

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

PRINTED: 03/20/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175517	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/06/2024
NAME OF PROVIDER OR SUPPLIER BROOKDALE OVERLAND PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 12000 LAMAR OVERLAND PARK, KS 66209		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey and Complaint Investigation # KS00185975.	F 000			
F 550 SS=D	The 2567 was sent electronically on 03/20/24. 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	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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F 550	Continued From page 1 resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: The facility identified a census of 78 residents. The sample included 23 residents with five residents reviewed for activities of daily living (ADLs). Based on observations, record review, and interviews, the facility failed to promote care for Resident (R) 30, who was dependent on staff assistance for all ADLs, in a manner that preserved R30's dignity. These deficient practices placed the resident at risk for impaired psychosocial well-being and an undignified living environment. Findings included: - On 03/04/24 at 11:06 AM R30's room was located across from an open communal dining room. R30's door was open. R30 lay in her bed; she wore an incontinence brief and was uncovered from the waist down. R30 was visible from the hallway and part of the dining room while she lay in her bed, with her brief and legs exposed. Staff walked past her room in the hallway while some residents sat in the dining room. On 03/05/24 at 03:25 PM, R30's door was open. R30 lay in bed and slid her bare feet across her	F 550			

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F 550	Continued From page 2 mattress. R30 wore only an incontinence brief, and she was uncovered. R30's exposed body was visible from the hallway and part of the dining room across from her room. There were some residents in the dining room. On 03/06/24 at 10:28 AM Certified Nurse Aide (CNA) M stated she was unsure if R30 was able to see or not. CNA M stated R30 was dependent, and staff had to do everything for her which included helping her get dressed. CNA M stated R30's door was left open so staff would keep an eye on her as R30 was a fall risk. CNA M further stated if R30 removed her clothing or blankets, CNA M would go in, cover her up, and help her get situated in bed. On 03/06/24 at 10:51 AM Licensed Nurse (LN) H stated R30 could not see very well but she was able to track to some degree. LN H stated R30 was dependent, and staff had to do everything for her which included dressing and helping her eat. LN H stated R30's door was left open for fall safety. LN H further stated that she would try and go by R30's room often to cover her up when she would pull her blanket off. LN H stated R30 was more comfortable wearing a nightgown instead of pants, and that staff were aware of her preference as they worked with her regularly. LN H stated that she was unsure if R30's clothing preferences were on her care plan. On 03/06/24 at 02:11 PM Administrative Nurse D stated she was not sure of the level of assistance R30 needed; however, she stated that she believed R30 at least required extensive assistance. Administrative Nurse D stated if R30 was in her room, in only a brief and was uncovered, that it was R30's choice as some	F 550			

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F 550	Continued From page 3 people were comfortable that way and R30 did not always want the door shut. Administrative Nurse D further stated she believed staff knew R30's preferences as they worked with her regularly and R30's preferences did not necessarily need to be on her care plan. Administrative Nurse D further stated she expected staff to get to know the resident and their family, and stated, "Let us be real here, staff are not reviewing an entire care plan." Administrative Nurse D stated the staff that cared for R30 were consistent, worked with her often, and knew what her preferences were. The facility provided a "Quality of Life - Dignity" policy with a last revised date of 10/22, documented that residents should be cared for in a manner that promotes and enhances their sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. Residents should be treated with dignity and respect. Associates should promote, maintain, and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures. The facility failed to promote care for R30, who was dependent on staff assistance for all ADLs in a manner that preserved R30's dignity. These deficient practices placed the resident at risk for impaired psychosocial well-being and an undignified living environment.	F 550			
F 637 SS=D	Comprehensive Assessment After Significant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the	F 637			

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F 637	Continued From page 4 resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: The facility identified a census of 78 residents. The sample included 23 residents. Based on observation, record review, and interviews, the facility failed to identify a significant change in the physical condition and complete a comprehensive "Significant Change Minimum Data Set" (MDS) for Resident (R) 33 with the addition of hospice services. This deficient practice placed R33 at risk for unidentified care needs. Findings included: - R33's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of atrial fibrillation (rapid, irregular heartbeat), cerebrovascular accident (CVA-stroke- the 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), dementia (a progressive mental disorder characterized by failing memory, confusion), and Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness). The "Significant Change Minimum Data Set"	F 637			

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F 637	Continued From page 5 (MDS) dated 12/09/23 documented a Brief Interview of Mental Status (BIMS) score of 10 which indicated moderately impaired cognition. The MDS documented R33 received hospice services during the observation period. The "Quarterly MDS" dated 02/28/24 documented a BIMS score of eight which indicated severely impaired cognition. The MDS documented that R33 received hospice services during the observation period. R33's "Functional Abilities Care Area Assessment" (CAA) dated 12/23/23 documented R33 had a CVA, and hospice services were provided to add additional support for him. R33's "Care Plan" dated 12/09/23 documented staff would keep hospice informed of durable medical equipment (DME) and supplies needed. Hospice would notify staff of any additional DME or supplies recommended or delivered. The plan of care dated 12/09/23 also documented the staff would adjust the provision of activities of daily living (ADL) to compensate for R33's changing abilities and staff would encourage his participation to the extent that he wished to participate. The plan of care also documented alternate bath days with hospice to promote and provide additional skin care unless R33 preferred alternate arrangements. The plan of care documented that staff would anticipate weight loss, decrease in fluid and/or caloric intake, skin alteration, ADLs, and/or cognitive decline related to terminal illness. The plan of care lacked a description of the services provided by hospice. R33's EMR under the "Orders" tab revealed the following physician orders:	F 637			

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F 637	Continued From page 6 Admit to hospice with a diagnosis of CVA; the resident has six months or less of life dated 10/19/23. A review of R33's clinical record lacked evidence the facility completed a "Significant Change MDS" to address the resident's recent physical decline and addition of hospice services within the required timeframe. On 03/05/24 at 11:06 AM, R33 sat upright in his Broda chair (specialized wheelchair with the ability to tilt and recline) at the dining table. R33 was asleep with his head tilted to the right side. On 03/06/24 at 11:34 AM, Administrative Nurse F stated she followed the "Resident Assessment Instrument" (RAI) manual when completing the resident's MDS. Administrative Nurse F stated she relied on the clinical team to inform her of any changes regarding a resident's decline or admission to hospice services. Administrative Nurse F stated she was not informed of R33's admission to hospice services until December 2023 and that is when she completed the "Significant Change MDS" for R33. The "RAI Manual" documented that a "Significant Change MDS" must be completed no later than 14 days after a resident was admitted to hospice services. The facility's "MDS Completion and Submission Timeframes" policy last revised in July 2017 documented the facility would conduct and submit resident assessments in accordance with current federal and state submission timeframes. The facility failed to identify a significant change	F 637			

