

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

PRINTED: 04/09/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175550	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/27/2024
NAME OF PROVIDER OR SUPPLIER SHAWNEE POST ACUTE REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7600 ANTIOCH ROAD OVERLAND PARK, KS 66204		
(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 KS00186062, KS00186377, and KS00186935.	F 000			
F 550 SS=D	The 2567 was sent electronically on 04/09/24. 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 80 residents. The sample included 18 residents with three residents reviewed for dignity. Based on observation, record review, and interviews, the facility failed to ensure Resident (R) 21 was treated with respect, and dignity related to personal hygiene, and the facility also failed to ensure a dignified dining experience when staff stood over R25 and R57 instead of sitting beside him while assisting them with meals. These deficient practices placed the residents at risk for negative psychosocial outcomes and decreased dignity. Findings included: - R21's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), dementia (a progressive mental disorder characterized by failing memory, and confusion), muscle weakness, and need for assistance with personal care. The "Significant Change Minimum Data Set" (MDS) dated 02/08/24 documented a Brief	F 550			

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F 550	Continued From page 2 Interview of Mental Status (BIMS) score of five which indicated severely impaired cognition. The MDS documented R21 required partial to moderate assistance from staff for her hygiene. R21's "Functional Abilities Care Area Assessment" (CAA) dated 02/15/24 documented she required assistance with activities of daily living. R21's "Care Plan" dated 11/03/23 directed staff she required maximum assistance with personal hygiene. On 03/25/24 at 08:01 AM R21 propelled her wheelchair in the hallway toward the dining room for breakfast. R21's hair was uncombed and was sticking up on the back of her head. On 03/26/24 at 08:08 AM R21 sat in her wheelchair at the dining room table as she drank a cup of coffee. R21's hair was uncombed and was sticking up. On 03/27/24 at 07:38 AM R21 sat at the dining room table and drank her coffee. R21's hair was uncombed and sticking up. R21 stated the staff did not always offer or assist her with combing her hair. R21 stated she was too old to ask for help. On 03/27/24 at 01:01 PM, Certified Medication Aide (CMA) R stated R21 needed more assistance after she was sick. CMA R stated R21 started to be stronger and was doing more for herself. CMA R stated she did not always have to assist R21 with her hygiene. On 03/27/24 at 01:45 PM, Licensed Nurse (LN) K	F 550			

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F 550	Continued From page 3 stated staff should offer R21 assistance with her care. LN K stated R21's hair should be combed and not standing straight upwards. On 03/27/24 at 02:43 PM, Administrative Nurse D stated she expected staff to assist or offer R21 with personal hygiene. Administrative Nurse D stated staff should make sure R21's hair was combed. The facility's "Promoting/Maintaining Resident Dignity" policy dated 01/01/23 documented it was the practice of the facility to protect and promote a resident's right 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 a resident's quality of life by recognizing each resident's individuality. All staff members are involved in providing care to residents to promote and maintain resident dignity and respect resident rights. The facility failed to ensure R21 was assisted with combing her hair. This deficient practice placed R21 at risk for negative psychosocial outcomes and decreased dignity. - On 03/25/24 at 12:16 PM R25 sat in his high-back wheelchair at the dining room table. Certified Medication Aide (CMA) R stood next to him and assisted him with his lunch. On 03/26/24 at 12:30 PM, R57 sat upright in her Broda chair (specialized wheelchair with the ability to tilt and recline) at the dining room table, she was served a ham sandwich and cheese puffs. The ham sandwich consisted of white bread and deli-styled ham. Certified Nurse Aide	F 550			

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F 550	Continued From page 4 (CNA) O stood beside R57's Broda chair and assisted her with a few bites and walked away and did not offer R57 a drink. On 03/26/24 at 12:33 PM, R25 sat at the dining room table in his high-back wheelchair at lunchtime. CMA R stood beside his wheelchair and offered him a few bites of his meal. On 03/27/24 at 12:28 PM, R57 sat upright at the dining room table in her Broda chair. CMA R stood on R57's right side and assisted her with eating. On 03/26/24 at 12:33 PM, R25 sat at the dining room table in his high-back wheelchair at lunchtime. CMA R stood beside his wheelchair and offered him a few bites of his meal. On 03/27/24 at 01:01 PM, CMA R stated she stood next to the resident during mealtime because she could not give her attention to only one resident. CMA R stated she must help everyone in the dining room, so she needed to be able to move around all the time. On 03/27/24 at 01:45 PM, Licensed Nurse (LN) K stated the staff cannot always sit and help only one person. LN K stated it depends on how many residents are in the dining room that require assistance. LN K stated the staff must be able to help everyone. On 03/27/24 at 02:43 PM, Administrative Nurse D stated she expected staff to sit down and assist a resident who required assistance. The facility's "Promoting/Maintaining Resident Dignity" policy dated 01/01/23 documented it was	F 550			

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F 550	Continued From page 5 the practice of the facility to protect and promote a resident's right 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 a resident's quality of life by recognizing each resident's individuality. All staff members are involved in providing care to residents to promote and maintain resident dignity and respect resident rights. The facility failed to ensure R25 and R57 were treated with dignity during dining. This deficient practice placed the residents at risk for weight loss and impaired dignity.	F 550			
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those	F 582			

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F 582	Continued From page 6 services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: The facility identified a census of 80 residents with 18 residents included in the sample. The facility identified 54 residents who were discharged from Medicare Part A services. Based on interview and record review the facility failed to issue CMS (Center for Medicare/Medicaid Services) Skilled Nursing Facility Advance Beneficiary Notification (SNF ABN) form 10055	F 582			

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F 582	Continued From page 7 (the form used to notify Medicare A participants of potential financial liability when a Medicare Part A episode ends) with the required information for Resident (R) 49 and R 336. This failure placed the residents at risk for decreased autonomy and impaired decision-making. Findings included: - R49's Electronic Medical Record (EMR) documented that the Medicare Part A episode began on 12/19/23 and ended on 03/09/23. R49 remained in the facility for custodial care. The facility issued SNF ABN 10055 lacked an estimated cost for continued services. - R336's Electronic Medical Record (EMR) documented that the Medicare Part A episode began on 12/11/23 and ended on 01/03/24. R336 remained in the facility for custodial care. The facility issued SNF ABN 10055 lacked an estimated cost for continued services. - On 03/26/24 at 10:45 AM Social Services X stated that she was unaware that form 10055 needed an estimated cost for continued services if the resident was staying in the facility. - The facility did not provide a policy for advance beneficiary notices. - The facility failed to ensure the forms provided at the end of skilled services contained the required information for the residents to make informed choices and appeal the non-coverage decisions. This failure placed the residents at risk for decreased autonomy and impaired decision-making.			F 582			

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F 623 F 623 SS=D	Continued From page 8 Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is	F 623 F 623			

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F 623	Continued From page 9 required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.	F 623			

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F 623	Continued From page 10 §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: The facility identified a census of 80 residents. The sample included 18 residents with two residents sampled for hospitalization and one resident sampled for discharge. Based on observation, record review, and interview, the facility failed to provide written notice of transfer as soon as practicable to Resident (R) 27 and R43 or their representative for their facility-initiated transfers and/or discharge. This deficient practice had the risk of miscommunication between the facility and resident/family and possible missed opportunities for healthcare service for R27 and R43. Findings included: - The electronic medical record (EMR) for R27 documented diagnoses of hypertension (HTN-elevated blood pressure), hemiplegia and	F 623			

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F 623	Continued From page 11 hemiparesis following cerebral infarction (paralysis and muscle weakness on one side of the body after a stroke), and dementia (a progressive mental disorder characterized by failing memory, confusion). The "Significant Change Minimum Data Set (MDS)" dated 12/19/23 documented R27 had both short and long-term memory problems. R27 had severely impaired cognitive skills for daily decision-making. R27 utilized a wheelchair for mobility. R27 was dependent on staff for all activities of daily living (ADLs). R27's "Discharge MDS" dated 12/02/23 documented a discharge to an acute hospital with a return anticipated 12/02/23. The "Nutrition Care Area Assessment (CAA)" dated 12/27/23 documented R27 was on a mechanically altered diet, had a history of hemiplegia and hemiparesis, and needed assistance to be fed. R27 had his gastrostomy tube (G-tube: tube surgically placed through an artificial opening into the stomach) removed. The area was not completely closed, and he had drainage. R27 will be care planned for nursing to assist with nutrition and hydration. A "Nursing Note" dated 12/02/23 at 02:25 PM documented R27 had not tolerated his 08:00 AM or 12:00 PM G-tube flush. R27 had significant residual from his G-tube noted. R27's stomach was severely distended (swollen due to pressure from the inside) when assessed and palpated. R27's dressing to his G-tube was saturated with bodily fluids and significant drainage from the G-tube was noted. R27's provider was called and notified. An order was received from the provider	F 623			

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F 623	Continued From page 12 to send the resident out to the hospital for further evaluation. The emergency contact was called with no answer. The resident was transported by emergency medical services (EMS). An "Admission Note" dated 12/13/23 at 11:40 PM documented R27 had readmitted to the facility at 07:15 PM via a stretcher and was accompanied by his wife and the transport drivers. R27's provider was notified of his readmission at that time. The "Misc." tab of the EMR lacked any document for discharge summary. The facility was unable to provide the required written notification of discharge for R27's 12/02/23 discharge upon request. On 03/26/24 at 07:45 AM R27 rested in bed. His bed was in a low position, with fall mats on both sides of the bed. On 03/26/24 at 10:35 AM Administrative Staff A stated the facility normally would just call the representative to notify them when a resident was being discharged to the hospital. Administrative Staff A was not aware that a written notification needed to be sent/mailed to the resident and or resident representative with the required information on it. Administrative Staff A stated he would begin providing the written notification from here forward. The facility provided an "Admission, Transfer, and Discharge Rights" policy revised in October 2023 that the subject matter was for discharge planning. This policy did not address the aspect of the required written notice of	F 623			

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F 623	Continued From page 13 transfer/discharge. The facility failed to provide written notice of transfer as soon as practicable to R27 or their representative for their facility-initiated transfers. This deficient practice had the risk of miscommunication between the facility and resident/family and possible missed opportunity for healthcare service for R27. - The electronic medical record (EMR) for Resident (R)43 documented diagnoses of chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), hemiparesis/hemiplegia (weakness and paralysis on one side of the body) following a 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) effecting left non-dominant side, and epilepsy (brain disorder characterized by repeated seizures). The "Quarterly Minimum Data Set (MDS)" dated 02/19/24 documented a Brief Interview of Mental Status (BIMS) score of 12 which indicated moderately impaired cognition. The MDS indicated R43 was dependent on staff for all activities of daily living (ADLs). R43's "Functional Care Area Assessment (CAA)" dated 12/14/23 documented R43 needs assistance with his care due to a CVA, right hip fracture, seizures, and COPD. The "Discharge MDS" dated 03/20/24 for R43	F 623			

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F 623	Continued From page 14 documented an unplanned discharge to an acute hospital with an anticipated return to the facility. R43's "Entry MDS" dated 03/25/24 documented a reentry to the facility from an acute hospital. R43's "Care Plan" dated 01/18/24 documented R43 had no plans to be discharged from the facility and planned to stay at the facility. R43's "Care Plan" dated 01/18/24 documented to monitor his progress and revise his plan as needed. A "Progress Note" dated 03/20/24 documented that R43 was lethargic with a half-full bag of red bloody urine. The provider gave a verbal order to send R43 to the emergency department (ED) for evaluation. Staff called the ambulance and it arrived at the facility and transported R43 to the hospital. The nurse notified R43's daughter of the resident's condition. A "Progress Note" dated 03/25/24 documented that R43 was readmitted to the facility from an acute care hospital visit. The facility was unable to provide evidence a written notification of transfer or discharge was provided to the resident and/or representative for the facility-initiated transfer to the hospital from 03/20/24 to 03/15/24. The facility was unable to provide evidence notification of the transfer was sent to the LTCO. On 03/26/24 at 08:12 AM R43 lay in bed resting comfortably. On 03/26/24 at 10:35 PM Administrative staff A	F 623			

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F 623	Continued From page 15 stated facility does not have the written notification of transfer. Administrative staff A stated that R43's daughter was notified verbally when he was transferred and given an update on his condition. The facility policy "Admission, Transfer and Discharge Rights" policy revised 10/2023 documented it is the policy of the facility that discharge planning and evaluation will be provided by the Social Services staff for each resident. Discharge planning involves the resident, family or responsible party, interdisciplinary team (IDT), and others involved in the resident's care plan. The facility failed to provide written notice of transfer as soon as practicable to R43 and their representative and failed to provide notification to the LTCO as well. This placed the resident at risk for miscommunication between the facility and the resident/family and possible missed opportunities for healthcare service for R43.	F 623			
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility;	F 625			

