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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey and Complaint Investigation 186199. The 2567 was sent electronically on 06/28/24.	F 000		
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; (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	F 625		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 06/28/2024

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

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by:
The facility had a census of 35 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to provide Resident (R) 13 or his representative with written information regarding the facility bed hold policy when he was transferred to the hospital. This placed the resident at risk of not being permitted to return and resume residence in the nursing facility.

Findings included:

- R13's Electronic Medical Record (EMR) documented R13 had a diagnosis of benign prostatic hyperplasia (BPH-non-cancerous enlargement of the prostate which can lead to interference with urine flow, urinary frequency and urinary tract infections (UTI-an infection in any part of the urinary system) reaction due to having an indwelling urinary catheter (insertion of a catheter into the bladder to drain the urine into a collection bag), and sepsis (life-threatening systemic reaction that develops due to infections which cause inflammation throughout the entire body).

R13's "Quarterly Minimum Data Set" (MDS), dated 05/15/24, documented R13 had a Brief Interview of Mental Status (BIMS) score of 14, which indicated intact cognition. The MDS documented the resident required substantial to maximal staff assistance with toileting and personal hygiene.

R13's "Care Plan," revised 05/13/24, documented R13 had an indwelling urinary catheter, was at risk for a UTI, and instructed staff to be sure R13 kept his catheter tubing and drainage bag below

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his bladder so urine didn't back up into his bladder. The care plan instructed staff to let the nurse know if R13 had pain around his catheter, noticed R13's urine was dark, red, or had very little urine output when draining it, and if the urine was cloudy or if it looked like there were things floating in the urine. The care plan instructed staff if R13 had urine in his brief to assess his catheter to ensure it was not kinked, occluded (to close up or block off), or the drainage bag was too full.

The "Progress Note," dated 05/06/24 at 10:39 PM, documented R13 was admitted to the hospital.

A review of R13's clinical record lacked evidence the resident or representative was provided the bed hold policy when he was transferred to the hospital.

On 06/18/24 at 11:54 AM, observation revealed R13 sat in a wheelchair at the dining room table with clear urine in his urinary catheter tubing and the covered catheter bag was hooked underneath the seat of his wheelchair.

On 06/24/24 at 11:25 AM, Administrative Staff A verified the resident had not been provided the bed hold policy when he was transferred to the hospital on 05/06/24. Administrative Staff A stated the residents are provided the bed hold policy on admission.

The facility's "Bed-Hold Policy," revised 11/28/17, documented that a written notice, which specifies the duration of the bed-hold policy, would be provided at the time of transfer of a resident for hospitalization or therapeutic leave.

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F 625	Continued From page 3 The facility failed to provide R13 or his representative with written information regarding the facility bed hold policy when he was transferred to the hospital. This placed the resident at risk of not being permitted to return and resume residence in the nursing facility.	F 625		
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 had a census of 35 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to assess Resident (R) 10's ability to smoke safely. This placed R10 at risk for injury during smoking. Findings included: - R10's Electronic Medical Record (EMR) included diagnoses of chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), peripheral vascular disease (PVD- slow and progressive circulation disorder causing narrowing, blockage, or spasms in a blood vessel), congestive heart failure (CHF-a condition with low heart output and the body	F 689		

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becomes congested with fluid), right femur (thigh-bone) fracture with routine healing, dementia (a progressive mental disorder characterized by failing memory, confusion), major depressive disorder (major mood disorder which causes persistent feelings of sadness), and personal history of nicotine and alcohol dependence.

The "Admission Minimum Data Set" (MDS), dated 05/04/24, documented R10 had refused to answer cognition questions and staff assessed R10 as modified independence with cognitive abilities. R10 had verbal behaviors directed toward others which occurred four to six days of the observation period which significantly interfered with the resident's care and put others at significant risk of physical injury. R10 rejected evaluation or care one to three days of the observation period. R10 required substantial assistance with upper body dressing and personal hygiene and was dependent for lower body dressing and toileting, sit to lying, and chair/bed transfers. The MDS further documented R10 had no current tobacco use and received an antidepressant (class of medications used to treat mood disorders), hypnotic (medication used to induce sleep), anticoagulant (medication used to prevent blood clotting), opioid (medications used to treat pain) and antiplatelet (medication used to stop blood cells from sticking together).