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F 637	Continued From page 7 and addition of hospice services for R33's physical condition and complete a comprehensive "Significant Change MDS," placing the resident at risk of not receiving needed care.	F 637			
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: The facility identified a census of 78 residents. The sample included 23 residents. Based on observations, record reviews, and interviews, the facility failed to ensure accurate assessment and documentation on the Minimum Data Set (MDS) related to Resident (R)87's discharge location. This deficient practice had the risk of miscommunication related to R87's continued care needs. Findings Included: - The "Medical Diagnosis" section within R87's Electronic Medical Records (EMR) included diagnoses of atrial fibrillation (A-fib: rapid, irregular heartbeat), hypertension (high blood pressure), muscle weakness, history of sepsis (a life-threatening systemic reaction that develops due to infections which cause inflammation throughout the entire body), syncope (fainting or passing out), and repeated falls. R87's "Admission MDS" completed 12/13/23 noted a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. The MDS indicated he was dependent on staff for bed	F 641			

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F 641	Continued From page 8 mobility, toileting, bathing, dressing, and hygiene. The MDS indicated he used a wheelchair for mobility and required staff assistance. The MDS indicated he received speech, physical, and occupational therapy services. R87's "Discharge MDS" completed 01/10/24 documented he was discharged to a short-term general hospital with no anticipated return. R87's "Functional Abilities Care Area Assessment (CAA)" completed 12/20/23 indicated he was hospitalized at an acute care facility before his admission related to a fall at his home. The CAA noted he was treated for A-Fib and diverticulitis with infection (pouch-like herniations through the muscular layer of the colon) and admitted to the skilled nursing facility. The CAA noted he had deficits with his activities of daily living (ADLs). R87's "Care Plan" initiated on 12/07/23 indicated he was at risk for falls, skin breakdown, weight loss, and ADL deficits related to his medical diagnoses. The plan indicated he required moderate to extensive assistance from staff related to bathing, bed mobility, dressing, and transfers. The MDS indicated his goal was to complete therapy services and discharge home. R87's EMR under "Progress Notes" indicated he was discharged home from the facility on 01/10/24 with physical, occupational, and nursing services. The note indicated he received his discharge paperwork and medication review. The note indicated he verbalized an understanding of his provided services and medications. The note indicated he left the facility with his personal belongings with his friend taking him home.	F 641			

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F 641	Continued From page 9 On 03/06/24 at 11:34 AM Administrative Nurse F stated R87 was not hospitalized and left the facility as a planned discharge. She stated the MDS should have been coded as a discharge to home/community. The facility's provided "Comprehensive Assessment" revised 03/2022 the comprehensive assessment will be free of significant errors related to coding of the MDS and changes in the resident status. The facility failed to ensure accurate assessment and documentation on the MDS related to R87's discharge location. This deficient practice had the risk of miscommunication related to R87's continued care needs.	F 641			
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: The facility identified a census of 78 residents. The sample included 23 residents with five residents reviewed for activities of daily living (ADLs). Based on observations, record review, and interviews, the facility failed to provide ADL assistance to Resident (R) 30, who was dependent on staff assistance for all ADLs. These deficient practices placed the residents at risk of decreased psycho-social well-being and impaired ADL. Findings included:	F 677			

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F 677	Continued From page 10 - R30's Electronic Medical Record (EMR) documented diagnoses of restless leg syndrome (a condition that causes a very strong urge to move the legs), Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), and dementia (progressive mental disorder characterized by failing memory, confusion). The "Significant Change Minimum Data Set (MDS)" dated 02/05/24, documented R30 had a Brief Interview for Mental Status (BIMS) score of 00 which suggested severely impaired cognition. The MDS documented R30 used a wheelchair and required substantial/maximal assistance for bathing, and upper body dressing. The MDS documented R30 was dependent on staff for toileting hygiene, lower body dressing, moving from lying to sitting position, and transfers. The MDS documented R30 had severely impaired vision with either no vision at all or only being able to see light, colors, or shapes; eyes do not appear to follow objects. The MDS Section F for resident preferences, which included R30's daily clothing choices, was not addressed. The "Cognitive Loss / Dementia Care Area Assessment (CAA)" dated 02/05/24, documented R30 had a diagnosis of Alzheimer's Disease and severe cognitive impairment. R30's "Care Plan" with an initiated date of 01/04/23, documented R30 had an ADL self-care performance deficit related to functional decline, malnutrition, weakness, and pain and was receiving hospice services. Interventions initiated on 01/04/23 documented R30 required assistance to turn and reposition in bed, personal	F 677			

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F 677	Continued From page 11 hygiene, bathing, eating, and toileting. R30's care plan lacked the level of assistance for dressing, or clothing preferences. On 03/04/24 at 11:06 AM R30's room was located across from an open communal dining room. R30's door was open. R30 lay in her bed; she wore an incontinence brief and was uncovered from the waist down. R30 was visible from the hallway and part of the dining room while she lay in her bed, with her brief and legs exposed. Staff walked past her room in the hallway while some residents sat in the dining room. On 03/05/24 at 03:25 PM, R30's door was open. R30 lay in bed and slid her bare feet across her mattress. R30 wore only an incontinence brief, and she was uncovered. R30's exposed body was visible from the hallway and part of the dining room across from her room. There were some residents in the dining room. On 03/06/24 at 10:28 AM Certified Nurse Aide (CNA) M stated she was unsure if R30 was able to see or not. CNA M stated R30 was dependent, and staff had to do everything for her which included helping her get dressed. CNA M stated R30's door was left open so staff would keep an eye on her due to R30 was a fall risk. CNA M further stated if R30 removed her clothing or blankets, CNA M would go in cover her up, and help her get situated in bed. On 03/06/24 at 10:51 AM Licensed Nurse (LN) H stated R30 could not see very well but she was able to track to some degree. LN H stated R30 was dependent, and staff had to do everything for her which included dressing and helping her eat. LN H stated R30's door was left open for fall	F 677			

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F 677	Continued From page 12 safety. LN H further stated that she would try and go by R30's room often to cover her up when she would pull her blanket off. LN H stated R30 was more comfortable wearing a nightgown instead of pants, and that staff were aware of her preference as they worked with her regularly. LN H stated that she was unsure if R30's clothing preferences were on her care plan. On 03/06/24 at 02:11 PM Administrative Nurse D stated she was not sure of the level of assistance R30 needed; however, she stated that she believed R30 at least required extensive assistance. Administrative Nurse D stated if R30 was in her room, in only a brief and was uncovered, that it was R30's choice as some people were comfortable that way and R30 did not always want the door shut. Administrative Nurse D further stated she believed staff knew R30's preferences as they worked with her regularly and R30's preferences did not necessarily need to be on her care plan. Administrative Nurse D further stated she expected staff to get to know the resident and their family, and stated, "Let us be real here, staff are not reviewing an entire care plan." Administrative Nurse D stated the staff that cared for R30 were consistent, worked with her often, and knew what her preferences were. The facility provided a "Supporting Activities of Daily Living" policy with a last revised date of 02/2024, documented appropriate care and services should be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and, or resident representative and in accordance with the plan of care, including appropriate support and assistance with hygiene, bathing, dressing,	F 677			