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F 625	Continued From page 16 (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: The facility identified a census of 80 residents. The sample included 18 residents with three residents sampled for hospitalization and discharge. Based on observation, record review, and interview, the facility failed to provide a bed hold with the required information to Resident (R) 43 or to their family representative when R43 was transferred to the hospital. This deficient practice placed R43 at risk for impaired ability to return to the facility or his same room. Findings include: - The electronic medical record (EMR) for R 43 documented diagnoses of chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), hemiparesis/hemiplegia (weakness and paralysis on one side of the body) following a cerebrovascular accident (CVA-stroke- the	F 625			

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F 625	Continued From page 17 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) effecting left non-dominant side, and epilepsy (brain disorder characterized by repeated seizures). The "Quarterly Minimum Data Set (MDS)" dated 02/19/24 documented a Brief Interview of Mental Status (BIMS) score of 12 which indicated moderately impaired cognition. The MDS indicated R43 was dependent on staff for all activities of daily living (ADLs). R43's "Functional Care Area Assessment (CAA)" dated 12/14/23 documented R43 needs assistance with his care due to a CVA, right hip fracture, seizures, and COPD. The "Discharge MDS" dated 03/20/24 for R43 documented an unplanned discharge to an acute hospital with an anticipated return to the facility. R43's "Entry MDS" dated 03/25/24 documented a reentry to the facility from an acute hospital. R43's "Care Plan" dated 01/18/24 documented R43 had no plans to be discharged from the facility and planned to stay at the facility. R43's "Care Plan" dated 01/18/24 documented to monitor his progress and revise his plan as needed. A "Progress Note" dated 03/20/24 documented that R43 was lethargic with a half-full bag of red bloody urine. The provider gave a verbal order to send R43 to the emergency department (ED) for evaluation. Staff called the ambulance and it arrived at the facility and transported R43 to the	F 625			

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F 625	Continued From page 18 hospital. The nurse notified R43's daughter of the resident's condition. A "Progress Note" dated 03/25/24 documented that R43 was readmitted to the facility from an acute care hospital visit. The facility was unable to provide evidence a bed hold notification was provided to the legal representative when R43 transferred to the hospital from 03/20/24 to 03/15/24. On 03/26/24 at 08:12 AM R43 lay in bed resting comfortably. On 03/26/24 at 10:35 AM Administrative Staff A stated he only had the bed hold notification the resident signed on admission. Administrative Staff A stated he did not have a bed hold notice for R43 for the 03/20/234-03/25/24. The facility was unable to provide a policy related to bed hold notification. The facility failed to provide a bed hold with the required information to R43 and his family representative when R43 transferred to the hospital. This deficient practice placed R43 at risk for impaired ability to return to the facility or his same room.	F 625			
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	F 677			

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F 677	Continued From page 19 by: The facility identified a census of 80 residents. The sample included 18 residents with three reviewed for activities of daily living (ADLs). Based on observation, record review, and interviews, the facility failed to provide consistent bathing opportunities for Residents (R)28 and R17. This deficient practice placed the residents at risk for infections and decreased psychosocial well-being. Findings Included: - The "Medical Diagnosis" section within R28's Electronic Medical Records (EMR) included diagnoses of congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), dysphagia (difficulty swallowing), cognitive-communication disorder, and dementia (a progressive mental disorder characterized by failing memory, confusion). R28's "Admission Minimum Data Set (MDS)" completed 02/20/24 noted a Brief Interview for Metal Status (BIMS) score of ten indicating moderate cognitive impairment. The MDS indicated he had no behaviors. The MDS indicated he used a wheelchair and was dependent on staff for mobility. The MDS indicated he had no upper or lower extremity impairments. The MDS noted he required substantial to maximal assistance for bathing, dressing, personal hygiene, toileting, and transfers. R28's "Functional Abilities CAA" completed 02/27/24 indicated he required assistance with his care. The CAA noted he was weak and	F 677			

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F 677	Continued From page 20 working to recover his strength. The CAA noted he was at risk for falls, depression, infections, and a decline in his activities of daily living (ADLs). R28's "Care Plan" initiated 02/14/24 indicated R28 was at risk for impaired cognitive function, behaviors, nutrition, and falls related to his medical diagnoses. The plan noted R28 lacks insight into his condition and risk factors. The plan noted he required two staff assistants for bed mobility and transfers. The plan indicated he required staff assistance for bathing, personal hygiene, dressing, toileting, and mobility with his wheelchair. A review of R28's "Documentation Survey Report" between 02/14/24 and 03/26/24 indicated he received bathing opportunities on three occasions (2/26, 3/11, and 3/26). The report indicated that "NA" was marked on seven occasions. The report indicated R28 refused on two occasions. On 03/25/24 at 12:04 PM R28 was woken up by his representative. R28 was wearing grey food-stained jogging clothing. His hair was greasy, and his fingernails were dirty. R28's representative reported staff let him sleep all morning and he missed breakfast. She stated R28 needed frequent reminders of mealtimes and hygiene. She stated she had to remind the facility to bathe him. She stated he was wearing the same clothing he had on was she visited him yesterday. She stated when R28 first arrived he didn't receive bathing for a week after he arrived. On 03/26/23 at 10:00 AM Certified Nurse Aid (CNA) Q stated resident had designated days for bathing. She stated if a resident refused or was	F 677			

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F 677	Continued From page 21 not available for the bath, they would have been rescheduled for the next available time or day. She stated multiple attempts would be documented and reported to the nurse for intervention. On 03/27/24 at 10:26 AM Licensed Nurse (LN) G stated shower days were listed in the EMR and alerted staff who was due on what day. She stated direct care staff can input the recorded bathing into the EMR and should designate the status of the provided bath or shower. She stated this would include bed baths, showers, and whirlpools. On 03/27/24 at 02:42 PM Administrative Nurse D stated staff should not be charting "NA" under the bathing. She stated it should be charted given the type of bath provided or if refused. She stated the residents would be provided a bath at the same time of day if they were not available. She stated the residents should receive a minimum of two baths per week and could request more or change their days if they wish. A review of the facility's "Activities of Daily Living" policy revised 10/2022 stated that bathing opportunities provided to the residents promote cleanliness, and comfort, and provide observations of the resident's skin. The policy noted that all bathing should be documented in the resident's EMR. The policy noted that if a resident refuses to bath the staff will notify the nurse. The facility failed to provide consistent bathing opportunities for R28. This deficient practice places him at risk for infections and decreased psychosocial well-being.	F 677			

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F 677	Continued From page 22 - The electronic medical record (EMR) for R17 documented diagnosis of hypertension (HTN-elevated blood pressure), type 2 diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made or the body cannot respond to the insulin), and peripheral vascular disease (PVD- slow and progressive circulation disorder causing narrowing, blockage, or spasms in a blood vessel). R17's "Annual Minimum Data Set (MDS)" dated 03/24/23 documented a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. R17 required extensive assistance from one staff for activities of daily living (ADLs). R17 received insulin injections seven of seven days during the lookback period. R17's "Quarterly MDS" dated 12/21/23 documented a BIMS score of 15 which indicated intact cognition. R17 was dependent on staff for shower/bathing and did not transfer to the shower/bath. R17's "ADL Care Area Assessment (CAA)" dated 04/07/23 documented R17 had a self-care and mobility deficit and balance problems. R17 was bed-bound per her choice. R17 was at risk for a decline in ADLs, falls, 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), contractures (abnormal permanent fixation of a joint or muscle), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), muscle wasting (decrease in size and wasting of muscle tissue) and infections.	F 677			

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F 677	Continued From page 23 R17's "Care Plan" last revised on 12/27/23 directed staff that R17 was dependent on staff to provide a bath as necessary. Staff was directed to do care in pairs and R17 required two-person assistance with a Hoyer lift (total body mechanical lift) for transfers. Under the "Tasks" tab of the EMR R17's preferred shower days were Tuesday and Friday. Review of R17's January 2024 "Documentation Survey Report" revealed R17 received a bath, shower, or sponge bath on 01/02/24, 01/07/24, 01/13/24, 01/21/24, 01/23/24, 01/28/24, and 01/30/24. There was no bathing recorded for the week of 01/14-20/24. 01/23/24, 01/28/24, and 01/30/24. R17 refused bathing on 01/05/24. Review of R17's February 2024 "Documentation Survey Report" revealed R17 received a bath, shower, or sponge bath on 02/02/24, 02/05/24, 02/06/24, 02/12/24, 02/13/23, 02/14/24, 02/16/24, 02/23/24, and 02/29/24. R17 refused a bath/shower on two instances 02/09/24 and 02/20/24. A review of R17's March 2024 "Documentation Survey Report" revealed R17 received a bath, shower, or sponge bath on 03/08/24, and 03/22/24 (14 days with no bathing). On 03/26/24 at 08:36 AM R17 lay in her bed. Her hair was disheveled. R17 wore a hospital gown with visible food residue on it. R17 stated that she did not always get her baths as scheduled on Tuesdays and Fridays. R17 stated that she would only get a bed bath sometimes/ She stated when agency staff worked, the agency staff just did not	F 677			

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F 677	Continued From page 24 want to take the time to do it. R17 stated she likes to be bathed and her hair washed every couple of days, or she just feels dirty. R17 stated staff told her she was on the list for a bath that day. On 03/27/24 at 01:59 PM Certified Nurse Aide (CNA) P stated there was a bath/shower book on the unit that had daily showers listed by day and room. CNA P stated the aide was to complete a bath sheet for all residents scheduled for bathing each day and if the resident refused the nurse was to be notified. CNA P stated all the shower sheets at the end of the day were to be given to the nurse so the nurse could sign off on them and tell the next shift aides to offer a bath to the residents who had refused. CNA P stated not applicable (NA) and should not be charted for a bath, the tasks in point of care (POC) have abbreviations that should be used for shower, full bath, and sponge bath. On 03/27/24 at 02:00 PM Licensed Nurse (LN) I stated the shower book listed the bath/showers for the day. LN I stated she would give the aides the list of who was to be showered that day and she expected the aide to fill out a shower sheet for each of those residents. LN I stated the aide was to give her the sheets at the end of the shift and should notify her when a resident had refused the shower. LN I stated staff should not document NA on days that a shower was given and would expect staff to use the appropriate abbreviation code when they charted in POC. On 03/27/24 at 03:15 PM Administrative Nurse D stated each resident has scheduled shower/bath days at least twice weekly. Administrative Nurse D stated each unit should have a shower book that listed who was to receive a shower each day.	F 677			

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F 677	Continued From page 25 Administrative Nurse D stated CNAs should not at any time be charting NA when a shower was given on unscheduled days. Administrative Nurse D stated she expected staff to chart in POC using the appropriate abbreviations and complete the shower sheets daily. Administrative Nurse D stated that the facility had been having issues with some of the agency staff not performing duties as expected and those agency staff had since been asked not to return. The "Activities of Daily Living (ADLs)" policy revised 01/01/23 documented the facility would, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADLs did not deteriorate unless unavoidable. Care and services would be provided for ADLs such as bathing, dressing, grooming, and oral care. The facility would develop a comprehensive care plan to assist the resident in achieving and maintaining the highest practicable outcome based on the comprehensive assessment. A resident who was unable to carry out the ADLs would receive the necessary services to maintain good nutrition, grooming, and personal and oral care. The facility failed to ensure staff provided consistent bathing to R17, who was unable to carry out ADLs. This deficient practice placed R17 at risk for impaired care and decreased quality of life.	F 677			
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.	F 686			

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F 686	Continued From page 26 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 80 residents. The sample included 18 residents with three residents reviewed for treatment/services to prevent/heal 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 pressure-reducing measures were placed on Resident (R) 57's and R36's bilateral lower extremities. This deficient practice placed these residents at risk of developing pressure ulcers and worsening of current wounds. Findings included: - R57's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of protein-calorie malnutrition (lack of proper nutrition, caused by not having enough to eat, not eating enough of the right things, or being unable to use the food that one does eat), pressure ulcer (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a	F 686			

