identify irregularities via written communication withing 72 hours of the review. The pharmacist shall forward to the facility's Consultant Pharmacist for follow up, if indicated. Facility staff shall act upon all recommendations according to procedures for addressing medication regimen review irregularities.

The facility failed to ensure the CP identified and reported R10's multiple antidepressants used for

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anxiety and further failed to ensure the physician acknowledged and responded to the CP recommendations. This placed R10 at risk for inappropriate use of psychotropic medications.

- R17's Electronic Medical Record (EMR) included diagnoses of a personal history of urinary tract infections (UTI), chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), neuralgia (intermittent along the course of a nerve) and neuritis (inflammation of nerves causing pain), unspecified disorders of the bladder, type two diabetes mellitus, chronic respiratory failure with hypoxia (inadequate supply of oxygen), benign prostatic hyperplasia (BPH-non-cancerous enlargement of the prostate which can lead to interference with urine flow, urinary frequency, and urinary tract infections) with lower urinary tract symptoms, low back pain, unspecified cirrhosis (chronic degenerative disease of the liver), obesity (excessive body fat) and a need for assistance with personal cares.

The "Quarterly Minimum Data Set" (MDS), dated 01/03/24, documented R17 had intact cognition. R17 had a functional range of motion impairment of both lower extremities and was dependent on staff for toileting, bathing, dressing of the lower and upper body, personal hygiene, and transfers. The MDS further documented R17 had an indwelling urinary catheter (tube placed in the bladder to drain urine into a collection bag) and was frequently incontinent of bowel. R17 had macerated (softening and breaking down of skin as a result of prolonged exposure to moisture, such as sweat, urine, feces, or wounds for extended periods) associated skin damage. R17

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had shortness of breath with exertion, sitting, resting, and lying flat. The MDS further documented R17 received medication for pain, an antidepressant (a class of medications used to treat mood disorders), a hypnotic (a class of medications used to induce sleep), a diuretic (medication to promote the formation and excretion of urine), insulin and used oxygen during the observation period.

R17's "Care Plan," initiated 05/19/23, documented R17 had diabetes mellitus, and directed staff to educate the resident, family, and caregivers as to the correct protocol for glucose monitoring and insulin (a hormone that lowers the level of glucose in the blood) injections and obtain return demonstrations. The care plan lacked parameters for physician notification of low or elevated blood sugar levels.

The "Physician Order", dated 05/22/23, directed staff to administer by injection insulin glargine (long-acting insulin) solution 15 units subcutaneously (under the skin) at bedtime for diabetes.

The "Physician Order", dated 05/30/23, directed staff to obtain a blood sugar twice a day (BID) for type 2 diabetes mellitus. The order lacked parameters on when to notify the physician.

R17's EMR recorded a postprandial (the timeframe of approximately two hours after eating) blood sugar obtained on 02/02/24 between 07:00 PM and 11:00 PM resulting in a reading of 456 milliliters (ml) per deciliter (dL). (Normal postprandial blood sugar levels for adults with DM are 180 ml/dL or less). R17's medical record lacked evidence of physician notification or

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assessment of the resident related to the abnormally high blood sugar reading.
On 02/28/24 at 01:39 PM, Administrative Nurse D could not verify whether the pharmacy recommendations recommended parameters for R17's blood sugar levels.

The facility's "Medication Regimen Review", dated 01/01/20, documented the drug regimen of each resident is reviewed at least monthly by a licensed pharmacist and included a review of resident's medial chart. Review of the medical record in order to prevent, identify, report, and resolve medication -related problems, medication errors, or other irregularities. The pharmacist shall communicate any recommendations and identify irregularities via written communication withing 72 hours of the review. The pharmacist shall forward to the facility's Consultant Pharmacist for follow up, if indicated. Facility staff shall act upon all recommendations according to procedures for addressing medication regimen review irregularities.

The facility failed to ensure the CP identified and reported the lack of parameters for monitoring related to R17's use of insulin. This placed R17 at risk of complications related to the use of insulin.

- R55's Electronic Medical Record (EMR) documented diagnoses of type two diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), post hemorrhagic (loss of a large amount of blood in a short period) anemia (inadequate number of healthy red blood cells to carry adequate oxygen to body tissues), muscle weakness, heart failure, dementia (progressive

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mental disorder characterized by failing memory, confusion), age related cognitive decline, pain, and the need of assistance with personal cares.