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F 677	Continued From page 13 grooming and oral care.	F 677			
F 686 SS=D	The facility failed to provide ADL assistance to R30, who was dependent on staff assistance for all ADLs. These deficient practices placed the residents at risk of decreased psycho-social well-being and impaired ADL. 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: The facility identified a census of 78 residents. The sample included 23 residents with four residents reviewed for pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, because of pressure, or pressure in combination with shear and/or friction). Based on observation, record review, and interviews, the facility failed to ensure two residents, Resident (R) 13 and R28 received pressure-reducing interventions for pressure ulcers. This placed R13 and R28 at increased risk for pressure ulcer development.	F 686			

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F 686	Continued From page 14 Findings included: - R13's Electronic Medical Record (EMR) documented diagnoses of venous insufficiency (poor circulation), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made, or the body cannot respond to the insulin) with diabetic neuropathy (weakness, numbness and pain from nerve damage, usually in the hands and feet), vascular dementia (a progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain), peripheral vascular disease (PVD- slow and progressive circulation disorder causing narrowing, blockage, or spasms in a blood vessel), generalized atherosclerosis (the buildup of fats, cholesterol, and other substances in and on the artery walls that can cause arteries to narrow, blocking blood flow), abnormalities of gait and mobility, lack of coordination and need for assistance with personal care. The "Admission Minimum Data Set (MDS)" dated 01/11/24, documented R13 had a Brief Interview for Mental Status (BIMS) score of 10 which suggested moderately impaired cognition. The MDS documented that R13 used a wheelchair and required substantial/maximal assistance for bathing, dressing, and personal hygiene, and he was dependent on staff for mobility and transfers. The MDS further documented that R13 had two unhealed Stage 2 (partial-thickness skin loss into but no deeper than the dermis including intact or ruptured blisters) pressure ulcers. The MDS documented R13 was frequently incontinent of urine with seven or more episodes of incontinence, but at least one episode of	F 686			

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F 686	Continued From page 15 continent voiding. The "Pressure Ulcer/Injury Care Area Assessment (CAA)" dated 01/11/24, documented that R13 had experienced a functional decline, had a recent fracture, and was no weight bearing to his left lower extremity. The CAA documented R13 required assistance with turning and repositioning. The CAA further documented R13 was readmitted to the facility with Stage 2 wounds to his bilateral (both sides) buttocks. R13's "Care Plan" with an initiated date of 12/22/23, documented R13 had potential, or actual impairment, to skin integrity related to mobility limitations, incontinence, peripheral vascular disease, venous insufficiency, and an immobilizer to his left lower extremity. An intervention initiated on 01/25/24, documented R13 needed his heels floated. An "Order" with a start date of 01/08/24, directed staff to float R13's heels while in bed as tolerated, every shift for pressure prevention. R13's "Treatment Administration Record (TAR)" documented on 03/04/24 day shift that R13's heels were floated. R13's TAR from 03/01/24 - 03/05/24 lacked evidence R13 refused to allow staff to float his heels while in bed. On 03/04/24 at 08:18 AM R13 rested in his bed. R13's heels rested directly on his mattress and the soles of his feet were pressed against the footboard of his bed. There was no evidence of a pillow, wedge, or other device in place to float R13's heels as he lay in bed. On 03/06/24 at 10:28 AM Certified Nurse Aide	F 686			

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F 686	Continued From page 16 (CNA) M stated she had access to the Kardex which contained the appropriate information for her to provide appropriate care for the residents. CNA M stated any relevant skin interventions, such as floating a resident's heels, would have been found in the Kardex. CNA M stated when floating a resident's heels, their heels could rest on a pillow, but not rest on a mattress or the footboard of the bed. CNA M stated she was not sure if staff were supposed to float R13's heels while he was in bed. On 03/06/24 at 10:51 AM Licensed Nurse (LN) H stated everyone had access to the care plan or Kardex which would allow staff to know which residents required pressure-relieving items or interventions. LN H stated R13 was at risk for skin breakdown and his heels should have been floated while in bed. LN H further stated when staff floated R13's heels, staff would place an item under his legs so that his heels were off the bed and that the soles of his feet should not be pressed against the footboard of the bed. LN H stated if a resident refused to have their heels floated, nurses would document the refusal in the resident's TAR. On 03/06/24 at 02:11 PM, Administrative Nurse D stated heels should not rest on the bed or footboard; however, she stated the residents would move around while in bed and sometimes end up with their heels no longer floating. Administrative Nurse D stated the expectation was that staff did not place the resident's heels on the bed or footboard and would use an item such as a pillow or heel risers to float the resident's heels. Administrative Nurse D stated if a resident refused to have their heels floated, she expected the CNAs to inform the nurse on duty, and if the	F 686			

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F 686	Continued From page 17 resident continued to refuse that should have been documented somewhere. The facility provided a "Skin Observation and Wound Prevention" policy with a last revised date of 10/22, documented the charge nurse should observe the condition of the resident's skin on admission and a routine basis. The policy further documented the charge nurse should initiate treatment interventions and the plan of care. The facility failed to ensure R13's heels were floated while he was in bed to prevent pressure ulcers. This placed R13 at increased risk for pressure ulcer development. - R28's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of dementia (a progressive mental disorder characterized by failing memory, and confusion) and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). The "Admission Minimum Data Set" (MDS) dated 10/09/23 documented a Brief Interview of Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS documented R28 was at risk of developing pressure-related injuries and there were pressure-reliving measures in place on her bed and in her wheelchair. R28 had nutritional measures in place during the observation period. The MDS documented R28 did not have any unhealed pressure-related injuries during the observation period. The "Quarterly MDS" dated 12/29/23 documented a BIMS score of 12 which indicated moderately impaired cognition. The MDS documented that R28 was at risk for the development of	F 686			

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F 686	Continued From page 18 pressure-related injuries and had pressure-relieving measures in place on her bed and in her wheelchair during the observation period. The MDS documented R28 had one unhealed pressure ulcer during the observation period. R28's "Pressure Ulcer Care Area Assessment" (CAA) dated 10/23/23 documented pressure relieving measures in place for R28 was a low air loss mattress, cushion in her wheelchair and staff would float her heels. R28's "Care Plan" revised 10/25/23 documented R28 had a low air loss mattress on her bed, a pressure relieving cushion in her wheelchair, and staff would float her heels. R28's "Care Plan" dated 11/03/23 documented R28 was to wear Prevalon boots (special pressure reducing heel protectors) on her bilateral (both sides) extremities at all times. R28's EMR under the "Orders" tab revealed the following physician order: Prevalon boots at all times as tolerated. Float heels when resident refused boots dated 03/04/24. On 03/05/24 at 11:00 AM R28 laid on her bed with her head slightly elevated. R28's bilateral heels rested on a pillow at the foot of her bed. Her heels were not floated, and she was not wearing Prevalon boots. On 03/06/24 at 10:28 AM Certified Nurse Aide (CNA) M stated she had access to the Kardex (a nursing tool that gives a brief overview of the care needs of each resident) which contained the appropriate information for her to provide	F 686			