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F 686	Continued From page 27 result of pressure, or pressure in combination with shear and/or friction) of the sacrum (large triangular bone/area between the two hip bones) region Stage 4 (full thickness tissue loss with exposed bone), dementia (progressive mental disorder characterized by failing memory, confusion), and dysphagia (swallowing difficulty). The "Admission Minimum Data Set" (MDS) dated 03/06/24 documented a Brief Interview of Mental Status (BIMS) score of two which indicated severely impaired cognition. The MDS documented R57 required partial to moderate assistance from staff for eating. The MDS documented R57 was at risk for pressure injuries and had one unhealed pressure ulcer. The MDS documented R57 had pressure relieving devices on the bed and in the chair for prevention and reduction of pressure in place during the observation period. R57's "Pressure Ulcer Care Area Assessment" (CAA) dated 03/13/24 documented she was at risk for pressure-related ulcers and currently had a sacral wound. R57's "Care Plan" dated 03/04/24 documented she required pressure relieving or reducing devices on her bed. R57's EMR under the "Orders" tab revealed the following physician orders: Monitor wound on sacral every shift for signs or symptoms of infection dated 02/29/24. R57's EMR under the "Assessment" tab revealed a "Braden Scale" (a scale for predicting pressure sore risk) dated 02/29/24 documented a score of nine indicating a very high risk for pressure	F 686			

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F 686	Continued From page 28 wounds. On 03/25/24 at 09:51 AM R57 laid on her back in her bed. R57's bilateral heels rested directly on the mattress, and her pressure-relieving boots laid on top of the dresser at the foot of her bed. On 03/26/24 at 08:13 AM R57 laid back asleep on the bed with her heels resting directly on the mattress. R57's pressure-relieving boots lay on top of her dresser at the foot of her bed. On 03/27/24 at 01:01 PM, Certified Medication Aide (CMA) R stated if R57 had pressure relieving boots they should be when she was in bed. On 03/27/24 at 01:45 PM, Licensed Nurse (LN) K stated pressure relieving boots should be placed on any resident with a physician's orders. LN K stated if a resident was at risk for pressure injuries staff would lay down in bed between meals, monitor their skin, and offer supplements. LN K stated she was not sure if R57 had orders for pressure-relieving boots. On 03/27/24 at 02:43 PM, Administrative Nurse D stated she expected the staff to apply pressure relieving devices if they had an order to do so. Administrative Nurse D stated every resident who was at risk for pressure-related injuries should have pressure-relieving devices in place. Administrative Nurse D stated the orders would be placed on the "Medication Administration record" (MAR) or the "Treatment Administration record" (TAR) and on tasks. Administrative Nurse D stated that pressure-relieving devices should be included in the resident's plan of care.	F 686			

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F 686	Continued From page 29 The facility's "Skin Management System" policy revised 12/2019 documented any resident who enters the facility without a pressure ulcer will have appropriate preventive measures taken to ensure that the resident does not develop pressure ulcers, or that resident admitted with wounds will not develop signs and symptoms of infect, unless the resident clinical condition makes the development unavoidable. The facility failed to ensure pressure-reducing measures were placed on R57's bilateral lower extremities who currently had a pressure-related ulcer. This deficient practice placed R57 at risk of developing further pressure ulcers and worsening or current pressure injuries. - R36's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of hypertension (HTN-elevated blood pressure), neuropathy (weakness, numbness, and pain from nerve damage, usually in the hands and feet), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), dementia (a progressive mental disorder characterized by failing memory, confusion), and a pressure ulcer of the left heel Stage 3 (full thickness pressure injury extending through the skin into the tissue below). The "Quarterly Minimum Data Set" (MDS) dated 02/17/24 documented a Brief Interview of Mental Status (BIMS) score of three which indicated severely impaired cognition. The MDS documented that R36 was dependent on staff for rolling from side to side. The MDS documented R36 was at risk for pressure ulcers during the observation period and had a Stage 3 pressure	F 686			

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F 686	Continued From page 30 ulcer during the observation period. The MDS documented that a pressure-reducing device was in place in R36's chair and on her bed during the observation period. R36's "Pressure Ulcer Care Area Assessment" (CAA) dated 05/19/23 documented R36 was free from pressure-related skin impairments but was at risk for skin breakdown or development of pressure ulcers related to mobility, impaired cognition, and incontinence. The "Braden Scale" (a scale for predicting pressure sore risk) dated 01/29/24 documented a score of fifteen indicating a low risk for pressure wounds. R36's "Care Plan" dated 12/07/23 documented that staff would assist R36 with repositioning about every two hours. The care plan dated 12/07/23 documented R36 was to wear bilateral heel float boots when she was in bed or chair and staff would ensure R36 had the boots on when in bed. R36's EMR under the "Orders" tab revealed the following physician orders: Ensure the left heel dressing is in place and clean, dry, and intact. Utilize as needed (PRN) order if soiled, frayed, or saturated. Notify the physician of any abnormal findings and document dated 12/15/23. Apply pillow boots to bilateral extremities as tolerated while in bed and up in chair every shift for pressure prevention dated 12/15/23. Left heel wound- cleanse the wound with normal saline, apply Skin-prep (liquid skin protectant) to the peri-wound area, and apply Santyl (prescription medicine that removes dead tissue	F 686			

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F 686	Continued From page 31 from wounds so they can heal) to the wound bed only. Apply collagen powder (powders to absorb wound exudate or as a gel to provide moisture to the wound site) over Santyl and cover with border gauze dressing every other day order dated 03/26/24. On 03/27/24 at 07:01 AM R36 laid asleep on her bed. R36 was not wearing boots and her bilateral heels rested directly on the mattress. On 03/27/24 at 07:03 AM Licensed Nurse (LN) K stated R36's boots were in her room last week. LN K helped look for the boots, and she could not find R36's boots in the resident's room. LN K stated the boots may have gotten soiled and gone to laundry. LN K stated she would be back in a half hour to do the wound dressing. R36's heels remained directly on the mattress. On 03/27/24 at 07:38 AM LN K stated there was an order to float R36's heels. LN K said the Certified Nursing Aides (CNA) were responsible for the boots and that task was documented in the EMR. LN K stated the nurse should follow up and sign on R36's "Treatment Administration Record" (TAR) after verifying the boots were on. On 03/27/24 at 07:50 AM CNA O stated she knew how to find the Kardex (a nursing tool that gives a brief overview of the care needs of each resident). CNA O stated she could find out what R36 needed for her care. On 03/27/24 at 08:20 AM CNA R stated she did not know how to access the residents' Kardex. CNA R stated the nurse lets her know what duties she needs to do for the residents.	F 686			

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F 686	Continued From page 32 On 03/27/24 at 02:41 PM Administrative Nurse D stated she was not aware that staff were unable to find R36's bilateral float heel boots. Administrative Nurse D stated she expected the staff to float R36's heels if there was an order to do so. She stated nurses should be checking to ensure the boots are on before they sign the TAR. The facility's "Skin Management System" policy revised 12/2019 documented any resident who enters the facility without a pressure ulcer will have appropriate preventive measures taken to ensure that the resident does not develop pressure ulcers, or that resident admitted with wounds will not develop signs and symptoms of infect, unless the resident clinical condition makes the development unavoidable. The facility failed to ensure that pressure-reducing boots were placed on R36's bilateral lower extremities as ordered. This deficient practice placed the resident at risk for delayed healing and/or wound worsening.	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.	F 688			

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F 688	Continued From page 33 §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 identified a census of 80 residents. The sample included 18 residents with three residents reviewed for position and mobility. Based on observation, record review, and interview, the facility failed to ensure Resident (R) 57 was provided services and treatment to prevent her contractures (abnormal permanent fixation of a joint or muscle) from worsening in her left and right hands. This deficient practice left R57 at risk for further decline and decreased range of motion (ROM- the full movement potential of a joint, usually its range of flexion and extension). or mobility. Findings included: - R57's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of protein-calorie malnutrition (lack of proper nutrition, caused by not having enough to eat, not eating enough of the right things, or being unable to use the food that one does eat), pressure ulcer (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction) of the sacrum (large triangular bone/area between the two hip bones) region Stage 4 (full thickness tissue loss with exposed bone), dementia (progressive mental disorder characterized by failing memory, confusion), and dysphagia (swallowing difficulty).	F 688			

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F 688	Continued From page 34 The "Admission Minimum Data Set" (MDS) dated 03/06/24 documented a Brief Interview of Mental Status (BIMS) score of two which indicated severely impaired cognition. The MDS documented R57 required partial to moderate assistance from staff for eating. R57's "Nutritional Status Care Area Assessment" (CAA) dated 03/13/24 documented she received a mechanically altered diet and had a pressure ulcer. R57's "Care Plan" dated 03/13/24 documented she was dependent on staff for transfer, bathing, bed mobility, and dressing. The plan of care lacked direction for staff to provide treatment for R57's hand contractures. On 03/26/24 at 12:30 PM, R57 sat upright in her Broda chair (specialized wheelchair with the ability to tilt and recline) at the dining room table; she was served a ham sandwich and cheese puffs. The ham sandwich consisted of white bread and deli-styled ham. Certified Nurse Aide (CNA) O stood beside R57's Broda chair and assisted her with a few bites and walked away and did not offer R57 a drink. R57's fingers on both hands were bent at the knuckles and she was unable to hold her water glass. On 03/27/24 at 11:40 AM Therapy Director GG reviewed R57's occupational therapy discharge note dated 03/14/24 and confirmed no preventive treatment was in place for R57's right and left contractures from worsening. Therapy Director GG stated the therapy department had a list of residents with contractures and reevaluated each resident for a decrease in ROM. Therapy Director	F 688			

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F 688	Continued From page 35 GG provided documentation R57 would be reevaluated in three months and reattempt under Medicare Part B services. On 03/27/24 at 01:01 PM, Certified Medication Aide (CMA) R stated usually therapy would usually recommend some type of brace or splint for a resident's contractures. CMA R stated she was not aware of any type of treatment for R57's bilateral hands. CMA R stated R57 was able to feed herself small bites using her hands but was unable to hold a glass of water in her hands because of her contractures. CMA R stated nursing did not provide any type of treatment for R57's hands. On 03/27/24 at 01:45 PM, Licensed Nurse (LN) K stated she was not aware of any concerns with R57's pain in her bilateral hands related to the contractures. LN K was not aware of any treatment for R57's right and left contractures to prevent a decline in her ability to participate in her activities of daily living. On 03/27/24 at 02:43 PM, Administrative Nurse D stated she was not aware of any treatment in place for R57's bilateral hand contractures. Administrative Nurse D stated therapy would track the contractures every three months. The facility's "Range of Motion" policy last revised 10/2023 documented it was the policy of the facility to prevent a resident's loss of range of motion (ROM). Appropriate treatment and services would be administered to increase the range of motion and/or prevent further decrease in the range of motion. The facility failed to ensure R57 received services	F 688			

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F 688	Continued From page 36 and treatment for her multiple contractures to prevent an avoidable reduction of ROM and/or mobility. This deficient practice left R57 at risk for further decline and decreased ROM.	F 688			
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility identified a census of 80 residents. The sample included 18 residents with three reviewed for falls. Based on observation, record review, and interviews, the facility failed to provide an environment free of accident hazards resulting in Resident (R)28's non-injury fall in the facility's spa room. The facility additionally failed to implement wandering interventions for R28 and failed to provide safe transferring practices for R25. These deficient practices placed both residents at risk for preventable falls and injuries. Findings Included: - The "Medical Diagnosis" section within R28's Electronic Medical Records (EMR) included diagnoses of congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), dysphagia (difficulty swallowing), cognitive-communication disorder, and dementia (a progressive mental	F 689			

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OMB NO. 0938-0391

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F 689	Continued From page 37 disorder characterized by failing memory, confusion). R28's "Admission Minimum Data Set (MDS)" completed 02/20/24 noted a Brief Interview for Metal Status (BIMS) score of ten indicating moderate cognitive impairment. The MDS indicated he had no behaviors. The MDS indicated he used a wheelchair and was dependent on staff for mobility. The MDS indicated he had no upper or lower extremity impairments. The MDS noted he required substantial to maximal assistance for bathing, dressing, personal hygiene, toileting, and transfers. The MDS noted no history of falls. The MDS entry for wandering was left incomplete. R28's "Care Area Assessment (CAA)" was not triggered for falls. R28's "Functional Abilities CAA" completed 02/27/24 indicated he required assistance with his care. The CAA noted he was weak and working to recover his strength. The CAA noted he was at risk for falls, depression, infections, and a decline in his activities of daily living (ADLs). R28's "Care Plan" initiated 02/14/24 indicated R28 was at risk for impaired cognitive function, behaviors, nutrition, and falls related to his medical diagnoses. The plan noted R28 lacks insight into his condition and risk factors. The plan noted he required two staff assistants for bed mobility and transfers. The plan instructed staff to ensure all needed items were left within his reach. The plan instructed staff to keep his bed in the lowest position (02/20/24), offer toileting before laying him in bed (02/20/24),	F 689			