The "Quarterly Minimum Data Set" (MDS), dated 01/24/24, documented R55 had intact cognition and verbal behavioral symptoms directed toward others which occurred one to three days of the look-back period. R55 had had functional range of motion to one side upper extremity and both lower extremities and required partial/moderate assistance with toileting and dressing. The MDS further documented R55 had an indwelling catheter (a flexible tube inserted through a narrow opening into a body cavity, particularly the bladder, for removing fluid) and was occasionally incontinent of bowel. R55 received scheduled pain medication, insulin (a hormone that lowers the level of glucose in the blood), and high-risk medication of a hypnotic (a class of medications used to induce sleep) class.

R55's "Care Plan" lacked any goals or directives related to R55's use of psychotropic medication.

The "Physician Order" dated 10/25/23, directed staff to administer alprazolam (antianxiety medication) 0.25 milligrams (mg) every eight hours PRN for anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear) and lacked a stop date.

The "Physician Order", dated 12/12/23, directed staff to administer alprazolam 0.25 mg twice a day for anxiety.

R55's EMR revealed the PRN alprazolam was administered nine times in December 2023, four

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times in January 2024, and once in February 2024.

The "Pharmacy Drug Regimen Review", dated 12/04/23, recorded a recommendation made to the attending physician that R55's alprazolam did not have an FDA-approved indication. The physician responded the use of alprazolam was for anxiety. The "Pharmacy Drug Regimen Review" lacked evidence The CP reported the lack of a required end date for the use of PRN alprazolam.

On 02/28/24 at 07:45 AM, observation revealed R55 in bed which was low to the floor; the catheter drainage bag rested on the floor mat next to the bed.

On 02/28/24 at 01:30 PM, Administrative Nurse D verified the PRN alprazolam had not been addressed by the pharmacist and confirmed it required an end date.

The facility's "Medication Regimen Review", dated 01/01/20, documented the drug regimen of each resident is reviewed at least monthly by a licensed pharmacist and included a review of the resident's medical chart. Review of the medical record to prevent, identify, report, and resolve medication-related problems, medication errors, or other irregularities. The pharmacist shall communicate any recommendations and identify irregularities via written communication within 72 hours of the review. The pharmacist shall forward to the facility's Consultant Pharmacist for follow-up if indicated. Facility staff shall act upon all recommendations according to procedures for addressing medication regimen review irregularities.

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The facility failed to ensure the CP identified and reported the lack of an end date for R55's PRN psychotropic medication. This placed R55 at risk for inappropriate use of psychotropic medications.

- R20 's Electronic Medical Record documented diagnoses of cerebral palsy (a progressive disorder of movement, muscle tone, or posture caused by injury or abnormal development in the immature brain, most often before birth), neuromuscular dysfunction of bladder (dysfunction of the urinary bladder caused by a lesion of the nervous system), anxiety disorder (mental or emotional disorder characterized by apprehension, uncertainty and irrational fear), depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and insomnia (inability to sleep).

The "Quarterly Minimum Data Set" (MDS), dated 01/25/24, documented a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS documented R20 had no behaviors and received an antianxiety (a class of medications that calm and relax people), an antidepressant (a class of medications used to treat mood disorders), and a hypnotic (a class of medications used to induce sleep) medication. The MDS documented R20 was independent with eating and required moderate staff assistance with dressing and bed mobility. R20 was dependent on staff for toileting and transfers.

R20's "Medication Care Plan," dated 02/07/24, directed staff to administer medications as ordered, monitor labs, and report findings to the Nurse practitioner (NP) or the physician. The plan directed staff to monitor and document for side

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effects and effectiveness. Staff were to ensure a pharmacy review monthly and arrange for psychiatric consult with follow-up as indicated. The plan directed staff to monitor behavior episodes and attempt to determine the underlying cause. Staff were to encourage the resident to express his feelings appropriately.

The "Physician Orders" included the following:
Zolpidem (hypnotic drug), 10 milligrams (mg) at bedtime for insomnia, started 02/03/23.
Buspar (antianxiety drug), 10 mg twice daily (BID) for anxiety, started 12/26/22.
Duloxetine (antidepressant) delayed release, 30 mg, BID, started 12/26/22.

The "Consultant Pharmacist Review," dated 04/05/23, documented the consultant pharmacist recommended a gradual dose reduction (GDR) for Buspar, duloxetine, and zolpidem. R20's clinical record lacked evidence the physician responded.

The "Consultant Pharmacist Review," dated 10/03/23, documented the consultant pharmacist recommended a GDR for Buspar, duloxetine, and zolpidem. R20's clinical record lacked evidence the physician responded.

The "Consultant Pharmacist Review," dated 02/08/24, recommended a GDR of zolpidem or a trial of melatonin. The physician replied no and documented the resident still required the hypnotic, and the benefit outweighed the risk.