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F 686	Continued From page 19 appropriate care for the residents. CNA M stated any relevant skin interventions, such as floating a resident's heels, would have been found in the Kardex. CNA M stated when floating a resident's heels, their heels could rest on a pillow, but not rest on a mattress or the footboard of the bed. CNA M stated she was not sure if the staff was supposed to float R28's heels while she was in bed, and she was sure R28 did not have any Prevalon boots. On 03/06/24 at 10:51 AM Licensed Nurse (LN) H stated everyone had access to the care plan or Kardex which would allow staff to know which residents required pressure-relieving items or interventions. LN H stated R28 was at risk for skin breakdown and her heels should have been floated while in bed. LN H further stated when staff floated a resident's heels, staff would place an item under her legs so that her heels were off the bed. LN H was not sure if R33 was to wear Prevalon boots. LN H stated if a resident refused to have their heels floated, nurses would document the refusal in the resident's "Treatment Administration Record" (TAR). On 03/06/24 at 02:11 PM, Administrative Nurse D stated heels should not rest on the bed or footboard; however, she stated the residents would move around while in bed and sometimes end up with their heels no longer floating. Administrative Nurse D stated the expectation was that staff did not place the resident's heels on the bed or on a pillow or heel risers to float the resident's heels. Administrative Nurse D stated if a resident refused to have their heels floated, she expected the CNAs to inform the nurse on duty, and if the resident continued to refuse that should have been documented somewhere.	F 686			

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F 686	Continued From page 20 The facility's "Skin Observation and Wound Prevention" policy with a last revised date of 10/22, documented the charge nurse should observe the condition of the resident's skin on admission and a routine basis. The policy further documented the charge nurse should initiate treatment interventions and the plan of care. The facility failed to ensure that pressure-reducing measures were placed on R28's bilateral lower extremities as ordered. This deficient practice placed these residents at risk of development of pressure ulcers, and of wound worsening.	F 686			
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2) For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition	F 690			

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F 690	Continued From page 21 demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: The facility identified a census of 78 residents. The sample included 23 residents with three reviewed for bowel and bladder management. Based on observations, record review, and interviews, the facility failed to ensure appropriate Foley catheter care (a tube inserted into the bladder to drain urine into a collection bag) for Resident (R)340 when staff failed to maintain the urine collection bag below R340's bladder to encourage dependent drainage. This deficient practice placed R340 at risk for complications related to urinary tract infections (UTI). Findings Included: - The "Medical Diagnosis" section within R340's Electronic Medical Records (EMR) included diagnoses of hypertension (high blood pressure), history of falling, recent hip fracture (broken bone), retention of urine, and cervical spondylosis (age-related breakdown of bones in her hip) R340's EMR indicated she was admitted on	F 690			

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F 690	Continued From page 22 02/29/24 and a "Minimum Data Set (MDS)" was not completed for review. R340's "Care Plan" initiated 02/29/24 indicated she had an indwelling catheter related to her urinary retention. The plan indicated staff were to check the catheter and provide care as ordered. The plan instructed staff to ensure the catheter's tubing and urine collection bag were positioned lower than her bladder. The plan instructed staff to check the catheter tubing for kinks. R340's "Physician's Orders" indicated an order dated 02/29/24 for staff to monitor her indwelling catheter and provide catheter care each shift. The order noted she had a size 16 French (Fr-size of the indwelling catheter) and ordered staff to ensure the urine collection bag was secured below her bladder. On 03/05/24 at 10:03 AM R340 sat in her wheelchair in her room. R340's catheter bag was placed in a dignity bag mounted on the right armrest of her wheelchair parallel to her bladder. Urine pooled in the tubing. As R340 adjusted her positioning in the chair the pooled urine back flowed towards her bladder. R340 stated she had just been admitted to the facility after a recent fall while at home. On 03/06/24 at 08:23 AM, R340 returned to her room after breakfast. R340's catheter urine collection bag and dignity bag still hung on her right armrest. Urine was visibly pooled in the tubing. On 03/06/24 at 10:01 AM Certified Nurse Aid (CNA) M stated the catheter tubing and bag should be placed below the bladder to ensure the	F 690			

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F 690	Continued From page 23 urine drained down to the collection bag with gravity. She stated staff checked the urine collection bag position during each encounter. On 03/06/24 at 11:10 AM Licensed Nurse (LN) G stated the catheter bag should be placed in a manner that allowed the urine to flow downward to the bag. On 03/06/24 at 02:10 PM Administrative Nurse D stated staff were expected to ensure the catheter bag was placed below R340's bladder. She stated urine should not be allowed to pool in the catheter tubing. The facility's provided "Urinary Catheter Care" policy indicated staff was expected to check each urinary catheter placement and ensure the drainage bag should be held or positioned lower than the bladder to prevent urine backflow into the tubing. The facility failed to ensure appropriate Foley catheter care and services for R340. This deficient practice placed R340 at risk for complications related to urinary tract infections.	F 690			
F 694 SS=D	Parenteral/IV Fluids CFR(s): 483.25(h) § 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. This REQUIREMENT is not met as evidenced by: The facility identified a census of 78 residents.	F 694			

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F 694	Continued From page 24 The sample included 23 residents with one resident sampled for intravenous (IV-administered directly into the bloodstream via a vein) therapy. Based on observation, record review, and interview, the facility failed to assess and document the location, appearance, and patency (the quality of being open and unobstructed) each shift for Resident (R) 191's IV access site. This placed R191 at risk of infection and complications related to IV therapy. Findings included: - The electronic medical record (EMR) for R191 documented diagnoses of infection and inflammation reaction due to internal joint prosthesis (a device that is placed inside a person's body during a procedure to permanently replace joint), and methicillin-susceptible staphylococcus aureus infection (MSSA- a bacterial infection that develops when bacteria enter the body through a cut or wound on the skin). The "Admission Minimum Data Set (MDS)" for R191 had not been completed yet due to her admission date of 02/27/24. The "Care Area Assessments (CAA)" for R191 had not been completed yet. R191's "IV Medications Care Plan" initiated 02/27/24 directed staff to monitor, document, and report to the physician any signs and symptoms of complications. Staff was to change the IV dressing as ordered. Staff was to check the dressing site daily. Staff was to monitor, document, and report signs and symptoms of infection or infiltration (leakage of fluid out of the			F 694			