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F 689	Continued From page 38 utilize an anti-rollback device on his wheelchair (02/20/24), and place floor mats bedside his bed (02/20/24), and ensure staff assist with all transfers (02/26/24). The care plan lacked documentation related to interventions for wandering behaviors as noted on 03/18/24. A review of a facility-provided fall investigation dated 03/18/24 indicated R28 had an unwitnessed fall in the second-floor spa room. The investigation indicated he was confused and wandered into the room. The report noted he told staff he was going to the post office. The report noted he was assessed with no injuries. The report indicated an anti-rollback device was added to his wheelchair. The report lacked documentation related to the resident's wandering into the spa room. On 03/25/24 at 12:45 PM, R28 was in his room with his representative. His representative stated R28 had days where he could get really confused and wander if not supervised. She stated his recent fall occurred because he thought he was going to the post office and fell out of his chair. An inspection of R28's room revealed his bed was in the low position and his fall mat was in place. R28 had non-slip socks on his feet. R28's wheelchair was positioned next to his bed with an anti-rollback device attached. On 03/25/24 at 01:24 PM, An inspection of the second-floor spa room revealed no lock on the entry doors. No chemicals or Sharps containers were stored in the room. All cabinets were locked. No electrical concerns were present. On 03/26/23 at 10:00 AM Certified Nurse Aid (CNA) Q stated R28 had moments of confusion	F 689			

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F 689	Continued From page 39 but was usually redirectable. She stated he rarely propelled himself and often staff would have to move him. She stated residents should not be alone in the shower/spa room due to the risk of falls from the flooring being slick. She stated the spa doors were usually closed. On 03/27/24 at 02:42 PM Administrative Nurse D stated the shower rooms should always be closed to deter falls from cognitively impaired residents. She stated wandering interventions should be included in the care plans for residents at risk. The facility's provided "Fall Management System" policy revised 12/2023 indicated the facility will provide a safe environment that remains free from accidents and falls. The policy indicated each resident would be assessed for potential high-risk factors and provided implemented interventions to address potential accidents. The policy indicated assessment would be completed after falls to identify the underlying causes and prevent further falls/injuries. The facility failed to provide an environment free of accident hazards resulting in R28's non-injury fall in the facility's spa room. The facility additionally failed to implement wandering interventions for R28 after his non-injury fall to prevent further accidents. These deficient practices placed the resident at risk for preventable falls and injuries. - R25's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremors, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness),	F 689			

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F 689	Continued From page 40 muscle weakness, difficulty walking, need for assistance with personal care, and dysphagia (swallowing difficulty). The "Admission Minimum Data Set" (MDS) dated 02/12/24 documented a Brief Interview of Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS documented R25 required supervision or touch assistance for eating. R25's "Functional Abilities Care Area Assessment" (CAA) dated 02/14/24 documented he required assistance with his activities of daily living related to his glaucoma (abnormal condition of elevated pressure within an eye caused by obstruction to the outflow). R25's "Care Plan" dated 02/07/24 documented that staff would ensure he was wearing appropriate footwear when walking. R25's EMR under the "Assessment" tab revealed a "Fall Risk Evaluation" dated 03/14/24 which documented R25 as a high fall risk. On 03/27/24 at 07:43 AM R25 laid on his bed in the lowest position. Certified Medication Aide (CMA) R explained to R25 she was going to assist him to the bathroom. CMA R assisted R25 into a sitting position. CMA R raised the bed, placed R25's walker in front of R25, and asked him to stand up. R25 was wearing socks on his feet, and CMA R assisted R25 to the bathroom while holding the resident's arm. The CNA did not place R25's tennis shoes on his feet or use a gait belt during the walk from the bed to the bathroom. The gait belt hung from the hand sanitizer dispenser on the wall by the bathroom and R25's tennis shoes laid on the floor next to	F 689			

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F 689	Continued From page 41 his wheelchair at the foot of his bed. On 03/27/24 at 01:01 PM, CMA R stated R25 was a high fall risk. CMA R stated she was supposed to use a gait belt when walking with R25. CMA R stated she had planned to put R25's shoes on after she assisted him with dressing. On 03/27/24 at 01:45 PM, Licensed Nurse (LN) K stated R25 was a high fall risk and had a couple of recent falls. LN K stated R25 should be wearing his shoes when walking and that staff should always use a gait belt when walking with a resident. On 03/27/24 at 02:43 PM, Administrative Nurse D stated she expected staff to use a gait belt when walking with a resident. Administrative Nurse D stated she expected staff to use the appropriate footwear for a resident who was a high fall risk. The facility's "Fall Management System" policy revised 12/2023 documented the facility would provide a safe environment that remained free from accidents and falls. The policy indicated each resident would be assessed for potential high-risk factors and provided implemented interventions to address potential accidents. The policy indicated assessment would be completed after falls to identify the underlying causes and prevent further falls/injuries. The facility failed to ensure staff applied the appropriate footwear and utilized a gait belt during ambulation for R25 who had a history of falls and was a high fall risk. This deficient practice placed R25 at risk of further falls and possible injuries.	F 689			

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F 690 F 690 SS=D	Continued From page 42 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 receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by:	F 690 F 690			

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F 690	Continued From page 43 The facility identified a census of 80 residents. The sample included 18 residents with four reviewed for bowel and bladder management. Based on observations, record reviews, and interviews, the facility failed to follow standards of practice related to sanitary catheter care for Resident (R)50. This deficient practice placed R25 at risk for complication-related urinary tract infections (UTI). Finding included: - R50's Electronic Medical Record (EMR) documented a diagnosis of neuromuscular dysfunction of the bladder (the muscles that control the flow of urine out of the body do not relax and prevent the bladder from fully emptying), paraplegia (paralysis characterized by motor or sensory loss in the lower limbs and trunk), and generalized muscle weakness. The "Admission /Medicare Minimum Data Set (MDS)," dated 08/24/23, documented R50 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS documented R50 required partial to moderate assistance with bathing and lower body dressing. The MDS further documented R50 had an indwelling catheter. The "Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA)" dated 08/24/23, documented R50 had an indwelling catheter, neurogenic bladder (dysfunction of the urinary bladder caused by a lesion of the nervous system), and paraplegia. The CAA further documented that nursing staff helped with R50's catheter care and that R50 was at risk for urinary tract infections (UTI-an infection in any part of the	F 690			

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F 690	Continued From page 44 urinary system). R50's "Care Plan" with an initiated date of 03/06/24, documented R50 had a urinary tract infection. An intervention with an initiated date of 09/01/23, directed staff to position R50's catheter bag and tubing below the level of the bladder. Interventions with an initiated date of 09/01/23, directed staff to provide catheter care every shift and as needed and to monitor, record, and report signs and symptoms of a UTI to the doctor. On 03/27/24 at 09:13 AM R50 was in his room in bed. R50's catheter tubing and collection bag contained urine. Licensed Nurse (LN) I performed catheter care on R50 and stated she needed to change his brief. LN I raised R50's catheter collection bag above the level of his bladder and laid it on top of the other side of R50's bed. R50's collection bag and tubing contained urine at that time, and the urine was noted to flow backward in his tubing. As LN I began to change R50's brief, R50's catheter collection bag fell on the floor, and LN I pulled it back onto his bed by the tubing. R50 asked LN I when the next time his catheter collection bag would need to be changed and LN I lifted R50's catheter bag to the level of her chest (above the level of R50's bladder) to inspect the date on R50's catheter collection bag and stated that it did not need to be changed at that time. There was no longer urine noted in R50's catheter tubing after R50's brief change was completed, and the backflow was observed. On 03/27/24 at 02:00 PM, LN I stated that she probably should have moved R50's catheter collection bag to the other side of his bed and hung it there before she began his brief change and turned him in bed. LN I further stated that she	F 690			

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F 690	Continued From page 45 should not have raised his catheter collection bag to chest level while she inspected the date on his catheter collection bag. On 03/27/24 at 02:41 PM Administrative Nurse D stated staff should never raise a catheter collection bag to a level above a resident's bladder as it could cause urine in the catheter tubing to flow back into the resident's bladder. Administrative Nurse D stated she expected staff to drain the catheter tubing of urine and place the catheter collection bag on the other side of a resident's bed, before turning them in bed to prevent urine from flowing back into the resident's bladder. Administrative Nurse D further stated urine flowing back into a resident's bladder, from the catheter tubing, could potentially cause an infection. The facility provided a "Catheter Care, Indwelling" policy with a revised date of 07/2013, and directed staff to keep catheter tubing below the level of the bladder. The facility failed to ensure R50's catheter collection bag was kept below his bladder during catheter care and a brief change. This deficient practice placed R50 at increased risk for infection and catheter-related complications.	F 690			
F 692 SS=G	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must	F 692			

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F 692	Continued From page 46 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 identified a census of 80 residents. The sample included 18 residents with one reviewed for nutrition. Based on observation, record review, and interviews, the facility failed to obtain accurate weights and verify weight changes related to Resident (R)28's physician-ordered weekly weights to effectively monitor weight trends and identify concerns before a significant weight loss occurred. The facility further failed to ensure staff served R28 a diet he could safely consume. As a result of the deficient practices, R28 had a significant unplanned weight loss of 28.38 percent (%) within one month. Findings Included: - The "Medical Diagnosis" section within R28's Electronic Medical Records (EMR) included diagnoses of congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), dysphagia	F 692			

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F 692	Continued From page 47 (difficulty swallowing), cognitive-communication disorder, and dementia (a progressive mental disorder characterized by failing memory, confusion). R28's "Admission Minimum Data Set (MDS)" completed 02/20/24 noted a Brief Interview for Metal Status (BIMS) score of 10, indicating moderate cognitive impairment. The MDS indicated R28 had no behaviors, used a wheelchair, and was dependent on staff for mobility. The MDS indicated he had no upper or lower extremity impairments, required set-up assistance with his meals, and had problems with choking or coughing during meals. The MDS noted he weighed 147 pounds (lbs.) and was on a mechanically altered diet. R28's "Nutritional Status Care Area Assessment (CAA)" completed 02/27/24 noted he was on a mechanically altered diet due to his cognition. The CAA noted he had difficulty swallowing with his dysphagia. The CAA noted he was on the grazing program (a weight loss program for dementia that increased opportunities for nutritional intake) due to his dementia. R28's "Activity of Daily Living Functional/Rehabilitation Potential CAA" completed 02/27/24 indicated he required assistance with his care. The CAA noted he was weak and working to recover his strength. The CAA noted he was at risk for falls, depression, infections, and a decline in his activities of daily living (ADL). R28's "Care Plan" initiated on 02/14/24 indicated he had a nutritional problem related to his medical diagnosis. The plan instructed staff to	F 692			

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F 692	Continued From page 48 provide his diet as ordered (02/14/24). The plan instructed staff to monitor for signs of dysphagia, coughing, drooling, and difficulty swallowing (02/27/24). The plan instructed staff to provide dietary supplements as ordered and weigh him weekly for four weeks (02/27/24). The plan noted he was placed on a grazing program on 03/21/24. The plan instructed staff to provide a slightly thick liquid consistency. R28's EMR under "Orders" revealed his diet was regular, minced, and moist on 03/19/24. R28's EMR under "Orders" noted an order dated 02/15/24 instructing staff to complete daily weights for three days, then weekly weights for four weeks, then monthly weights. A "Mini-Nutritional Assessment" completed on 02/16/24 revealed a score of six indicating he was malnourished (lack of nutrients, which can result in stunted growth, wasting, and underweight). A "Nutrition Evaluation" completed 02/16/24 indicated R28 weighed 147.5 lbs. The evaluation indicated his ideal body weight range was 142 lbs. The assessment indicated he was on a soft and bite-sized diet and required limited assistance with meals. The assessment indicated his appetite was poor and often refused meals. The assessment noted supplements were ordered and the registered dietitian would be available as needed. R28's EMR under "Weight History" between 02/14/24 through 03/26/24 revealed his weight upon admission was 148 lbs. on 02/14/24. The EMR revealed he weighed 107 lbs. on 03/07/24,	F 692			

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F 692	Continued From page 49 indicating a 27.70% weight loss since his admission (23 days). The EMR revealed his weight decreased to 106 lbs. on 03/12/24 indicating a 28.38% weight loss since his admission to the facility (28 days). R28's EMR under "Tasks" revealed the facility entered and struck out three weights marked as incorrect entries on 02/20/24 (146.5 lbs.), 03/04/24 (106 lbs.), and 03/04/24 (109.2 lbs.). The review revealed the lack of weights or reweighs for R28 between 02/17/24 and 03/07/24 during his significant weight loss timeframe. A "Weight Change" note completed on 03/15/24 indicated a weight warning triggered his weight as 106 lbs. on 03/07/24. The note indicated a significant weight loss occurred, but the facility was unable to assess its related concerns with weight accuracy. The note recommended reweighing R28. R28's EMR as of 03/26/24 at 08:00 AM revealed R28 had not been reweighed. On 03/27/24 at 10:00 AM the facility weighed R28 upon request. R28 weighed 108 lbs. On 03/25/24 at 08:10 AM R28 slept in his bed. His bed was in the low position with a fall mat positioned to the left side. At 11:50 AM R28's representative arrived and woke him up. She stated he slept through breakfast and needed to get up for lunch. She stated he had times of confusion and would not understand where he was or what times meals were. She stated he wore the same clothes he had on the day prior, and she had to remind the facility to give him baths and brush his teeth.	F 692			