On 02/27/24 at 02:27 PM, observation revealed R20 lay in bed with his eyes closed; music played in his room. R20 wore foam boots and had an air mattress on the bed. His urine collection bag

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hung low on the side of his bed.

On 02/28/24 at 02:42 PM, Administrative Nurse D verified the physician had not written a risk versus benefit rationale for the continued use of Buspar, zolpidem, or duloxetine when the pharmacist recommended a GDR or a risk versus benefit rationale on 04/05/23 and 10/03/23.

On 02/29/24 at 07:55 AM, Administrative Nurse D verified the facility should have followed through with the physician when he did not answer the pharmacist's recommendations for a GDR or a risk versus benefit rationale.

The facility's "Use of Psychotropic Drugs" policy, dated 01/09/24, stated the indications for use of any psychotropic drug would be documented in the medical record and initiated only after medical, physical, functional, psychosocial, and environmental causes had been identified and addressed. Residents who receive psychotropic drugs would receive gradual dose reductions unless clinically contraindicated. The physician in collaboration with the consultant pharmacist would re-evaluate the use of the medication and consider if the medication could be reduced or discontinued.

The facility's "Medication Regimen Review" policy, dated 01/01/2020, stated the drug regimen of each resident would be reviewed at least monthly by a licensed pharmacist to prevent, identify, report, and resolve potential risks associated with medication. The pharmacist would communicate any irregularities to the facility's Director of Nursing, the physician, and the facility's medical director. The policy stated the pharmacist did not need to document a

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continuing irregularity in the report each month if the physician had documented a valid clinical rationale for rejecting the pharmacist's recommendation.

The facility failed to ensure the physician reviewed and acknowledged the consultant pharmacist recommendations for a GDR with a response and documented rationale. This placed the resident at risk for unnecessary psychotropic medications.

- The Electronic Medical Record (EMR) for R38 documented diagnoses of vascular dementia (a progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain) with agitation (feeling of aggravation or restlessness brought on by a provocation or a medical condition), posttraumatic stress disorder (PTSD- mental disorder characterized by an acute emotional response to a traumatic event or situation involving severe environmental stress), diabetes mellitus (DM-when the body cannot use glucose, not enough sepsis made or the body cannot respond to the insulin), and depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest).

The "Annual Minimum Data Set" (MDS), dated 02/01/24, documented R38 had intact cognition. R38 was independent will all activities of daily living (ADLs). R38 was continent of bowel and bladder. The MDS recorded R38 had no behaviors and received an antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality), an antidepressant (a class of medications used to treat mood disorders), and a hypnotic (a class of

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medications used to induce sleep) medication during the observation period.

R38's "Care Plan," dated 02/07/24, initiated on 06/10/21, documented R38 received psychotropic (alters mood or thought) medication and directed staff to monitor for side effects. Staff completed the "Abnormal Involuntary Movement Scale" (AIMS-a rating scale that was designed to measure the involuntary movements that developed as a side effect from antipsychotic medications) assessment, consulted with the pharmacy to consider dosage reduction when clinically appropriate and monitored for behaviors.

The "Physician's Order," dated 06/15/21 directed staff to administer quetiapine fumarate (antipsychotic), 25 milligrams (mg), by mouth, twice per day, for dementia without behavioral disturbance.

Review of the CP's monthly medication reviews for R38 dated 03/06/23-02/26/24, documented the pharmacist had no recommendations related to quetiapine use.

R38's EMR lacked evidence of a documented physician rationale which included the multiple unsuccessful attempts for nonpharmacological symptom management and risk versus benefits for the ongoing quetiapine use.

On 02/28/24 at 08:17 AM, observation revealed R38 wore a stocking cap, and a red sweatshirt which had multiple food stains on it.

On 02/28/24 at 03:30 PM, Administrative Nurse D stated R38 did not have an appropriate indication for the use of quetiapine.

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F 756	Continued From page 103 The facility's "Medication Regimen Review," policy, dated 01/01/20, documented the drug regimen of each resident was reviewed at least once a month by a licensed pharmacist and included a review of the resident's medical chart and the pharmacist should communicate ay recommendations and identified irregularities via written communication within 72 hours of the review. The policy further documented the staff shall act upon all recommendations according to procedures for addressing medication regimen review irregularities. The facility failed to ensure the CP identified and reported the lack of an appropriate indication for R38's quetiapine. This placed the resident at risk for unnecessary medications and adverse side effects.	F 756		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse	F 757		

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consequences which indicate the dose should be reduced or discontinued; or

§483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 59 residents. The sample included 17 residents. Based on observation, record review, and observation, the facility failed to obtain blood sugar parameters to ensure adequate monitoring for Resident (R) 17 who received insulin (a hormone that lowers the level of glucose in the blood) which placed the resident at risk of unnecessary medications and complications related to diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin).