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F 694	Continued From page 25 vein) at the site including drainage, inflammation, swelling, redness, and warmth. The "Treatment Administration Record (TAR)" for R191 documented to observe the peripherally inserted central catheter (PICC - a thin, flexible tube that is inserted into a vein in the upper arm and guided into a large vein above the right side of the heart) site and document in a progress note every shift with intermittent therapy before and after administration of medications, during dressing changes and as needed for infiltration and extravasation (leakage of intravenously administered solution into surrounding tissues) every shift for PICC site observation. R191's TAR documented an order dated 03/05/24 to change the valved PICC needleless connector and transparent dressing weekly and as needed. Document upper arm circumference in centimeters (cm) and external catheter length in cm with each dressing change. Compare to previous measurements. Notify the physician if the length has changed since the last measurement. One time a day every Tuesday for PICC line maintenance and measurements. A review of R191's "Progress Notes" from her admission on 02/27/24 through 03/06/24 lacked evidence staff monitored, assessed, and documented R191's PICC line access site before and after the administration of any medication or flush including the type of access, the location of site, or any sign or symptoms of infection or infiltration. On 03/04/24 at 10:53 AM R191 lay in bed with her right arm in an immobilizer (a device used to keep the arm stable and close to the body) and	F 694			

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F 694	Continued From page 26 elevated on a pillow. R191 had a PICC line access to her right arm. On 03/06/24 at 08:28 AM Licensed Nurse (LN) G stated that R191's PICC line access was observed and documented on each shift after administration of her medication. LN G stated she only documented on R191's PICC line if she noted any abnormal findings or complications during the administration of her antibiotic (a medication used to treat infections). On 03/06/24 at 02:40 PM Administrative Nurse D stated the facility charted the status of IV access sites by exception (only if there were abnormal findings). Administrative Nurse D stated in the TAR records that the nurse observed the access site, but nursing staff only documented the appearance of the IV site if an abnormality was noted. The facility did not provide a policy regarding the care of IV access sites. The facility failed to ensure that nursing staff appropriately assessed and documented the location, appearance, and patency of R191's PICC line IV access site. This placed R191 at risk of infection and complications related to IV therapy.	F 694			
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.	F 756			

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F 756	Continued From page 27 §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: The facility identified a census of 78 residents. The sample included 23 residents with seven residents reviewed for unnecessary medication. Based on observation, record review, and interviews, the facility failed to ensure the	F 756			

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F 756	Continued From page 28 Consultant Pharmacist (CP) identified and reported irregularities regarding the lack of dosing instructions for Voltaren (topical pain reliever medication) gel for Resident (R) 33. This deficient practice had the risk of unnecessary medication use and physical complications for R33. Findings included: - R33's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of atrial fibrillation (rapid, irregular heartbeat), cerebrovascular accident (CVA-stroke- the 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), dementia (a progressive mental disorder characterized by failing memory, confusion), and Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness). The "Significant Change Minimum Data Set" (MDS) dated 12/09/23 documented a Brief Interview of Mental Status (BIMS) score of 10 which indicated moderately impaired cognition. The MDS documented R33 received hospice services during the observation period. The "Quarterly MDS" dated 02/28/24 documented a BIMS score of eight which indicated severely impaired cognition. The MDS documented that R33 received hospice services during the observation period. R33's "Functional Abilities Care Area Assessment" (CAA) dated 12/23/23 documented R33 had a CVA, and hospice services were	F 756			

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F 756	Continued From page 29 provided to add additional support for him. R33's "Care Plan" dated 03/22/23 documented that nursing staff would administer medications as ordered by the physician. R33's EMR under the "Orders" tab revealed the following physician orders: Voltaren external gel one percent (topical) apply to the neck topically three times a day for neck pain dated 03/24/23. A review of the "Monthly Medication Review" (MMR) provided by the facility from June 2023 through February 2024 lacked evidence of notification for a lack of dosing instructions for Voltaren. The facility provided an order dated 03/06/24 for R33's Voltaren gel that included dose instructions. On 03/05/24 at 11:06 AM, R33 sat upright in his Broda chair (specialized wheelchair with the ability to tilt and recline) at the dining table. R33 was asleep with his head tilted to the right side. On 03/06/24 at 10:52 AM, Licensed Nurse (LN) H stated she did not review or handle the MMRs provided by the pharmacist. On 03/06/24 at 02:13 PM, Administrative Nurse D stated R33's Voltaren gel should have a dose for application. Administrative Nurse D stated she would expect the CP to identify that irregularity during their monthly reviews. Administrative Nurse D stated that Voltaren orders that needed a dose added were one of the most common recommendations from the pharmacist.	F 756			

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F 756	Continued From page 30 The facility's "Medication Regimen Review (MRR) Policy" dated July 2018 documented a drug regimen review was performed for each resident at the time of admission, monthly thereafter, and as indicated, based upon a resident's condition. This Medication Regimen Review (MRR) included, but was not limited to, time frames for 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. The Consulting Pharmacist would review each resident's medical record (including lab tests/results), progress notes, and other applicable documents as necessary per state and federal regulations, to determine whether irregularities exist in his/her medication regimen and complete a Medication Regimen Review (MRR). The facility would maintain copies of MRRs within resident's medical records. The facility failed to ensure the CP identified and reported irregularities in the lack of dosing instructions for Voltaren gel for R33. This deficient practice placed R33 at risk for unnecessary medication use, side effects, and physical complications.	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	F 757			

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F 757	Continued From page 31 §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: The facility identified a census of 78 residents. The sample included 23 residents with five residents sampled for unnecessary medications. Based on observation, record review, and interview, the facility failed to ensure a dosage was indicated for the use of Voltaren (a topical gel used for the treatment of pain) for Resident (R) 73 and R33. This deficient practice placed R73 and R33 at risk for unnecessary medication administration and possible adverse side effects. Findings included: - The electronic medical record (EMR) for R73 documented diagnosis of effusion (accumulation of fluid) of the left knee, pain in the left knee, and fracture of the left tibia (the inner and typically larger of the two bones between the knee and the ankle) The "Admission Minimum Data Set (MDS)" dated 02/04/24 documented R73 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. R73 had a functional limitation in the range of motion on one side of both upper and lower extremities. R73	F 757			

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F 757	Continued From page 32 required substantial/maximal assistance to dependence with activities of daily living (ADL). R73 received scheduled pain medications. R73 frequently had pain. R73 received an opioid (a medication used for pain relief) while being a resident. The "Pain Care Area Assessment (CAA)" dated 02/05/24 documented R73 had a fractured left tibia and reported pain at a six out of 10 on the pain scale (0 to 10 scale with zero being no pain and 10 the worst pain imaginable) that interfered with his sleep and day to day activities. R73 received routine and as-needed pain medication. R73's "Pain Care Plan" initiated 01/29/24 for R73 directed staff to encourage the resident to report pain. The March 2024 "Treatment Administration Record" (TAR) in the EMR for R73 documented an order dated 02/15/24 for Voltaren topical gel 1% to be applied to the left knee topically every morning and a bedtime for pain. The order on the TAR lacked an indicated dose amount to apply. On 03/05/24 at 02:05 PM, R73 sat in his wheelchair with his feet on foot pedals. Staff propelled R73 down the hall. On 03/06/24 at 08:28 AM Licensed Nurse (LN) G stated she expected all medications that were to have a dosage amount. LN G stated she believed typically the dose was included in the order for Voltaren. On 03/06/24 at 02:42 PM Administrative Nurse D stated that R73's order for Voltaren under the "Orders" tab of the EMR did show the amount to apply for the medication. Administrative Nurse D	F 757			