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F 692	Continued From page 50 On 03/26/24 at 09:09 AM R28 laid supine in his bed with the head of his bed elevated. R28 ate his breakfast of oatmeal and scrambled eggs. R28 consumed his supplement drink and reported no concerns with breakfast. R28 stated he is not always hungry and would often refuse to eat certain meals. He stated he knew he had lost a lot of weight and he stated his normal weight was 160 lbs. On 03/26/24 at 01:14 PM, R28 was in the dining room and served minced chicken and potato salad. R28's plate also contained three uncut Brussels sprouts he was unable to eat. A review of R28's meal ticket noted he was to be served a regular diet that was minced and moist. At 01:20 AM Certified Nurse Aide (CNA) Q offered to cut up the Brussels sprouts. R28 declined to eat them. On 03/26/24 at 10:00 AM, CNA Q stated each resident was weighed based on their orders. She stated some residents were weighed daily, weekly, or monthly. She stated she thought R28 had weekly weights due to his dementia and weight loss risk. She stated if a resident refused weights the nurse would be notified. She stated multiple attempts would be made to complete the weight before rescheduling the next day. She stated the nurse would be notified of the weight changes. On 03/27/24 at 10:26 AM Licensed Nurse (LN) G stated weight changes were reported to the registered dietician (RD) and medical provider. She stated weights should be completed based on the physician's orders and the risk level of the residents. She stated that missed weights should	F 692			

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F 692	Continued From page 51 be attempted the next possible day to ensure consistent monitoring. She stated the facility had multiple scales if accuracy concerns appeared. On 03/27/24 at 02:42 PM Administrative Nurse D stated she believed R28 was on weekly weights due to his medical diagnoses. She stated she expected staff to review the weights collected and report the changes to herself, the RD, and the medical provider. She stated the interdisciplinary team (IDT) reviewed weight loss weekly and provided interventions to combat the weight loss such as dietary adjustment, snacks, supervision, supplementation, and reviews. She stated the facility implemented a "Grazing Program" to assist with residents with dementia. She stated R28 had recent weight loss. She stated staff should make multiple attempts to weigh the residents and reschedule the missed weight for the next possible day. The RD was not available for interview on 03/28/24. The facility provided a "Weight Monitoring" policy revised 01/2022 indicated the facility would establish a baseline weight upon admission and continue to weigh the resident using the same scale. The policy indicated staff were to record and report weight changes to the interdisciplinary team. The facility failed to obtain accurate weights and verify weight changes related to R28's physician-ordered weekly weights to effectively monitor weight trends and identify concerns before a significant weight loss occurred. The facility further failed to ensure staff served R28 a diet he could safely consume. As a result of the	F 692			

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F 692	Continued From page 52	F 692			
F 698	deficient practices, R28 had a significant unplanned weight loss of 28.38% within one month.				
SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: The facility identified a census of 80 residents. The sample included 18 residents with one resident reviewed for dialysis (blood purifying treatment given when kidney function is not optimum). Based on observation, record review, and interviews, the facility failed to ensure ongoing communication and collaboration with the dialysis facility regarding dialysis care and services for Resident (R) 46. This deficient practice placed R46 at risk of delayed services, potential adverse outcomes, and physical complications related to dialysis. Findings included: - R46's Electronic Medical Record (EMR) documented a diagnosis of end-stage renal disease (ESRD-a terminal disease of the kidneys) and dependence on renal dialysis. The "Annual Minimum Data Set (MDS)," dated 10/09/23, documented R46 had a Brief Interview for Mental Status (BIMS) score of 12 which indicated moderately impaired cognition. The	F 698			

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F 698	Continued From page 53 MDS documented R46 was independent of activities of daily living (ADL) and received dialysis services. The "Nutritional Status Care Area Assessment (CAA)" dated 10/09/23, documented R46 was on dialysis three times a week. R46's "Care Plan" with an initiated date of 11/24/22, documented R46 had ESRD with hemodialysis. An intervention with an initiated date of 11/24/22 documented R46 received dialysis every Monday, Wednesday, and Friday. An intervention with an initiated date of 06/28/23 documented R46 would refuse to go to dialysis at times. R46's EMR under the "Orders" tab revealed physician orders: Receives dialysis on Monday, Wednesday Friday at 05:40 AM with a start date of 03/22/24. Dialysis communication form to be completed and filed after dialysis treatment ordered 03/20/24. R46's EMR under the "Miscellaneous" tab revealed scanned dialysis communication forms. Dialysis communication forms, under the "Miscellaneous" tab, reviewed from 12/29/23 to 03/27/24 (90 days) revealed no dialysis communication forms scanned for the following dialysis dates: 01/12/24, 02/02/24, 02/12/24, 02/16/24, 02/21/24, 02/23/24, 02/28/24, 03/08/24 and 03/22/24. R46's EMR under the "Progress Notes" tab lacked evidence of R46's refusal to attend his dialysis appointments for the above dates.	F 698			

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F 698	Continued From page 54 R46's dialysis communication forms for the above dates were requested from the facility and the facility was unable to provide a dialysis communication form or evidence R46 refused dialysis for the above dates. On 03/27/24 at 09:30 AM R46 was propelled in a wheelchair down the hallway to his room. Licensed Nurse (LN) I entered R46's room and began a post-dialysis assessment on R46. R46 stated he left dialysis early because he did not feel well. On 03/27/24 at 02:00 PM, LN I stated dialysis communication forms were scanned into R46's EMR and found under the "Miscellaneous" tab. LN I stated the forms were completed by the nurse once R46 returned to the facility and the forms would have been sent to medical records to be scanned into the EMR. LN I stated the facility did not keep dialysis communication forms in a book or binder and that they were instead scanned into the EMR. LN I stated if R46 refused to go to dialysis staff should have documented his refusal in a progress note. On 03/27/24 at 02:41 PM Administrative Nurse D stated staff were expected to have filled out a dialysis communication forms the morning before the resident left for dialysis. Administrative Nurse D stated the facility expected to receive the communication forms back once the resident returned from their dialysis appointment; however, Administrative Nurse D further stated the dialysis staff were not always fantastic about sending the forms back with the resident. Administrative Nurse D stated sometimes the nurse would have called the dialysis center to request the forms be sent, but the forms would	F 698			

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F 698	Continued From page 55 not always make it back to the facility. Administrative Nurse D stated dialysis communication forms would have been sent to medical records to be scanned and uploaded into the resident's EMR. Administrative Nurse D stated R46 would sometimes refuse to go to his dialysis appointments due to transport running late to pick him up and she further stated R46 would refuse to reschedule for a later time if offered. Administrative Nurse D stated if R46 refused a dialysis appointment she expected staff to document the refusal in a progress note in R46's EMR. Administrative Nurse D stated the facility did not have the dialysis communication forms for the dates requested and stated she believed they were not returned from the dialysis center. The facility provided a "Dialysis (Renal), Pre- and Post-Care" policy with an original date of 03/2009, documented it was the policy of the facility to participate in ongoing communication and collaboration with the dialysis facility regarding dialysis care and services. The care of the resident receiving dialysis services will reflect ongoing communication, coordination, and collaboration between the nursing home and dialysis staff. Documentation related to pre-and post-dialysis care will be placed in the clinical record. The facility failed to ensure ongoing communication and collaboration with the dialysis facility regarding dialysis care and services for R46. This deficient practice placed R46 at risk of delayed services, potential adverse outcomes, and physical complications related to dialysis.	F 698			
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records	F 755			

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F 755	Continued From page 56 CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: The facility had a census of 80 residents. The sample included 18 residents and two medication carts. Based on observation, record review, and interview the facility failed to provide a consistent	F 755			

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F 755	Continued From page 57 reconciliation of controlled drugs at the end of each work shift. This placed the 14 residents with controlled substances on the cart at risk for misappropriation of medications. The facility also failed to ensure Resident (R) 42's physician-prescribed medication was available from the pharmacy for administration. This placed R42 at risk for ineffective medication regimen and related complications. Findings included: - On 03/26/24 at 08:14 AM, observation on the Maple Hill One medication cart "Controlled Drug Record" flow sheet lacked evidence the staff completed the narcotic reconciliation for day shifts on 02/01/24, 02/02/24, 02/03/24, 02/04/24, 02/09/24, 02/10/24, 02/12/24, 02/16/24, 02/19/24, 02/23/24, 02/26/24, 02/27/24, 03/01/24, 03/02/24, 03/03/24, 03/04/24, 03/07/24, 03/08/24, 03/09/24, 03/15/24, 03/16/24, 03/17/24, 03/18/24, 03/22/24, and 03/25/24, for night shifts; 02/01/24, 02/02/24, 02/03/24, 02/09/24, 02/10/24, 02/11/24, 02/12/24, 02/16/24, 02/19/24, 02/12/24, 02/26/24, 02/27/24, 03/01/24, 03/02/24, 03/03/24, 03/06/24, 03/14/24, 03/15/24, 03/16/24, 03/17/24, 03/18/24, and 03/25/24 (forty-eight times out of possible 109 work shifts). On 03/26/24 at 08:15 AM, Licensed Nurse (LN) J stated nurses were expected to count the narcotics with another nurse each shift. LN J stated the nurse coming on duty and the nurse going off duty should ensure the narcotic count is correct each shift. LN J stated the facility has a policy regarding controlled substances, and everyone was educated on the policy and expectations of counting narcotics.	F 755			

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F 755	Continued From page 58 On 03/27/24 at 02:41 PM, Administrative Nurse D stated she expected the nurse coming on duty and the nurse leaving duty to count their narcotic cards and bottles on all carts. Administrative Nurse D stated nurses or medication aides count each card, and the total number was recorded. Administrative Nurse D stated the two nurses together determined the count was correct. The "Controlled Medication" policy revised 12/2023 stated controlled medications reconciliation is conducted by two licensed nurses and is documented on an audit record at each shift change. Any discrepancies in the controlled medication should be reported to the Director of Nursing Services immediately. The facility failed to provide a consistent reconciliation of controlled drugs at the end of daily work shifts, placing the 14 residents with controlled substances on the cart at risk for misappropriation of medications by staff. - The electronic medical record for R42 documented diagnoses of hypothyroidism (a condition characterized by decreased activity of the thyroid gland), hypotension (low blood pressure), and dementia (progressive mental disorder characterized by failing memory, and confusion). R42's "Annual Minimum Data Set (MDS)" dated 02/10/24 documented a Brief Interview for Mental Status (BIMS) score of 13 which indicated intact cognition. R42 utilized a walker and wheelchair for mobility. R42 required setup to supervision/touching assistance with his activities of daily living (ADLs). R42 had no history of falls since the last assessment.	F 755			

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F 755	Continued From page 59 R42's "ADL Care Area Assessment (CAA)" dated 02/22/24 documented he needed assistance with his care. R42 ambulated with a walker. Nursing provided ADL, mobility, and transfer assistance as needed. R42's "Care Plan" last revised 02/27/24 directed staff to administer medications as ordered. R42's "Order Summary Report" documented an order dated 03/17/22 for levothyroxine (a medication used to treat hypothyroidism) 75 micrograms (mcg) by mouth 30 minutes before breakfast daily for hypothyroidism. R42's January 2024 "Medication Administration Record (MAR)" on 01/01/24, 01/02/24, and 01/03/24 recorded a seven (7- other/see nurse notes) in the administration box for his levothyroxine. On 01/1/24 at 05:36 AM an "eMAR-Medication Administration Note" documented staff were waiting on the delivery from the pharmacy. On 01/2/24 at 05:09 AM an "eMAR-Medication Administration Note" documented levothyroxine sodium tablet 75 mcg; the medication was not available, and the pharmacy was notified. On 01/3/24 at 04:13 AM an "eMAR-Medication Administration Note" documented staff continued waiting on a delivery from the pharmacy. Staff would notify the day nurse to call the pharmacy. On 03/26/24 at 08:38 AM R42 sat in a chair at the dining table eating breakfast; his walker was beside his chair.	F 755			