The "Behavioral Symptoms Care Area Assessment" (CAA), dated 05/07/24, documented R10 had many behaviors during the observation period which included verbal outbursts, rejection of care, often yelling and cursing, and becoming agitated and upset about smoking rules. The CAA further documented R10

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was provided reminders of smoking rules and policy.

R10's "Care Plan," dated 05/10/24, documented that R10's smoking supplies were kept locked in the nurses' station. The plan directed staff to notify R10's family members when needing more cigarettes. R10 was able to smoke safely with the supervision of a staff member at smoke breaks but needed assistance to and from the smoke breaks. The care plan further documented R10 became upset at times about the smoke breaks and rules.

R10's EMR recorded a "Smoking Assessment" dated 12/09/19 from a previous admission. The EMR lacked a current admission "Smoking Assessment".

The "Progress Note" dated 04/30/24 at 02:06 AM documented R10 had been yelling out throughout the shift, leaving inappropriate, threatening, voicemails on family member's phones. R10 was angry with staff about not being able to smoke at undesignated times. Staff provided R10 with a copy of the smoking rules. The note further documented that at 07:00 PM, R10 refused to come in after one cigar and staff stayed outside with R10 for 70 minutes on the smoking patio.

On 06/20/24 at 01:33 PM, observation revealed R10 in the dining room and reported to the activity staff person that he and other residents wondered who was going to bring the smoking supplies. R10 also reported the residents were on time for the smoke break and staff was not there and available for the smoke time.

On 06/20/24 at 01:35 PM, observation revealed

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facility staff brought smoking materials for residents and assisted residents outside to smoke. The staff remains outside with residents during the smoke time.

On 06/20/24 at 01:53 PM, observation revealed R10 was assisted through the threshold of the patio door. R10 commented "What are you looking at?" though no one else was present. He then began to wheel himself through the dining room and another resident began to push his wheelchair toward his room when he remarked "We are probably breaking the rules somehow."

On 06/24/24 at 10:10 AM, Licensed Nurse (LN) G reported R10 was compliant with the smoking routine although they will push the time longer than the set limit. LN G reported staff had to remind him of the time frames, and staff were present during smoking time. LN G reported a smoking assessment was done on admission and changes in the resident's condition.

On 06/24/24 at 10:17 AM, Administrative Nurse D reported initially the nursing staff marked "no" for resident smoking and that the facility had not completed a smoking assessment for the safety of the resident.

The facility's "Smoking" policy, dated 11/28/17, documented that if a resident chooses to smoke, the facility will offer the resident the opportunity to do so in a safe environment within the guidelines. Residents who express a desire to smoke will have a Smoking Assessment completed. If the resident's smoking assessment indicates he/she is unable to smoke independently, the facility will implement a supervised smoking program.
The Smoking Assessment is completed quarterly

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F 689	Continued From page 7 and with any significant change in the resident condition. If the assessment indicates the resident is no longer able to safely smoke independently, the supervised smoking procedures will be followed. A resident has the right to state a formal complaint or request a smoking re-assessment at any time, should they feel their smoking rights have been violated. The facility failed to evaluate R10's ability to safely smoke with R10's recent admission to the facility. This placed R10 at risk for injury during smoking.	F 689		
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	F 758		

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behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;

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

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

§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 35 residents. The sample included 12 residents with five reviewed for unnecessary medications. Based on observation, interview, and record review the facility failed to obtain a stop date from the physician for the continued use of Ativan (antianxiety medication) as needed (PRN) for two residents, Resident (R)30 and R188. This placed the residents at risk for complications related to psychotropic (alters mood or thought) medications and unnecessary medications.

Findings included:

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- R30's Electronic Medical Record documented diagnoses of a generalized anxiety disorder (excessive, ongoing anxiety and worry that can interfere with daily activities), convulsions (involuntary series of contractions of a group of muscles), sleep apnea (a disorder of sleep characterized by periods without respirations), obsessive-compulsive disorder (OCD- anxiety disorder characterized by recurrent and persistent thoughts, ideas and feelings of obsessions severe to cause marked distress, consume considerable time or significantly interfere with the resident's occupational, social or interpersonal functioning), and insomnia (inability to sleep).