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F 757	Continued From page 33 could not state a reason why the amount to apply for the Voltaren did not show up on the MAR/TAR. The facility policy "Physician Order Chart Audit" last revised in July 2015 documented the resident's physician order section of the medical record and electronic orders would be reviewed every 24 hours for accuracy. The charge nurse would verify the order had been written correctly and that all medications and treatments were transcribed accurately to the electronic MAR and TAR. Notify the health care provider as indicated for any discrepancies found in the orders. The facility failed to ensure a dosage was indicated on R73's order for Voltaren. This deficient practice placed R73 at risk for unnecessary medication administration and possible adverse side effects. - R33's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of atrial fibrillation (rapid, irregular heartbeat), cerebrovascular accident (CVA-stroke- the 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), dementia (a progressive mental disorder characterized by failing memory, confusion), and Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness). The "Significant Change Minimum Data Set" (MDS) dated 12/09/23 documented a Brief Interview of Mental Status (BIMS) score of 10 which indicated moderately impaired cognition.	F 757			

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F 757	Continued From page 34 The MDS documented R33 received hospice services during the observation period. The "Quarterly MDS" dated 02/28/24 documented a BIMS score of eight which indicated severely impaired cognition. The MDS documented that R33 received hospice services during the observation period. R33's "Functional Abilities Care Area Assessment" (CAA) dated 12/23/23 documented R33 had a CVA, and hospice services were provided to add additional support for him. R33's "Care Plan" dated 03/22/23 documented that nursing staff would administer medications as ordered by the physician. R33's EMR under the "Orders" tab revealed the following physician orders: Voltaren external gel one percent (topical) apply to the neck topically three times a day for neck pain dated 03/24/23. The facility provided an order dated 03/06/24 for R33's Voltaren gel that included dose instructions. On 03/05/24 at 11:06 AM, R33 sat upright in his Broda chair (specialized wheelchair with the ability to tilt and recline) at the dining table. R33 was asleep with his head tilted to the right side. On 03/06/24 at 10:52 AM, Licensed Nurse (LN) H stated she did not know if R33's Voltaren gel had dose instructions included for administration. LN H stated she would clarify the order if the order lacked dosage instructions. On 03/06/24 at 02:13 PM, Administrative Nurse D	F 757			

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F 757	Continued From page 35 stated R33's Voltaren gel should have a dose for application. Administrative Nurse D stated she would expect there to be clarification. Of the order. The facility's "Physician Order Chart Audit" policy last revised in July 2015 documented the resident's physician order section of the medical record and electronic orders would be reviewed every twenty-four hours for accuracy on a designated shift. Ensure orders have been written correctly. Notify the health care provider as indicated for any discrepancies found in the orders.	F 757			
F 775 SS=D	Lab Reports in Record - Lab Name/Address CFR(s): 483.50(a)(2)(iv) §483.50(a)(2) The facility must- (iv) File in the resident's clinical record laboratory reports that are dated and contain the name and address of the testing laboratory. This REQUIREMENT is not met as evidenced by: The facility identified a census of 78 residents. The sample included 23 residents. Based on observation, record review, and interviews, the facility failed to ensure that physician-ordered laboratory test results for Resident (R) 28 were included in R28's clinical record. This deficient practice could result in unnecessary tests and delayed treatment. Findings included:	F 775			

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F 775	Continued From page 36 - R28's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of dementia (a progressive mental disorder characterized by failing memory, and confusion) and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). The "Admission Minimum Data Set" (MDS) dated 10/09/23 documented a Brief Interview of Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS documented R28 received diuretic medication (medication to promote the formation and excretion of urine) during the observation period. The "Quarterly MDS" dated 12/29/23 documented a BIMS score of 12 which indicated moderately impaired cognition. The MDS documented that R28 received diuretic medication during the observation period. R28 's "Dehydration Care Area Assessment" (CAA) dated 10/15/23 documented fluids for hydration would be provided and labs as available. R28's "Care Plan" dated 10/10/23 documented that nursing staff would monitor labs and report abnormal lab values to the physician. R28's EMR under the "Orders" tab revealed the following physician orders: Complete Blood Count (CBC-laboratory blood test) and comprehensive Metabolic Panel (CMP-laboratory blood test) on 11/22/23 dated 11/21/23. Obtain Basic Metabolic Panel (BMP-laboratory blood test) on Monday dated 11/23/23.	F 775			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175517	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/06/2024
NAME OF PROVIDER OR SUPPLIER BROOKDALE OVERLAND PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 12000 LAMAR OVERLAND PARK, KS 66209		
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F 775	Continued From page 37 Repeat potassium level (laboratory blood test) on 11/30/23 dated 11/27/23. Obtain potassium level on 12/05/23 for follow-up hypokalemia (low level of potassium in the blood) dated 12/01/23. Obtain CBC on 12/05/23 dated 12/02/23. Obtain CBC, and CMP on 12/21/23 for follow-up hypokalemia dated 12/19/23. Obtain CBC, BMP on 01/16/24 dated 01/12/24. A review of R28's clinical record lacked evidence of the results of the physician-ordered laboratory tests. The facility was able to provide unsigned copies of the results after a request on 03/06/24. On 03/05/24 at 11:00 AM R28 laid on her bed with her head slightly elevated. R28's bilateral heels rested on a pillow at the foot of her bed. Her heels were not floated, and she was not wearing Prevalon boots (special pressure-reducing heel protectors). On 03/06/24 at 10:05 AM, Administrative Nurse D stated she was not sure if the laboratory results for R28 were in R28's clinical record. Administrative Nurse D stated she printed the results from the laboratory provider's portal. Administrative Nurse D stated the facility expected the physicians to log into the laboratory portal and review the lab work that was ordered daily. Administrative Nurse D stated the facility nurses did not print or review the lab results or	F 775			

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F 775	Continued From page 38 notify the physician unless a critical lab value was called to the facility. The facility's "Laboratory Services and Critical Lab Values Policy" last revised August 2023 documented that the purpose of this policy was to provide laboratory services to meet the needs of residents and to provide information concerning critical lab values to the healthcare provider. Reporting laboratory results, the laboratory would submit the results of tests to the community. The nurse would submit the results of laboratory tests to the healthcare provider. The facility failed to ensure that physician-ordered laboratory test results for R28 were included in R28's clinical record. This deficient practice could result in unnecessary tests and delayed treatment.	F 775			
F 849 SS=D	Hospice Services CFR(s): 483.70(o)(1)-(4) §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice,	F 849			

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F 849	Continued From page 39 the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's	F 849			

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F 849	Continued From page 40 responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation. (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff. §483.70(o)(3) Each LTC facility arranging for the	F 849			

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F 849	Continued From page 41 provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each	F 849			