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F 755	Continued From page 60 On 03/27/24 at 01:55 PM Certified Medication Aide (CMA) S stated she would let the pharmacy know when a resident had five or fewer doses left of a medication to ensure that the medication was received before the medication was out. CMA S stated if she noticed that a resident was out of medication, she would immediately call the pharmacy to order the medication as well as notify the nurse that the medication was out and had been ordered. On 03/27/24 at 01:58 PM Licensed Nurse (LN) I stated a medication that was almost out should be ordered several days to a week before being completely out to ensure that the medication was received before completely out. LN I stated at times medications were not available from the pharmacy to be delivered due to a holiday or some other circumstance. LN I stated she would not expect a resident to be without medication for more than one day and would expect the nurse to document a reason why the medication was not available. On 03/27/24 at 03:15 PM Administrative Nurse D stated nursing staff had been educated numerous times to make sure that medication was ordered at least five days before being out to ensure the medication was received before being out. Administrative Nurse D stated she could not say for certain why R42's medication had run out or had not been ordered/received. The "Pharmacy Services/Nursing Services" policy revised in July 2015 documented drugs and biologicals that were required to be refilled must be ordered from the issuing pharmacy not less than three days before the last dosage being	F 755			

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F 755	Continued From page 61 administered to ensure that refills were on hand. The facility failed to ensure R42's physician-ordered levothyroxine was available for administration. This deficient practice placed R42 at risk for ineffective medication regimen and related health consequences.	F 755			
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (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 62 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 identified a census of 80 residents. The sample included 18 residents with five residents reviewed for unnecessary medications. Based on observation, record review, and interview Based on observation, record review, and interview the facility failed to ensure an appropriate indication, or a documented physician rationale which included the multiple unsuccessful attempts for nonpharmacological symptom management and risk versus benefits for the continued use of an antipsychotic (class of medications used to treat a mental disorder characterized by gross impairment in reality testing) for Resident (R)28's Seroquel (antipsychotic medication). This placed the resident at risk for unnecessary psychotropic (alters perception, mood, consciousness, cognition, or behavior) medications and related complications.	F 758			

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F 758	Continued From page 63 Findings Included: - The "Medical Diagnosis" section within R28's Electronic Medical Records (EMR) included diagnoses of congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), dysphagia (difficulty swallowing), cognitive-communication disorder, and dementia (a progressive mental disorder characterized by failing memory, confusion). R28's "Admission Minimum Data Set (MDS)" completed 02/20/24 noted a Brief Interview for Metal Status (BIMS) score of 10 indicating moderate cognitive impairment. The MDS indicated R28 had no behaviors. The MDS indicated he used a wheelchair and was dependent on staff for mobility. The MDS indicated he had no upper or lower extremity impairments. The MDS indicated he was not taking psychotropic medications upon admission. R28's "Functional Abilities CAA" completed 02/27/24 indicated he required assistance with his care. The CAA noted he was weak and working to recover his strength. The CAA noted he was at risk for falls, depression, infections, and a decline in his activities of daily living (ADLs). R28's "Care Plan" initiated 02/14/24 indicated he was started on antipsychotic medication related to behaviors. The plan noted he took Seroquel and instructed staff to monitor for changes in mood/behaviors and potential side effects. The plan noted Seroquel had a black box warning (BBW- highest safety-related warning that	F 758			

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F 758	Continued From page 64 medications can have assigned by the Food and Drug Administration). The plan noted that non-pharmacological interventions provided for R28 included back rubs, redirections, snacks, pain assessment, activities, and reassurance. R28's EMR under "Orders" indicated an order started on 03/06/24 for staff to administer 25 milligrams (mg) of Seroquel by mouth twice daily for dementia with behaviors and agitation. R28's clinical record lacked documentation showing appropriate indication or a documented physician rationale which included the multiple unsuccessful attempts for nonpharmacological symptom management and risk versus benefits before R28's medication was started. The facility was also unable to provide this documentation upon request. The facility provided an email for review from the physician dated 03/27/24 which indicated the medical provider acknowledged R28 was combative with aggressive behaviors during care. The email indicated staff exhausted non-pharmacological interventions including individual groups, speech therapy, and placement at the nurses' station for supervision and support. On 03/25/24 at 12:04 PM R28 was woken up by his representative. R28 was wearing grey food-stained jogging clothing. His hair was greasy, and his fingernails were dirty. On 03/27/24 at 10:29 AM Licensed Nurse (LN) G stated antipsychotic medication should not be used for dementia diagnoses alone but sometimes was used with other behavioral illnesses.	F 758			

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F 758	Continued From page 65 On 03/27/24 at 02:45 PM Administrative Nurse D stated dementia was not an appropriate diagnosis for antipsychotic medications but was used when other symptoms were present. She stated the facility had tried multiple interventions for R28's behaviors and the medical provider closely reviewed the medication use but was unable to provide the documentation. A review of the facility's provided "Psychotropic medication" policy revised 08/2017 indicated the facility will ensure all residents with psychotropic medications were closely reviewed for correct indication and appropriateness. The facility failed to ensure an appropriate indication or a documented physician rationale which included the multiple unsuccessful attempts for nonpharmacological symptom management and risk versus benefits for the continued use of an antipsychotic for R28, who had a diagnosis of dementia. This placed the resident at risk for unnecessary psychotropic medications and related complications.	F 758			
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: The facility identified a census of 80 residents. The sample included 18 residents. Based on observation, record review, and interview, the	F 759			

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F 759	Continued From page 66 facility failed to ensure the medication error rate did not exceed five percent (%) when staff failed to administer Resident (R)62 ' s medications as ordered. This resulted in a medication error rate of 26.67%. Findings included: - R62's Electronic Medical Record (EMR) under "Physician ' s Orders" revealed the following: An order dated 12/30/23 instructing to administer 400 milligrams (mg) of Gabapentin (medication used to treat nerve pain) via an enteral (within or via the small intestine) tube each morning for neuromuscular pain. An order dated 12/30/23 instructing to administer 200 mg of Amiodarone (medication used to treat irregular heart rhythms) via enteral tube each morning for irregular heartbeat. An order dated 12/30/23 instructed to administer one tablet of Sennoside docusate (laxative) via enteral tube each morning for constipation. An order dated 12/29/23 instructing to administer 5 mg of Eliquis (medication used to prevent the blood from clotting) via enteral tube each morning to prevent blood clots related to irregular heartbeat. A review of R62 ' s "Physician Orders" lacked evidence of any order allowing enterally administrated medications to be given orally. On 03/27/24 at 09:10 AM Licensed Nurse (LN) G completed hand hygiene and prepared R62 ' s medications for oral administration. R62 received his amiodarone (200mg), Gabapentin (400mg), senna-lax (8.6mg-50mg), and Eliquis (5mg) medications by mouth. LN G stated R62 preferred to receive his medication by mouth	F 759			

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F 759	Continued From page 67 except for his liquid supplement. On 03/27/24 at 02:42 PM Administrative Nurse D stated staff were expected to follow the physician's orders and notify the physician of changes in the resident ' s status and orders. The facility ' s provided "Medication Error and Adverse Reactions" revised 01/2022 indicated the facility will ensure each resident ' s medications were prescribed accurately and administered following the appropriate order, route, patient, dosage, time, and medication. The facility failed to ensure the medication error rate did not exceed five percent. This resulted in a medication error rate of 26.67%.	F 759			
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: The facility identified a census of 80 residents. The sample included 18 residents. Based on observation, record review, and interview, the facility failed to ensure Resident (R) 17 was free from significant medication errors when staff failed to administer insulin (a hormone that lowers the level of glucose in the blood) and antihypertensive (class of medication used to treat high blood pressure) medications as ordered. This placed R17 at risk for adverse side effects and medical complications. Findings included:	F 760			

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F 760	Continued From page 68 - The electronic medical record (EMR) for R17 documented diagnosis of hypertension (HTN-elevated blood pressure), type 2 diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made or the body cannot respond to the insulin), and peripheral vascular disease (PVD- slow and progressive circulation disorder causing narrowing, blockage, or spasms in a blood vessel). R17's "Annual Minimum Data Set (MDS)" dated 03/24/23 documented a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. R17 required extensive assistance from one staff for activities of daily living (ADLs). R17 received insulin injections seven of seven days during the lookback period. R17's "ADL Care Area Assessment (CAA)" dated 04/07/23 documented R17 had a self-care and mobility deficit and balance problems. R17 was bed-bound per her choice. R17 was at risk for a decline in ADLs, falls, 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), contractures (abnormal permanent fixation of a joint or muscle), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), muscle wasting (decrease in size and wasting of muscle tissue) and infections. R17's "Care Plan" last revised on 09/26/23 directed staff to give diabetic medication as ordered. Staff was directed to monitor/document for side effects and effectiveness.	F 760			

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F 760	Continued From page 69 R17's "Care Plan" revised 07/04/23 directed staff to take blood pressure as ordered and as needed. The staff was directed to give antihypertensive medications as ordered. R17's February 2024 "Medication Administration Record (MAR) documented an order dated 06/22/23 for carvedilol (a beta blocker used to lower blood pressure) 25 milligrams (mg) tablet by mouth twice a day for hypertension hold for systolic blood pressure (SBP- top number, the force your heart exerts on the walls of your arteries each time it beats) below 110, heart rated below 55, call the physician for blood pressure greater than 175. R17's February 2024 MAR documented an order for hydralazine (medication used to treat HTN) tablet 25 mg give two tablets by mouth three times a day for HTN. Hold if SBP was less than 120 and/or pulse was below 60. R17's "Order Summary Report" dated 02/01/24 to 02/29/24 documented an order dated 02/09/24 for Levemir 100unit/milliliter (ml) (a long-acting insulin that starts to work in 15 minutes, peaks within 60 minutes, and its effects last for three to five hours) to inject 27 units subcutaneously (beneath the skin) at bedtime for DM. R17's "Order Summary Report" dated 02/01/24 to 02/29/24 documented an order dated 02/16/24 for Levemir 100 units/ml to inject 30 units SQ one time a day for DM. This order was discontinued on 02/20/24 at 03:25 PM. R17's "Order Summary Report" dated 02/01/24 to 02/29/24 documented an order dated 02/16/24 for Levemir 100 units/ml to inject 30 units SQ at	F 760			

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F 760	Continued From page 70 bedtime for DM. This order was discontinued on 02/20/24 at 03:25 PM. R17's "Order Summary Report" dated 02/01/24 to 02/29/24 documented an order dated 02/20/24 at 03:25 PM for Levemir 100unit/ml to inject 30 units SQ one time a day for DM until 02/21/24 at 11:59 PM. R17's "Order Summary Report" dated 02/01/24 to 02/29/24 documented an order dated 02/20/24 at 03:25 PM for Levemir 100unit/ml to inject 30 units SQ at bedtime for DM until 02/22/24 at 11:59 PM. R17's "Order Summary Report" dated 02/01/24 to 02/29/24 documented an order dated 02/02/24 for basaglar 100 unit/ml (long-acting insulin) to inject 50 units SQ at bedtime for DM2 start once finished with current Levimir pens. This order was discontinued on 03/06/24. R17's February 2024 MAR lacked staff sign-off that Levemir was injected on 02/20/24 at bedtime as scheduled or on 02/21/24 at 07:00 AM. R17's February 2024 MAR documented on 02/23/24 at bedtime that her basaglar was not administered as ordered due to R17 still having Levemir pens left however R17's MAR documented the basaglar was administered on 02/22/24 and 02/24/24. R17's February 2024 MAR lacked documentation on 02/25/24 the 08:00 AM carvedilol was given and not applicable (NA) was documented for the blood pressure and pulse readings. R17's February 2024 MAR lacked documentation on 02/25/24 at midday that her blood pressure	F 760			

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F 760	Continued From page 71 and pulse were monitored and her physician ordered hydralazine was administered as ordered. R17's EMR lacked a "Progress Note" or other documentation to address the missed administration of the above medications. On 03/26/24 at 08:36 AM R17 stated that she filed a grievance and her daughter called in a complaint when she missed her insulin injections and her blood pressure medication last month around 02/20/24 through 02/25/24. R17 stated the facility needs to make sure they have staff that will give the residents the medications they were supposed to have. On 03/27/24 at 01:52 Licensed Nurse (LN) I stated that a blood pressure medication cannot be signed off as given until the blood pressure and pulse readings were entered into the MAR. LN I stated R17's insulin should have been given or the nurse should have documented to explain why the insulin was not administered as ordered. On 03/27/24 at 03:10 PM Administrative Nurse D stated she was in the process of providing education to the medication aides and the nurses to ensure that medication was being given as ordered and if the medication was not given or was not available that the nurse needed to be documenting a nurse note to reflect why the medication was not given. Administrative Nurse D stated the MAR would not allow the user to sign off that a blood pressure medication had been given until the reading had been entered so she was to assume that the medication had not been given. Administrative Nurse D stated she did not have an answer as to why R17 had not been	F 760			