Findings included:

- R17's Electronic Medical Record (EMR) included diagnoses of a personal history of urinary tract infections (UTI), chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), neuralgia (intermittent along the course of a nerve) and neuritis (inflammation of nerves causing pain), unspecified disorders of the bladder, type two diabetes mellitus, chronic respiratory failure with hypoxia (inadequate supply of oxygen), benign prostatic hyperplasia (BPH-non-cancerous enlargement of the prostate which can lead to interference with urine flow, urinary frequency, and urinary tract infections) with lower urinary tract symptoms, low back pain,

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unspecified cirrhosis (chronic degenerative disease of the liver), obesity (excessive body fat) and a need for assistance with personal cares.

The "Quarterly Minimum Data Set" (MDS), dated 01/03/24, documented R17 had intact cognition. R17 had a functional range of motion impairment of both lower extremities and was dependent on staff for toileting, bathing, dressing of the lower and upper body, personal hygiene, and transfers. The MDS further documented R17 had an indwelling urinary catheter (tube placed in the bladder to drain urine into a collection bag) and was frequently incontinent of bowel. R17 had macerated (softening and breaking down of skin as a result of prolonged exposure to moisture, such as sweat, urine, feces, or wounds for extended periods) associated skin damage. R17 had shortness of breath with exertion, sitting, resting, and lying flat. The MDS further documented R17 received medication for pain, an antidepressant (a class of medications used to treat mood disorders), a hypnotic (a class of medications used to induce sleep), a diuretic (medication to promote the formation and excretion of urine), insulin and used oxygen during the observation period.

R17's "Care Plan," initiated 05/19/23, documented R17 had diabetes mellitus, and directed staff to educate the resident, family, and caregivers as to the correct protocol for glucose monitoring and insulin (a hormone that lowers the level of glucose in the blood) injections and obtain return demonstrations. The care plan lacked parameters for physician notification of low or elevated blood sugar levels.

The "Physician Order", dated 05/22/23, directed

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staff to administer by injection insulin glargine (long-acting insulin) solution 15 units subcutaneously (under the skin) at bedtime for diabetes.

The "Physician Order", dated 05/30/23, directed staff to obtain a blood sugar twice a day (BID) for type 2 diabetes mellitus. The order lacked parameters on when to notify the physician.

R17's EMR recorded a postprandial (the timeframe of approximately two hours after eating) blood sugar obtained on 02/02/24 between 07:00 PM and 11:00 PM resulting in a reading of 456 milliliters (ml) per deciliter (dL). (Normal postprandial blood sugar levels for adults with DM are 180 ml/dL or less). R17's medical record lacked evidence of physician notification or assessment of the resident related to the abnormally high blood sugar reading.

On 02/28/24 at 01:39 PM, Administrative Nurse D could not verify whether staff notified the physician regarding R17's high blood sugar.

The facility's "Medication Regimen Review", dated 01/01/20, documented the drug regimen of each resident is reviewed at least monthly by a licensed pharmacist and included a review of the resident's medical chart. Review of the medical record to prevent, identify, report, and resolve medication-related problems, medication errors, or other irregularities. The pharmacist shall communicate any recommendations and identify irregularities via written communication within 72 hours of the review. The pharmacist shall forward to the facility's Consultant Pharmacist for follow-up if indicated. Facility staff shall act upon all recommendations according to procedures for

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F 757	Continued From page 107 addressing medication regimen review irregularities. The facility to obtain blood sugar parameters for R17 who received insulin. This placed the resident at risk of unnecessary medications and complications related to diabetes mellitus.	F 757		
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order	F 758		

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F 758	Continued From page 108 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 59 residents. The sample included 17 residents. Based on observation, record review, and interview, the facility failed to ensure Resident (R) 10's antidepressant (class of medications used to treat mood disorders) medications had an approved indication, failed to ensure R55 had an end date for the use of an as needed (PRN) antianxiety (class of medications that calm and relax people), failed to ensure R20's recommended gradual dose reduction of psychotropic (alters mood or thought) medications were addressed, and failed to ensure R38's antipsychotic (class of medications used to treat major mental conditions which cause a break from reality) had an appropriate indication or the required physician documentation. This placed the residents at risk of receiving unnecessary psychotropic medication.	F 758		

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Findings included:

- R10's Electronic Medical Record (EMR) documented diagnoses of anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear) disorder, hypersomnia (excessive sleepiness or drowsiness), age-related physical debility, communication deficit, bipolar disorder (a major mental illness that caused people to have episodes of severe high and low moods), dementia, muscle weakness, and pain.