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F 849	Continued From page 42 patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by: The facility identified a census of 78 residents. The sample included 23 residents with two residents reviewed for hospice services. Based on observation, record review, and interviews, the facility failed to ensure a communication process was implemented, which included how the communication would be documented between the facility and the hospice provider, and a failed to provide a description of the services, medication, and equipment provided to Resident (R) 33 by hospice. This deficient practice created a risk for missed or delayed services and impaired physical, and psychosocial care for R33. Findings included:	F 849			

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F 849	Continued From page 43 - R33's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of atrial fibrillation (rapid, irregular heartbeat), cerebrovascular accident (CVA-stroke- the 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), dementia (a progressive mental disorder characterized by failing memory, confusion), and Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness). The "Significant Change Minimum Data Set" (MDS) dated 12/09/23 documented a Brief Interview of Mental Status (BIMS) score of 10 which indicated moderately impaired cognition. The MDS documented R33 received hospice services during the observation period. The "Quarterly MDS" dated 02/28/24 documented a BIMS score of eight which indicated severely impaired cognition. The MDS documented that R33 received hospice services during the observation period. R33's "Functional Abilities Care Area Assessment" (CAA) dated 12/23/23 documented R33 had a CVA, and hospice services were provided to add additional support for him. R33's "Care Plan" dated 12/09/23 documented that staff would keep hospice informed of durable medical equipment (DME) and supplies needed. Hospice would notify staff of any additional DME or supplies recommended or delivered. The plan of care dated 12/09/23 also documented the staff would adjust the provision of activities of daily	F 849			

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F 849	Continued From page 44 living (ADL) to compensate for R33's changing abilities and staff would encourage his participation to the extent that he wished to participate. The plan of care also documented alternate bath days with hospice to promote and provide additional skin care unless R33 preferred alternate arrangements. The plan of care documented that staff would anticipate weight loss, decrease in fluid and/or caloric intake, skin alteration, ADLs, and/or cognitive decline related to terminal illness. The plan of care lacked a description of the services provided by hospice. R33's EMR under the "Orders" tab revealed the following physician orders: Admit to hospice with a diagnosis of CVA, the resident has six months or less of life dated 10/19/23. On 03/05/24 at 11:06 AM, R33 sat upright in his Broda chair (specialized wheelchair with the ability to tilt and recline) at the dining table. R33 was asleep with his head tilted to the right side. On 03/06/24 at 10:28 AM, Certified Nurse Aide (CNA) M stated she knew which residents were on hospice services from the shift report. CNA M stated if a hospice person needed anything, she would tell the nurse. CNA M stated she did not know for sure if any of the hospice information was found on the care plan or Kardex (a nursing tool that gives a brief overview of the care needs of each resident). On 03/06/24 at 10:52 AM, Licensed Nurse (LN) H stated all staff had access to the Kardex and care plan to review for information regarding each resident's care. LN H stated hospice information should be on the Kardex for the staff to be aware	F 849			

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F 849	Continued From page 45 of the care provided by hospice. On 03/06/24 at 02:13 PM, Administrative Nurse D stated hospice information and services provided by hospice should be included in R33's care plan for collaboration of care. The facility's "Hospice" policy last revised on 10/20/16 documented that hospice care may be provided when ordered by the health care provider and agreed to by the resident and or legal representative. The selected hospice would have a current contract with the community which follows federal requirements. The purpose of this policy was to provide hospice care for the resident who was terminally ill and to coordinate the care of residents who elect hospice services. A designated member of the interdisciplinary group who was responsible for providing the overall coordination of hospice care with the skilled nursing community. A collaboration on a revised, integrated care plan. A significant change Minimum Data Set (MOS) would be completed per Resident Assessment Instrument (RAI) guidelines. The community and hospice staff would collaborate regularly concerning the resident's care. Hospice progress notes would be included in the resident's medical record and nursing associates would be informed of any changes recommended by the hospice staff. The facility failed to ensure a communication process was implemented, which included how the communication would be documented between the facility and the hospice provider and failed to provide a description of the services, medication, and equipment provided to R33 by hospice. This deficient practice placed R33 at risk for delayed services which could affect her	F 849			

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F 849	Continued From page 46	F 849			
F 880	Infection Prevention & Control	F 880			
SS=E	CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify 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				

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F 880	Continued From page 47 to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: The facility identified a census of 78 residents. The sample included 23 residents. Based on record review, observations, and interviews, the facility failed to ensure adequate infection control standards were followed during Resident (R)189's enteral meal (provision of nutrients through the gastrointestinal tract when the resident cannot ingest, chew, or swallow food) administration and	F 880			

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F 880	Continued From page 48 storage of R290's oxygen therapy equipment. The facility additionally failed to ensure clean linen storage. This deficient practice placed the residents at risk for infectious diseases. Findings Included: - On 03/04/24 at 07:17 AM an inspection of the 400 Hall clean linen storage closet revealed a dusty, visibly soiled vacuum cleaner stored in the closet next to uncovered clean linen. On 03/04/24 at 07:52 AM, an inspection of R290's room revealed his continuous positive airway pressure (CPAP- ventilation device that blows a gentle stream of air into the nose to keep the airway open during sleep) mask placed face down on the nightstand next to his bed. No clean storage container was present in his room for his tubing or mask. On 03/06/24 at 08:30 AM Licensed Nurse (LN) G prepped R189 for her morning enteral nutritional meal via her percutaneous endoscope gastrostomy tube (PEG-a tube inserted through the wall of the abdomen directly into the stomach). LN G completed hand hygiene and entered R189's room. LN placed enteral feeding supplies on a clean barrier on the table. LN G washed her hands in the bathroom sink and donned protective gloves. LN G grabbed an enteral syringe (a large syringe used to assist with feedings and flushes) and attached it to the catheter port. LN G checked for residual fluid volume within R189's stomach and removed the syringe plunger. LN G placed a clean barrier over R189's stomach area and removed her gloves. LN G donned new gloves but did not complete hand hygiene in between glove changes. LN G	F 880			

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F 880	Continued From page 49 flushed the syringe with 30 milliliters (ml) of water and then added the premixed enteral solution to the syringe. LN G completed the tube feedings without further issues or concerns. On 03/06/24 at 10:01 AM Certified Nurses Aid (CNA) M stated oxygen tubing and CPAP masks were to be stored in a plastic bag when not in use. She stated hand hygiene should be completed in between glove changes. She stated the vacuum should not be stored in the same closet as the uncovered linens. On 03/06/24 at 11:31 AM Administrative Nurse E stated staff were expected to perform hand hygiene in between changing all personal protective equipment including glove changes. She stated oxygen equipment should be stored in a clean bag to prevent contamination of the masks. She stated dirty or soiled equipment should not be stored in the same area as clean linen. On 03/06/24 at 02:13 PM Administrative Nurse D stated staff were expected to complete hand hygiene in between glove changes. She stated each resident with oxygen equipment should have been provided a bag to store when not in use. She stated soiled equipment should not be stored with clean linens. On 03/06/24 at 08:45 AM LN G stated she would complete hand hygiene in between glove changes. She stated oxygen equipment and masks should be stored in a clean barrier bag to prevent contamination and respiratory infections. The facility's provided "Handwashing / Hand Hygiene" policy revised 01/2021 indicated staff	F 880			