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F 760	Continued From page 72 administered her insulin as ordered. The "Medication Errors and Adverse Reactions" policy last revised in January 2022 documented adverse drug reactions and medication errors with adverse clinical consequences must be reported to the resident's attending physician immediately. Nursing services must immediately implement and follow the physician's orders. The facility failed to ensure R17 was free from significant medication errors when staff failed to administer her insulin and antihypertensive medications. This placed R17 at risk for adverse side effects and medical complications.	F 760			
F 801 SS=F	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e) This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified 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	F 801			

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F 801	Continued From page 73 a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services. (i) The director of food and nutrition services must at a minimum meet one of the following qualifications- (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food 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	F 801			

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F 801	Continued From page 74 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 identified a census of 80 residents. The facility had one main kitchen and four dining areas. Based on observation, record review and interview the facility failed to ensure the director of food and nutrition services had the required qualifications of a certified dietary manager (CDM). This placed residents at risk for unmet dietary and nutritional needs. Findings included: - On 03/26/24 at 11:28 AM Dietary BB stated he and Dietary CC had not completed the course yet to become a CDM. Dietary BB stated he and Dietary CC had begun the courses. Dietary BB stated both himself and Dietary CC had completed the "ServSafe" class and said he would provide a copy of the certification.	F 801			

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F 801	Continued From page 75 The facility did not provide a policy for Qualified Dietary Staff but did provide the Federal regulation guideline 483.60(a)(1). The facility failed to ensure the director of food and nutrition services was a certified dietary manager. This deficient practice placed the affected residents at risk for unmet dietary and nutritional needs.	F 801			
F 803 SS=D	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices.	F 803			

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F 803	Continued From page 76 This REQUIREMENT is not met as evidenced by: The facility identified a census of 80 residents. The sample included 18 residents with three reviewed for nutritional diets. Based on observation, record review, and interviews, the facility failed to follow Resident (R)28's specialized dietary requirements during meal services. This deficient practice placed the residents at risk for impaired nutrition and aspiration (inhaling foreign material or vomit). Findings Included: - The "Medical Diagnosis" section within R28's Electronic Medical Records (EMR) included diagnoses of congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), dysphagia (difficulty swallowing), cognitive-communication disorder, and dementia (a progressive mental disorder characterized by failing memory, confusion). R28's "Admission Minimum Data Set (MDS)" completed 02/20/24 noted a Brief Interview for Metal Status (BIMS) score of 10 indicating moderate cognitive impairment. The MDS indicated R28 had no behaviors. The MDS indicated he used a wheelchair and was dependent on staff for mobility. The MDS indicated he had no upper or lower extremity impairments. The MDS noted he required set-up assistance with his meals. The MDS indicated he had problems with choking or coughing during meals. The MDS noted he weighed 147 pounds and was on a mechanically altered diet. R28's "Nutrition Care Area Assessment (CAA)"	F 803			

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F 803	Continued From page 77 completed 02/27/24 noted he was on a mechanically altered diet due to his cognition. The CAA noted he had difficulty swallowing with his dysphagia. The CAA noted he was on the grazing program (a weight loss program for dementia that increased opportunities for nutritional intake) due to his dementia. R28's "Functional Abilities CAA" completed 02/27/24 indicated he required assistance with his care. The CAA noted he was weak and working to recover his strength. The CAA noted he was at risk for falls, depression, infections, and a decline in his activities of daily living (ADLs). R28's "Care Plan" initiated on 02/14/24 indicated he had a nutritional problem related to his medical diagnosis. The plan instructed staff to provide his diet as ordered (02/14/24). The plan instructed staff to monitor for signs of dysphagia, coughing, drooling, and difficulty swallowing (02/27/24). The plan instructed staff to provide dietary supplements as ordered and weigh him weekly for four weeks (02/27/24). The plan noted he was placed on a grazing program on 03/21/24. The plan instructed staff to provide a slightly thick liquid consistency (03/21/24). R28's EMR under "Orders" revealed his diet was changed to minced and moist (regular diet) on 03/19/24. R28's dietary meal ticket revealed he was to be served a regular diet that was minced and moist. On 03/26/24 at 01:14 PM, R28 was in the dining room. R28 was served minced chicken and potato salad. R28's plate also contained three	F 803			

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F 803	Continued From page 78 uncut Brussels sprouts he was unable to chew them. At 01:20 AM Certified Nurses Aid (CNA) Q offered to cut up his Brussels sprouts. R28 Refused to eat them. On 03/26/23 at 10:00 AM Certified Nurse Aid (CNA) Q stated the dining staff filled the food order and the kitchen staff were responsible for verifying what was on the plate matched the meal ticket. On 03/26/24 at 01:30 PM, Dietary Staff BB stated each resident on a specialized diet was listed on the diet tickets. He stated kitchen staff were expected to review the tickets and ensure the correct food was placed in the resident's place before serving. The facility provided a "Diet Orders" policy (undated) which indicates the facility will ensure each resident's dietary needs, preferences, and assessed abilities are respected and followed. The policy noted accurate communication between dietary and nursing staff was expected to ensure the accuracy of the meal service. The policy indicated each resident's diet would be reviewed during meal service by both dietary and nursing staff. The facility failed to follow R28's specialized dietary requirements during meal services. This deficient practice placed the resident at risk for impaired nutrition and aspiration.	F 803			
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F 812			

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F 812	Continued From page 79 §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: The facility identified a census of 80 residents. The facility had one main kitchen and four kitchenettes with dining areas. Based on observation and interview, the facility failed to ensure staff stored, prepared and served food items and maintained the freezer unit in accordance with the professional standards for food service safety. This placed residents at risk of foodborne illness, and cross-contamination (the transfer of harmful substances to food). Findings included: - Observation during the initial kitchen tour on 03/25/24 at 07:15 AM revealed in the kitchen storage freezer were two open bags of fried potatoes that had no label or date and were not in a sealed bag. The walk-in freezer unit leaked and had ice around some of the pipes. The walk-in freezer had an area of what appeared to be water	F 812			

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F 812	Continued From page 80 that had dripped from the freezer unit and froze on the floor. Observation during the lunchtime services of food on 03/25/24 at 12:23 AM in the Maple Hills 2 dining area revealed that plates, bowls, and saucers were stored right-side up on the counter. An unidentified dietary staff wore gloves while serving food on the resident's plates. She left the serving area to obtain a bowl from the cupboard and returned to the serving area without changing her gloves or performing hand hygiene. Observation on 03/26/24 at 11:18 AM revealed during the preparation of the puree foods by Dietary CC failed to sanitize the metal food container and the lid after each food item was pureed. Dietary CC rinsed the food container and lid under hot water at the sink after each food item. On 03/26/24 at 11:35 AM Dietary CC stated normally he washed and sanitized the food container and lid in the dishwasher. Dietary CC stated he was running behind and it was a simple mistake he made since the surveyor was observing him. On 03/26/24 at 11:15 AM Dietary BB stated that any staff that was assisting during the dining task should be washing their hand and performing hand hygiene after serving each resident. The dietary staff serving the food did wear gloves but were expected to change the gloves and perform hand hygiene if they had left the serving line. Dietary BB stated staff would be re-educated to ensure proper hand hygiene was being performed during food service. Dietary BB stated Dietary CC should have properly washed and	F 812			

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F 812	Continued From page 81 sanitized the container and lid after pureeing each food item. On 03/27/24 at 03:15 PM Administrative Nurse D stated staff was expected to perform hand hygiene during meal service just as they would during care of the residents. Hand hygiene should be performed after the service of each resident. The "Routine Procedures- General Food Handling/Storage/Preparation" policy reviewed in 2021 documented that it was the policy of this facility to provide safe and sanitary storage, handling, and consumption of all food including food and fluids brought to residents by family and other visitors. This included the storage, preparation, distribution, and serving of food in accordance with professional standards for food service safety. Refrigerated items should be covered, labeled, and dated with an expiration date indicated. Dishes should be cleaned and sanitized using the proper water temperature and with the appropriate concentration of sanitizer solution. The dishes must be held in the sanitizing solution for the proper amount of time, and all dishes must be air-dried. Nurses, CNAs, and other staff members who handle and distribute food to residents must receive training on good food safety practices. The facility failed to ensure staff stored, prepared and served food items and maintained the freezer unit in accordance with the professional standards for food service safety. This placed residents at risk of food-borne illness, and cross-contamination.	F 812			
F 849 SS=D	Hospice Services CFR(s): 483.70(o)(1)-(4)	F 849			

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F 849	Continued From page 82 §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining 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	F 849			

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F 849	Continued From page 83 that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related 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	F 849			

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F 849	Continued From page 84 delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation. (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff. §483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following: (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	F 849			

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NAME OF PROVIDER OR SUPPLIER SHAWNEE POST ACUTE REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7600 ANTIOCH ROAD OVERLAND PARK, KS 66204		
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F 849	Continued From page 85 conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(o)(4) Each LTC facility providing hospice 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.	F 849			

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F 849	Continued From page 86 This REQUIREMENT is not met as evidenced by: The facility identified a census of 80 residents. The sample included 18 residents with three 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 describe the services and equipment provided to Resident (R) 21 by hospice. This deficient practice created a risk for missed or delayed services and impaired physical, and psychosocial care for R21. Findings included: - R21's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), dementia (a progressive mental disorder characterized by failing memory, and confusion), muscle weakness, and need for assistance with personal care. The "Significant Change Minimum Data Set" (MDS) dated 02/08/24 documented a Brief Interview of Mental Status (BIMS) score of five which indicated severely impaired cognition. The MDS documented R21 required partial to moderate assistance from staff for her personal hygiene. The MDS documented R21 had received hospice services during the observation period. R21's "Functional Abilities Care Area Assessment" (CAA) dated 02/15/24 documented	F 849			

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F 849	Continued From page 87 she required assistance with activities of daily living. R21's "Care Plan" dated 02/15/24 documented the hospice service contact information. The plan of care also directed staff to observe closely for pain, administer pain medications as ordered, and notify the physician immediately if there was breakthrough pain. The plan of care documented the registered nurse would visit weekly and as needed; a Certified Nurse Aide (CNA) would visit weekly and as needed, and the social worker and chaplain would visit as needed. The plan of care directed the facility to work collaboratively with the hospice provider team to ensure R21's spiritual, emotional, intellectual, physical, and social needs were met. The plan of care lacked a description of the additional services provided by hospice including equipment and medication. R21s EMR under the "Orders" tab revealed the following physician orders: Admit to hospice with a diagnosis of sarcopenia (an age-related involuntary loss of skeletal muscle mass and strength) dated 02/02/24. A review of R21's communication book provided by hospice lacked a hospice care plan, signed admission paperwork with the physician documentation of a terminal diagnosis for admission to hospice services, services, or equipment that would be provided by hospice. On 03/27/24 at 07:38 AM R21 sat at the dining room table and drank her coffee. R21's hair was uncombed and sticking up. R21 stated the staff did not always offer or assist her with combing her hair. R21 stated she was too old to ask for help.			F 849			

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F 849	Continued From page 88 On 03/27/24 at 01:01 PM, Certified Medication Aide (CMA) R stated she would know who was on hospice services when staff from the hospice providers would stop her in the hallway and ask about specific residents. CMA R stated the hospice book would contain information about what was provided by the hospice company. CMA R stated she was not certain what was provided by R21's hospice services provider. On 03/27/24 at 01:45 PM, Licensed Nurse (LN) K confirmed R21's communication book provided by hospice lacked a hospice care plan, signed admission paperwork with the physician documentation of a terminal diagnosis for admission to hospice services, and services or equipment that would be provided by hospice. LN K stated R21's care plan should contain information about what the hospice provider would provide. On 03/27/24 at 02:43 PM, Administrative Nurse D confirmed R21's communication book provided by hospice lacked a hospice care plan and signed admission paperwork with the physician documentation of a terminal diagnosis for admission to hospice services, services, or equipment that would be provided by hospice. Administrative Nurse D stated the hospice provider for R21 was new and would have to investigate the information that was not in the communication book. Administrative Nurse D stated R21's "Care Plan" should have what medical equipment and medication are covered by the hospice provider listed on her care plan. The facility's "Hospice Program Policy" dated 10/2023 documented that when a resident	F 849			

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F 849	Continued From page 89 participated in the hospice program, a coordinated plan of care between the facility, hospice agency, and resident/family would be developed and would include directives for managing pain and other uncomfortable symptoms. The care plan would be revised and updated as necessary to reflect the resident's status. The facility failed to ensure collaboration between the facility and the hospice provider and failed to develop a care plan both by hospice and the facility that included a description of the services, medication, and equipment provided to R21 by hospice. This deficient practice placed R21 at risk for delayed services which could affect her mental, and psychosocial well-being.	F 849			
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals	F 880			