The "Quarterly Minimum Data Set" (MDS), dated 01/11/24, documented R10 had moderately impaired cognition, and had not exhibited behaviors. R10 required substantial to maximal assistance of staff for activities of daily living (ADL) and mobility. R10 took an antipsychotic (class of medications used to treat major mental conditions that cause a break from reality) and an antidepressant (class of medications used to treat mood disorders) with no gradual dose reduction (GDR) or physician documentation the GDR was clinically contraindicated.

The "Psychotropic Drug Use Care Area Assessment" (CAA), dated 10/24/23, documented R10 received antipsychotic and antidepressant medications. R10 was at risk for adverse reactions to medications and the pharmacist reviewed the medications on admission and monthly thereafter.

R10's "Care Plan," revised 10/27/23, documented R10 was prescribed psychotropic medications and was at risk for complications. The care plan directed staff to administer medications as

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ordered by the physician, monitor for side effects and effectiveness each shift, and consult with the pharmacy and physician to consider dosage reduction when clinically appropriate at least quarterly. The care plan further directed staff to discuss with the physician and family the ongoing need for the use of medication. Staff were to review behaviors, and alternate therapies attempted and their effectiveness, monitor, document, and report any adverse reactions.

The "Physician Order", dated 10/14/23, directed staff to administer:
Aripiprazole (antipsychotic) two milligrams (mg) by mouth in the morning related to bipolar disorder.
Duloxetine (antidepressant) 30 mg by mouth every morning related to anxiety disorder.
Mirtazapine (antidepressant) 15 mg by mouth at bedtime related to anxiety disorder.
Hydralazine (blood pressure medication) 50 mg by mouth two times a day with meals related to anxiety disorder.

The "Pharmacy Drug Regimen Review" dated 10/14/23, documented a recommendation to R10's attending physician which noted R10 had an order of mirtazapine that did not have a Food and Drug Administration (FDA) labeled indication and recommended to reassess the indication for use or a Risk versus Benefit assessment. An order of mirtazapine that was prescribed "Off-Label" could potentially be considered an unnecessary medication. R10's clinical record lacked evidence of a physician response.

The "Pharmacy Drug Regimen Review" dated 11/01/23, documented a recommendation to the attending physician that R10 had an order for

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hydralazine with an indication of anxiety, if applicable change the indication. Hydralazine was not FDA-approved for anxiety but the benefit to the resident outweighs any potential adverse side effects. R10's clinical record lacked evidence of a physician response.

On 02/27/24 at 01:39 PM, observation revealed R10 sat in a wheelchair in the hallway.

On 02/28/24 at 01:39 PM, Administrative Nurse D verified anxiety was not an approved use of R10's depression medications or hydralazine.

The facility's "Medication Regimen Review", dated 01/01/20, documented the drug regimen of each resident is reviewed at least monthly by a licensed pharmacist and included a review of the resident's medical chart. Review of the medical record to prevent, identify, report, and resolve medication-related problems, medication errors, or other irregularities. The pharmacist shall communicate any recommendations and identify irregularities via written communication within 72 hours of the review. The pharmacist shall forward to the facility's Consultant Pharmacist for follow-up if indicated. Facility staff shall act upon all recommendations according to procedures for addressing medication regimen review irregularities.

The facility failed to ensure R10 had an appropriate indication for multiple antidepressants. This placed R10 at risk of receiving unnecessary psychotropic medications.

- R55's Electronic Medical Record (EMR) documented diagnoses of type two diabetes mellitus (DM-when the body cannot use glucose,

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not enough insulin made or the body cannot respond to the insulin), post hemorrhagic (loss of a large amount of blood in a short period) anemia (inadequate number of healthy red blood cells to carry adequate oxygen to body tissues), muscle weakness, heart failure, dementia (progressive mental disorder characterized by failing memory, confusion), age related cognitive decline, pain, and the need of assistance with personal cares.

The "Quarterly Minimum Data Set" (MDS), dated 01/24/24, documented R55 had intact cognition and verbal behavioral symptoms directed toward others which occurred one to three days of the look-back period. R55 had had functional range of motion to one side upper extremity and both lower extremities and required partial/moderate assistance with toileting and dressing. The MDS further documented R55 had an indwelling catheter (a flexible tube inserted through a narrow opening into a body cavity, particularly the bladder, for removing fluid) and was occasionally incontinent of bowel. R55 received scheduled pain medication, insulin (a hormone that lowers the level of glucose in the blood), and high-risk medication of a hypnotic (a class of medications used to induce sleep) class.