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OMB NO. 0938-0391

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F 880	Continued From page 50 will complete hand hygiene before, during, and after encountering contaminated surfaces, in between changes of personal protective equipment (PPE), and when visibly soiled. The facility's provided "Infection Prevention and Surveillance" policy revised 01/2020 indicated the facility will ensure the separation of room and equipment storage between soiled and clean surfaces. The policy indicated clean equipment will never be stored in soiled areas to prevent cross-contamination. The facility failed to ensure appropriate infection control standards were followed during R189's enteral meal administration and storage of R290's oxygen therapy equipment. The facility additionally failed to ensure clean linen storage. This deficient practice placed the residents at risk for infectious diseases.	F 880			
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and	F 883			

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F 883	Continued From page 51 (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by:	F 883			

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F 883	Continued From page 52 The facility identified a census of 78 residents. The sample included 23 residents with 10 reviewed for pneumococcal (type of bacterial infection) immunizations. Based on record review and interviews, the facility failed to ensure the resident and/or resident's representatives were informed and educated on the pneumococcal vaccination options and provided the current "Vaccination Information Statements (VIS)" for Residents (R) 30, R48, R50, R66, and R76. This deficient practice placed the residents at risk for complications related to infectious diseases. Findings Included: - On 03/06/24 at 08:00 AM a review of pneumococcal immunizations was completed for R13, R20, R30, R32, R33, R48, R50, R59, R66, and R76. R30's (severely cognitively impaired resident) Electronic Medical Record (EMR) indicated she was admitted to the facility on 12/23/22. The EMR noted she received the Pneumovax 23 (PPSV23-pneumococcal vaccination) before her admission in 2018. An electronically filed "Informed Consent for Pneumococcal Vaccine" was signed by R30's representative on 09/26/23 but lacked dates the pneumococcal vaccinations were offered, dates of the vaccination information statement (VIS), and dates the vaccination information statement was given to the representative. R48's (severely cognitively impaired resident) EMR indicated she was admitted to the facility on 11/04/21. The EMR indicated her last pneumococcal vaccination was PPSV23 in 2006. An "Informed Consent for Pneumococcal	F 883			

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F 883	Continued From page 53 Vaccine" was completed on 11/08/21. The consent form indicated a declination of the pneumococcal conjugate vaccine (PCV13-pneumococcal vaccination) and PPSV23. The form acknowledged her last vaccine was in 2006. The form lacked a signature or verbal consent to decline confirmation from her responsible representative. R50's (severely cognitively impaired resident) EMR indicated she was admitted to the facility on 12/02/21. The EMR indicated she received a PPSV23 vaccination before her facility admission on 09/15/21. An "Informed Consent for Pneumococcal Vaccine" completed on 09/19/23 noted that R50's resident representative declined consent for the pneumonia vaccinations. The consent form lacked dates the pneumococcal vaccinations were offered, dates of the vaccination information statement (VIS), and dates the vaccination information statement was given to her representative. R66's (severely cognitively impaired resident) EMR indicated he was admitted to the facility on 09/29/23. The EMR indicated no previously documented pneumococcal vaccination for R66. R66's electronically filed "Informed Consent for Pneumococcal Vaccine" was signed by his representative on 09/29/23 but lacked information regarding which pneumococcal vaccination was offered and if a vaccination information statement was provided for the vaccines. R76's (severely cognitively impaired resident) EMR indicated he was admitted to the facility on 02/01/24. R76's EMR indicated he had no previous pneumonia vaccinations documented. R76's electronically filed "Informed Consent for	F 883			

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F 883	Continued From page 54 Pneumococcal Vaccine" was signed by his representative on 02/01/24 but lacked information regarding which pneumococcal vaccination was offered and if a vaccination information statement was provided for vaccines. On 03/06/24 at 08:20 AM R48's representative stated R48 had been in the facility for quite a while but was not offered a pneumococcal vaccination or education related to R48's pneumococcal vaccination options. She stated that R48 recently started hospice (end-of-life comfort care) services in January 2024 and may not need more vaccinations now, but the facility has not offered the vaccinations since her admission. On 03/06/24 at 08:45 AM R76's representative stated that R76 was admitted recently, and she could not remember being offered any pneumonia vaccination for R76. She stated she would not refuse them if offered. On 03/06/24 at 10:01 AM R66's representative stated he notified the facility he wanted R66 fully immunized and consented to all the vaccines. He stated that R66 received his COVID-19 (highly contagious respiratory virus) and influenza (highly contagious viral infection) vaccinations but was not aware that R66 was due for a pneumococcal vaccination. He stated the facility never offered or discussed R66's pneumococcal vaccination options with him. On 03/06/24 at 10:25 AM R50's representative stated she didn't think R50 needed another vaccination since she received one before she came to the facility but had not been informed by the facility or offered other pneumonia	F 883			

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F 883	Continued From page 55 vaccinations since her admission. She stated she would not decline the vaccinations if newer vaccinations were out and offered to R50. On 03/06/24 at 12:04 PM, R30's representative stated the facility had not offered any pneumonia vaccinations for R30 since her admission. She stated she would not decline any immunizations to keep R30 safe or improve her health. She stated that R30 received her influenza and COVID-19 vaccinations recently but was never offered a pneumococcal vaccination. On 03/06/24 at 01:10 PM Administrative Nurse E stated the pneumonia vaccinations were offered by the floor nurses upon admission. She stated the nurses asked at the time of admission and got the orders to give the vaccines. She stated the nurses should provide education related to the vaccinations to the representative and ensure they understand the information provided to them before asking them to sign the paperwork. She stated the facility was currently working on a system to track the updated pneumococcal guidelines. On 03/06/24 at 02:13 PM Administrative Nurse D stated the vaccination consents were provided to the residents upon admission by the nurses. She stated the nurses gave the vaccinations once the physician's order was placed. She stated the nurses were expected to provide education related to the vaccinations and ensure the representatives received the VIS statements. She stated the consent and VIS statements were mailed out to the representative but said she was not sure why resident representatives were not aware of the vaccines or declinations.	F 883			

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F 883	Continued From page 56 The facility's provided "Pneumococcal Vaccine" policy revised 05/2023 indicated each resident will be offered pneumococcal vaccinations when medically eligible. The policy indicates the facility will provide information and education to the resident or representative reflective of benefits and potential side effects. The policy indicated that pneumococcal vaccinations will be offered following the Centers for Disease Control (CDC) recommendations. The facility failed to ensure the resident's representatives were informed and educated on the pneumococcal vaccination options and provided a VIS for R30, R48, R50, R66, and R76. This deficient practice placed the residents at risk for complications related to infectious diseases.	F 883			