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F 880	Continued From page 90 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 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.	F 880			

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F 880	Continued From page 91 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 80 residents. The sample included 18 residents with two residents where on transmission-based precautions. Based on observation, record review, and interviews, the facility failed to ensure proper infection control standards were followed related to hand hygiene, the disinfecting of shared equipment, and the replacement of respiratory equipment. The facility also failed to ensure laundry temperatures for laundry including laundry from transmission-based precaution rooms with infectious diseases were assessed for appropriate temperatures. This deficient practice placed the residents at risk for complications related to infectious diseases. Findings included: - Observation on 03/25/24 at 10:52 AM Resident (R) 56's oxygen tubing was dated 01/03/24. R56 stated he asked staff to change the oxygen tubing and staff informed him the facility did not have long enough tubing to replace it. Observation on 03/26/24 at 08:14 AM Licensed Nurse (LN) G pushed her medication cart down the hallway and stopped at R29's room. LN G donned gloves pushed the vitals machine into R29's room and applied the blood pressure cuff onto R29's right upper arm. LN G obtained R29's	F 880			

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F 880	Continued From page 92 temperature with the forehead contact sensor and then placed the thermometer back into the basket of the vital sign machine without disinfecting the thermometer. LN G removed the blood pressure cuff and placed the cuff back onto the vital sign machine without disinfecting the blood pressure cuff. LN G pushed the vital sign machine from R29's room back into the hallway. LN G removed her gloves, did not perform hand hygiene, and donned a new pair of gloves. She prepared R29's medication and administered the medication to R29. LN G exited R29's room, doffed her gloves but did not perform hand hygiene. LN G pushed the medication cart and the vital sign machine down the hallway to another resident's room. LN G entered the room with the vital sign machine. On 03/26/24 at 11:29 AM survey of the laundry room revealed the washing machine water temperatures were monitored weekly. Maintenance Director U stated he tested and recorded the water temperatures weekly. Maintenance Director U stated the facility did have two residents currently in isolation. Maintenance Director U stated the only way he could think to ensure the water temperatures were sufficient to kill the germs from the transmission-based precautions rooms, one with COVID-19 (highly contagious respiratory virus) and clostridium difficile (C-diff: contagious bacteria characterized by foul-smelling frequent loose bowel movements), would be to monitor the water temperature with each load of transmission based laundry at least. On 03/27/24 at 01:01 PM, Certified Medication Aide (CMA) R stated shared medical equipment was disinfected by the night shift. CMA R stated	F 880			

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F 880	Continued From page 93 she would perform hand hygiene between donning and doffing her gloves and between each resident. On 03/27/24 at 01:45 PM, Licensed Nurse (LN) K stated shared equipment should be disinfected between each use. LN K stated she would perform hand hygiene between each resident when administering medication. On 03/27/24 at 02:43 PM, Administrative Nurse D stated she expected the staff to disinfect shared equipment between each use and perform hand hygiene between providing care. Administrative Nurse D stated she expected staff to change the oxygen tubing as indicated. The facility's "Handling Linen" policy dated 08/29/17 documented that soiled laundry /bedding would be handled in a manner that prevented gross microbial contamination of the air and persons handling the linen. The facility's undated "Hand Hygiene" policy documented the facility considered hand hygiene the primary means to prevent the spread of infections. The facility failed to ensure staff practiced standard infection control precautions to prevent the spread of infection when staff failed to perform hand hygiene during glove changes and between administration of medication, also failed to replace oxygen tubing as ordered and perform disinfecting of shared equipment. The facility also failed to ensure laundry temperatures for laundry including infectious disease from transmission-based precaution rooms were assessed for appropriate disinfecting	F 880			

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F 880	Continued From page 94 temperatures. This had the potential to increase the risk of transmission of infectious diseases to residents.	F 880			
F 883 SS=D	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 (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	F 883			

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F 883	Continued From page 95 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: The facility identified a census of 80 residents. The sample included 18 residents with five residents reviewed for immunizations. Based on observation, record review, and interviews, the facility failed to provide Resident (R) 42, R27, and R23 with the Pneumococcal Conjugate Vaccine (PCV20- vaccination for bacterial infections) as consented. This placed the residents at increased risk for complications related to pneumonia. Findings included: - R42's Electronic Medical Record (EMR) revealed he was eligible and within the required vaccination date range to receive the PCV20 vaccination. A review of "Resident Consent for Influenza, Pneumococcal, and COVID-19	F 883			

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F 883	Continued From page 96 Vaccination" form for R42 dated 10/19/23 provided by the facility revealed a signed consent to receive the pneumococcal vaccination. The form indicated R42 was provided educational information related to the vaccination but never received the PCV 20 vaccination. The facility was unable to provide evidence the PCV20 was administered to R42. R27's EMR revealed he was eligible and within the required vaccination date range to receive the PCV20 vaccination. A review of "Resident Consent for Influenza, Pneumococcal, and COVID-19 Vaccination" form for R27 dated 10/19/23 provided by the facility revealed a signed consent to receive the pneumococcal vaccination. The form indicated R27 was provided educational information related to the vaccination but never received the PCV 20 vaccination. The facility was unable to provide evidence the PCV20 was administered to R27. R23's EMR revealed he was eligible and within the required vaccination date range to receive the PCV20 vaccination. A review of "Resident Consent for Influenza, Pneumococcal, and COVID-19 Vaccination" form for R23 dated 10/19/23 was provided by the facility and revealed a signed consent to receive the pneumococcal vaccination. The form indicated R23 was provided educational information related to the vaccination but never received the PCV 20 vaccination. The facility was unable to provide evidence that PCV 20 was administered to R23. On 03/27/24 at 10:45 AM Administrative Nurse E, the facility Infection Preventionist, stated she had obtained the consent for the pneumococcal vaccination during influenza season.	F 883			

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F 883	Continued From page 97 Administrative Nurse E stated the facility started giving pneumococcal vaccinations to the eligible resident in February 2024. On 03/27/24 at 11:03 AM, Administrative Nurse D stated she expected the pneumococcal vaccination to be administered at the time of consent. The facility's undated "Pneumococcal Vaccine" policy documented it was the facility's policy to offer residents and staff immunization against pneumococcal disease in accordance with current Centers for Disease Center guidelines and recommendations. The facility failed to provide R42, R27, and R23 with the PCV20 vaccination as consented. This placed these residents at increased risk for complications related to pneumonia.	F 883			
F 941 SS=F	Communication Training CFR(s): 483.95(a) §483.95(a) Communication. A facility must include effective communications as mandatory training for direct care staff. This REQUIREMENT is not met as evidenced by: The facility identified a census of 80 residents. Based on record review and interviews, the facility failed to ensure direct care staff received the required communication training. This placed the residents at risk for impaired care and decreased quality of life. Findings Included: - On 03/27/24 at 11:40 AM a review of the	F 941			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175550	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/27/2024
NAME OF PROVIDER OR SUPPLIER SHAWNEE POST ACUTE REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7600 ANTIOCH ROAD OVERLAND PARK, KS 66204		
(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 941	Continued From page 98 facility's training for Certified Nurses Aid (CNA) PP, CNA QQ, Licensed Nurse (LN) L, LN NN, and LN OO revealed the following: CNA PP's facility-provided credentialling file lacked documented and completed training completed for communication. The file noted she passed abuse, neglect, and exploitation (ANE) and a mental health course. CNA QQ's facility-provided credentialling file lacked documented and completed training completed for communication. The file noted she had ANE and mental health courses. LN L's facility-provided credentialling file lacked documented and completed training completed for communication. The file noted she had ANE training and mental health courses. LN NN's facility-provided credentialling file lacked documented and completed training completed for communication. The file noted she had ANE training and mental health courses. LN OO's facility-provided credentialling file lacked documented and completed training completed for communication. The file noted she had ANE training and mental health courses. On 03/27/24 at 12:45 PM Administrative Nurse D stated the selected agency that provided the staff was new to the facility. She stated the only documentation available for the agency staff was on the online portal. On 03/27/24 at 12:45 PM Administrator A stated he had very limited ability to view the online documentation provided by the contract agency	F 941			

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F 941	Continued From page 99 for the selected employees. He stated he could not open the files of training courses noted as passed to verify what material they covered. The facility's provided "Nursing Staff Competency" policy revised 12/2023 indicated the facility will ensure all staff have the appropriate competencies and skill sets to provide nursing and related services to assure resident safety and maintain the highest practicable well-being of each resident. The facility failed to ensure the completion of the required communication training for staff who provided care in the facility. This placed the residents at risk for impaired care and decreased quality of life.	F 941			
F 942 SS=F	Resident Rights Training CFR(s): 483.95(b) §483.95(b) Resident's rights and facility responsibilities. A facility must ensure that staff members are educated on the rights of the resident and the responsibilities of a facility to properly care for its residents as set forth at §483.10, respectively. This REQUIREMENT is not met as evidenced by: The facility identified a census of 80 residents. Based on record review and interviews, the facility failed to ensure all staff were educated on the rights of the residents and the facility's responsibility to provide proper care. This placed the residents at risk for impaired care and decreased quality of life. Findings Included:	F 942			

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F 942	Continued From page 100 -On 03/27/24 at 11:40 AM a review of the facility's training for Certified Nurses Aid (CNA) PP, CNA QQ, Licensed Nurse (LN) L, LN NN, and LN OO revealed the following: CNA PP's facility-provided credentialling file lacked documented and completed training completed for resident rights. The file noted she passed abuse, neglect, and exploitation (ANE) and a mental health course. CNA QQ's facility-provided credentialling file lacked documented and completed training completed for resident rights. The file noted she had ANE and mental health courses. LN L's facility-provided credentialling file lacked documented and completed training completed for resident rights. The file noted she had ANE training and mental health courses. LN NN's facility-provided credentialling file lacked documented and completed training completed for resident rights. The file noted she had ANE training and mental health courses. LN OO's facility-provided credentialling file lacked documented and completed training completed for resident rights. The file noted she had ANE training and mental health courses. On 03/27/24 at 12:45 PM Administrative Nurse D stated the selected agency that provided the staff was new to the facility. She stated the only documentation available for the agency staff was on the online portal. On 03/27/24 at 12:45 PM Administrator A stated he had very limited ability to view the online	F 942			

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F 942	Continued From page 101 documentation provided by the contract agency for the selected employees. He stated he could not open the files of training courses noted as passed to verify what material they covered. The facility's provided "Nursing Staff Competency" policy revised 12/2023 indicated the facility will ensure all staff have the appropriate competencies and skill sets to provide nursing and related services to assure resident safety and maintain the highest practicable well-being of each resident. The facility failed to ensure all staff were educated on the rights of the residents and the facility's responsibility to provide proper care. This placed the residents at risk for impaired care and decreased quality of life.	F 942			
F 947 SS=F	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff.	F 947			

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F 947	Continued From page 102 §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: The facility had a census of 80 residents. The sample included 18 residents and five Certified Nurse Aides (CNA) reviewed for required in-service training. Based on record review and interview, the facility failed to ensure one of the five CNA staff reviewed had the required 12 hours of in-service education. This placed the residents at risk for inadequate care. Findings included: - A review of the facility's in-service records revealed the following: CNA N, hired 06/07/19, had 3.50 hours of in-service education in the past 12 months. On 03/27/24 at 08:10 AM Administrative Staff A stated staff had from February through October to complete their yearly education and that the system flagged all of the staff that completed their assigned education for the year. Administrative Staff A stated CNA N's record showed their education as completed in the system and he was unsure as to why the system had reported so few hours. Administrative Staff A stated he compared CNA N's record with another CNA and found that the assigned education was not the same. Administrative Staff A further stated he contacted their compliance staff to discuss the issue and was unable to find an answer as to why CNA N's assigned education topics and hours were different. Administrative Staff A further stated he believed it may have been an issue with CNA N being an as-needed (PRN) employee.	F 947			

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F 947	Continued From page 103 Administrative Staff A stated the education completion was tracked in the system, but no one reviewed the recorded hours for CNA N and it wasn't caught. Administrative Staff A stated the facility provided in-services education in addition to the online education courses; however, he stated CNA N's sister also worked at the facility and he was unable to tell the difference between their signatures to show that CNA N had completed the 12 hours of required education for the year. The facility provided a "CNA Orientation and Annual Training" policy with a reviewed date of 02/24 documented the facility will complete a performance review of every CNA at least once every 12 months and will provide regular in-service education. The in-service training will be sufficient to ensure the continuing competence of nurse aides but must be no less than 12 hours per year. The facility failed to ensure one of the five CNA staff reviewed had the required 12 hours of in-service education. This placed the residents at risk for inadequate care.	F 947			