R55's "Care Plan" lacked any goals or directives related to R55's use of psychotropic medication.

The "Physician Order" dated 10/25/23, directed staff to administer alprazolam (antianxiety medication) 0.25 milligrams (mg) every eight hours PRN for anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear) and lacked a stop date.

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The "Physician Order", dated 12/12/23, directed staff to administer alprazolam 0.25 mg twice a day for anxiety.

R55's EMR revealed the PRN alprazolam was administered nine times in December 2023, four times in January 2024, and once in February 2024.

The "Pharmacy Drug Regimen Review", dated 12/04/23, recorded a recommendation made to the attending physician that R55's alprazolam did not have an FDA-approved indication. The physician responded the use of alprazolam was for anxiety. The "Pharmacy Drug Regimen Review" lacked evidence The CP reported the lack of a required end date for the use of PRN alprazolam.

On 02/28/24 at 07:45 AM, observation revealed R55 in bed which was low to the floor; the catheter drainage bag rested on the floor mat next to the bed.

On 02/28/24 at 01:30 PM, Administrative Nurse D verified the PRN alprazolam had not been addressed by the pharmacist and confirmed it required an end date.

The facility's "Medication Regimen Review", dated 01/01/20, documented the drug regimen of each resident is reviewed at least monthly by a licensed pharmacist and included a review of the resident's medical chart. Review of the medical record to prevent, identify, report, and resolve medication-related problems, medication errors, or other irregularities. The pharmacist shall communicate any recommendations and identify irregularities via written communication within 72

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hours of the review. The pharmacist shall forward to the facility's Consultant Pharmacist for follow-up if indicated. Facility staff shall act upon all recommendations according to procedures for addressing medication regimen review irregularities.

The facility failed to ensure R55's PRN psychotropic medication had a 14-day stop date or specific duration with the physician's documented rationale for extended use. This placed R55 at risk for unnecessary psychotropic medications and related side effects.

- R20 's Electronic Medical Record documented diagnoses of cerebral palsy (a progressive disorder of movement, muscle tone, or posture caused by injury or abnormal development in the immature brain, most often before birth), neuromuscular dysfunction of bladder (dysfunction of the urinary bladder caused by a lesion of the nervous system), anxiety disorder (mental or emotional disorder characterized by apprehension, uncertainty and irrational fear), depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and insomnia (inability to sleep).

The "Quarterly Minimum Data Set" (MDS), dated 01/25/24, documented a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS documented R20 had no behaviors and received an antianxiety (a class of medications that calm and relax people), an antidepressant (a class of medications used to treat mood disorders), and a hypnotic (a class of medications used to induce sleep) medication. The MDS documented R20 was independent with eating and required moderate staff assistance

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with dressing and bed mobility. R20 was dependent on staff for toileting and transfers.

R20's "Medication Care Plan," dated 02/07/24, directed staff to administer medications as ordered, monitor labs, and report findings to the Nurse practitioner (NP) or the physician. The plan directed staff to monitor and document for side effects and effectiveness. Staff were to ensure a pharmacy review monthly and arrange for psychiatric consult with follow-up as indicated. The plan directed staff to monitor behavior episodes and attempt to determine the underlying cause. Staff were to encourage the resident to express his feelings appropriately.

The "Physician Orders" included the following:
Zolpidem (hypnotic drug), 10 milligrams (mg) at bedtime for insomnia, started 02/03/23.
Buspar (antianxiety drug), 10 mg twice daily (BID) for anxiety, started 12/26/22.
Duloxetine (antidepressant) delayed release, 30 mg, BID, started 12/26/22.

The "Consultant Pharmacist Review," dated 04/05/23, documented the consultant pharmacist recommended a gradual dose reduction (GDR) for Buspar, duloxetine, and zolpidem. R20's clinical record lacked evidence the physician responded.

The "Consultant Pharmacist Review," dated 10/03/23, documented the consultant pharmacist recommended a GDR for Buspar, duloxetine, and zolpidem. R20's clinical record lacked evidence the physician responded.

The "Consultant Pharmacist Review," dated 02/08/24, recommended a GDR of zolpidem or a

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trial of melatonin. The physician replied no and documented the resident still required the hypnotic, and the benefit outweighed the risk.