The "Quarterly Minimum Data Set" (MDS), dated 05/02/24, documented a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. The MDS documented R30 was independent for eating and dependent on staff for all other activities of daily living (ADLs) including mobility. The MDS documented R30 received antianxiety (a class of medications that calm and relax people) medications.

R30's "Care Plan," dated 05/16/24, stated information regarding the medications R30 received with black box warnings (BBW- highest safety-related warning that medications can be assigned by the Food and Drug Administration) was located in the medication administration record. The care plan stated R30 often became anxious which resulted in fast-talking, restlessness, wiggling around, worried about pain, and other things. R30 had PRN Ativan if needed. The plan directed staff to administer this if needed. The plan documented R30 sometimes

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would press the call light repeatedly without realizing she was it when she felt anxious. She did this at times even when a staff member or her husband was right next to her. The care plan directed staff to watch for any side effects R30 may have due to the antianxiety medications such as sedation, drowsiness, or dizziness. The plan documented that sometimes instead of alerting staff that she was feeling anxious or upset, she called her husband on her cell phone and talked to him about it. Usually, he called the facility to alert staff of R30's feelings. When R30 feels anxious about her oxygen or breathing, checking her oxygen will help reassure her and calm her down.

The "Physician Order," dated 06/10/24, directed staff to administer Ativan, 0.5 milligrams (mg) three times daily PRN for anxiety. The order documented it was to be indefinite (no specific stop date).

On 06/20/24 at 11:30 AM, observation revealed R30 in bed, awake, and Certified Medication Aide (CMA) M administered medications to her. R30 took the pills whole with water.

On 06/24/24 at 1045 AM, Administrative Nurse D verified staff should have obtained a stop date for the use of PRN Ativan.

The facility's "Psychoactive Medication" policy, dated 11/28/2017, stated PRN antianxiety, antidepressant, hypnotic, and sedative medications would be limited to 14 days unless the attending physician or prescribing practitioner believed it appropriate to extend the order. The attending physician or prescribing practitioner must document the rationale for the extended

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time period in the medical record and indicate a specific duration.

The facility failed to obtain a stop date from the physician for the use of Ativan PRN for R30, placing the resident at risk for complications related to unnecessary psychotropic medications.

- R188's Electronic Medical Record (EMR) documented R188 had a diagnosis of anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear).

R188's "Quarterly Minimum Data Assessment" (MDS), dated 03/28/24, documented R188 had a Brief Interview of Mental Status (BIMS) of 13, which indicated intact cognition. The MDS documented R188 was dependent on staff with most activities of daily living (ADLS). The MDS documented R188 had not received an antianxiety (class of medications that calm and relax people) medication during the observation period.

R188's "Care Plan," revised 04/09/24, documented R188 received medications that had black box warnings and instructed staff to watch R188 for the indicated reactions and notify the physician right away if they see any of them. The care plan instructed staff to leave R188 alone to either watch television (TV) or write when she became angry or agitated.

The "Physician Order," dated 06/14/24 at 02:34 PM, instructed staff to administer Ativan, 0.5 milligrams (mg), every four hours as needed (PRN) anxiety. The order lacked an end date for the medication.

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F 758	Continued From page 12 On 06/20/24 at 08:57 AM, observation revealed R188 rested quietly in bed with eyes open with oxygen on per nasal cannula at two liters. On 06/24/24 at 10:51 AM, Administrative Nurse D verified that R188's physician order for PRN Ativan lacked a stop date and stated it should have a 14-day stop date from when it was ordered. The facility's "Psychoactive Medications Policy, "revised 11/28/17, PRN antianxiety, antidepressant, hypnotic, and sedative time limitation 14 days order may be extended beyond 14 days if the attending physician or prescribing practitioner believes it is appropriate to extend the order. The facility failed to obtain a stop date on R188's PRN Ativan. This placed the resident at risk for unnecessary medications and related complications.	F 758		