On 02/27/24 at 02:27 PM, observation revealed R20 lay in bed with his eyes closed; music played in his room. R20 wore foam boots and had an air mattress on the bed. His urine collection bag hung low on the side of his bed.

On 02/28/24 at 02:42 PM, Administrative Nurse D verified the physician had not written a risk versus benefit rationale for the continued use of Buspar, zolpidem, or duloxetine when the pharmacist recommended a GDR or a risk versus benefit rationale on 04/05/23 and 10/03/23.

On 02/29/24 at 07:55 AM, Administrative Nurse D verified the facility should have followed through with the physician when he did not answer the pharmacist's recommendations for a GDR or a risk versus benefit rationale.

The facility's "Use of Psychotropic Drugs" policy, dated 01/09/24, stated the indications for use of any psychotropic drug would be documented in the medical record and initiated only after medical, physical, functional, psychosocial, and environmental causes had been identified and addressed. Residents who receive psychotropic drugs would receive gradual dose reductions unless clinically contraindicated. The physician in collaboration with the consultant pharmacist would re-evaluate the use of the medication and consider if the medication could be reduced or discontinued.

The facility's "Medication Regimen Review" policy, dated 01/01/2020, stated the drug regimen

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of each resident would be reviewed at least monthly by a licensed pharmacist to prevent, identify, report, and resolve potential risks associated with medication. The pharmacist would communicate any irregularities to the facility's Director of Nursing, the physician, and the facility's medical director. The policy stated the pharmacist did not need to document a continuing irregularity in the report each month if the physician had documented a valid clinical rationale for rejecting the pharmacist's recommendation.

The facility failed to ensure a GDR was attempted or the physician documented a rationale for the risks versus the benefits of continued use for R20's psychotropic medications. This placed R20 at risk for complications related to psychotropic medications and unnecessary medications.

- The Electronic Medical Record (EMR) for R38 documented diagnoses of vascular dementia (a progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain) with agitation (feeling of aggravation or restlessness brought on by a provocation or a medical condition), posttraumatic stress disorder (PTSD- mental disorder characterized by an acute emotional response to a traumatic event or situation involving severe environmental stress), diabetes mellitus (DM-when the body cannot use glucose, not enough sepsis made or the body cannot respond to the insulin), and depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest).

The "Annual Minimum Data Set" (MDS), dated

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02/01/24, documented R38 had intact cognition. R38 was independent will all activities of daily living (ADLs). R38 was continent of bowel and bladder. The MDS recorded R38 had no behaviors and received an antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality), an antidepressant (a class of medications used to treat mood disorders), and a hypnotic (a class of medications used to induce sleep) medication during the observation period.

R38's "Care Plan," dated 02/07/24, initiated on 06/10/21, documented R38 received psychotropic (alters mood or thought) medication and directed staff to monitor for side effects. Staff completed the "Abnormal Involuntary Movement Scale" (AIMS-a rating scale that was designed to measure the involuntary movements that developed as a side effect from antipsychotic medications) assessment, consulted with the pharmacy to consider dosage reduction when clinically appropriate and monitored for behaviors.

The "Physician's Order," dated 06/15/21 directed staff to administer quetiapine fumarate (antipsychotic), 25 milligrams (mg), by mouth, twice per day, for dementia without behavioral disturbance.

R38's EMR lacked evidence of a documented physician rationale which included the multiple unsuccessful attempts for nonpharmacological symptom management and risk versus benefits for the ongoing quetiapine use.

On 02/28/24 at 08:17 AM, observation revealed R38 wore a stocking cap and a red sweatshirt which had multiple food stains on it.

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F 758	Continued From page 119 On 02/28/24 at 03:30 PM, Administrative Nurse D stated R38 did not have an appropriate indication for the use of quetiapine. The facility's "Use of Psychotropic Drugs" policy, dated 01/01/20, documented that residents are not given psychotropic drugs unless the medication was necessary to treat a specific condition as diagnosed and documented in the clinical record and the medication was beneficial to the residents as demonstrated by monitoring and documentation of the resident response to the medication. Non-pharmacological interventions that have been attempted and the target symptoms for monitoring shall be included in the documentation. The facility failed to ensure an appropriate indication or the required physician documentation for the continued use of R38's antupsychotic, placing the resident at risk for unnecessary side effects.	F 758		
F 801 SS=F	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e) This includes: §483.60(a)(1) A qualified dietitian or other	F 801		

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

§483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services.
(i) The director of food and nutrition services must at a minimum meet one of the following qualifications-

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F 801	Continued From page 121 (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; or (E) Has 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, 2023, that includes topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by: The facility had a census of 59 residents. The sample included 19 residents. Based on observation, record review, and interview, the facility failed to employ a full-time certified dietary manager for the residents who resided in the facility and received meals from the facility kitchen. This placed the residents at risk for inadequate nutrition. Findings included:	F 801		

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F 801	Continued From page 122 - On 02/28/24 at 11:04 AM, a review of the noon meal consisted of butter noodles, pork chops, and yellow squash. On 02/28/24 at 11:04 AM, Dietary Staff BB verified she was not a certified dietary manager. Dietary Staff BB stated she had started the certified dietary manager classes. On 02/28/24 at 08:30 AM, Administrative Staff A verified Dietary Staff BB did not have a dietary manager certification. The facility's " Director of Food Policy," revised 07/02/21, documented the director of food and nutrition services would be qualified according to the position's job description and guidelines put forth by the agency that regulates the facility. The facility failed to employ a full-time certified dietary manager for the residents who resided in the facility and received meals from the kitchen. This placed the residents at risk for inadequate nutrition.	F 801		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention	F 880		

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and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed

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by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 59 residents. The sample included 17 residents. Based on observation, record review, and interview, the facility failed to provide sanitary indwelling urinary catheter (tube placed in the bladder to drain urine into a collection bag) care per the standards practice related to infection prevention for Resident (R) 17, R55, and R54. This placed the affected residents at increased risk for urinary tract infections (UTI) and related complications.

Findings included:

- On 02/27/24 at 01:47 PM, observation revealed R17 lay in bed and watched TV. The indwelling catheter drainage bag hung on the bedframe at the foot of the bed, without a privacy bag.

On 02/28/24 at 07:39 AM, observation revealed R17 lying on his back in the bed. His catheter drainage bag lay directly on the floor, not attached to the bed. Licensed Nurse (LN) H stated the catheter bag should not be lying on the

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floor and confirmed R17 had a history of UTIs. LN H drained the catheter bag and hooked it to the frame of the bed.

On 02/28/24 at 07:45 AM, observation revealed R55 in bed which was low to the floor; the catheter drainage bag rested on the floor mat next to the bed.

On 02/28/24 at 08:37 AM, R54 sat on the toilet. Certified Nurse Aide (CNA) N placed the uncovered urinary catheter bag on the floor in front of the toilet and placed a plastic container on the floor without a clean barrier. CNA N used an alcohol pad to wipe the tip of the drainage port, then picked up the catheter bag and opened the port. CNA N drained the clear yellow urine into the container. CNA N used an alcohol pad to wipe the drainage port tip again and reinserted the port into the holder then placed the catheter bag on the floor in front of R54. CNA N then applied gloves, stepped on the bag and tubing with her shoe, then used an alcohol wipe and wiped the catheter starting from the tubing insertion site, down to the connection site. R54 stood up and CNA N, with the same soiled gloves, pulled R54's cloth underwear and pants up, then removed and discarded the gloves. CNA N placed R54's catheter bag in her ungloved hand and followed the resident to his wheelchair. Further observation revealed CNA N placed the uncovered catheter bag on the floor, then picked it up with ungloved hands and fastened it to the right-hand side of R54's walker. CNA N left the room without washing her hands and went into another resident's room.

On 02/28/24 at 12:00 PM, observation revealed staff brought R55 to the dining room with the

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catheter drainage bag and tubing dragging on the floor under the wheelchair.

On 02/28/24 at 08:55 AM, CNA N verified she placed the urinary catheter bag on the floor and did not change her gloves or wash her hands after providing catheter care. CNA N stated she was going to hang the catheter on the walker but did not think she could. She said she should have changed her gloves and washed her hands after providing catheter care.

On 02/28/24 at 03:28 PM, Administrative Nurse D stated she expected staff to follow infection prevention protocols when providing urinary catheter care. Administrative Nurse D said staff should hang the urinary catheter bag below the level of the bladder and never place it on the floor. Administrative Nurse D stated she expected staff to change gloves between dirty and clean and wash hands immediately after removing gloves.

The facility's "Hand Hygiene Policy," revised 10/25/2002, documented that staff involved with direct resident contact would perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors.

The facility's "Catheter Care Policy," revised 01/09/24, instructed staff to apply gloves, provide catheter care to the perineal area, bag and gather all supplies used, discard disposable items in the trash can, assist resident to a comfortable, appropriate position, return room back to the original order and then perform hand hygiene.

The facility failed to provide sanitary indwelling

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F 880	Continued From page 127 urinary catheter care per the standards practice related to infection prevention for R17, R55, and R54. This placed the affected residents at increased risk for infections and related complications.	F 880		