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	175466	A. BUILDING _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEPOINT WICHITA, LLC	1315 N WEST STREET WICHITA, KS 67203

(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 KS00191939, KS00190832, and KS00190273. The 2567 was sent electronically on 12/10/24.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the	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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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 had a census of 79 residents. The sample included 20 residents, with two reviewed for dignity. Based on observation, record review, and interview, the facility failed to promote dignity for Resident (R)29, when staff referred to the resident as "a feeder" and stood to assist the resident with her meal. This placed R29 at risk for impaired dignity.

Finding included:

- The Electronic Medical Record (EMR) for R29 documented diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), major depressive disorder (major mood disorder that causes persistent feelings of sadness), delusional disorder (untrue persistent belief or perception held by a person although evidence shows it was untrue), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and hypertension (high blood pressure).

The "Quarterly Minimum Data Set" (MDS), dated 10/17/24, documented R29 had severely impaired cognition. R29 was dependent on staff

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for toileting, dressing, mobility, and transfers. R29 required assistance with eating. R29 had unclear speech and rarely made herself understood. She had highly impaired vision and adequate hearing.

R29's "Care Plan," dated 10/28/24, documented R29 had impaired cognition and thought process due to diagnoses of Alzheimer's dementia, and chronic disease. The care plan directed the staff to offer assistance with her needs.

On 12/04/24 at 11:45 AM, observation revealed R29 sat in her Broda chair (specialized wheelchair with the ability to tilt and recline). Certified Nurse Aide (CNA) O pushed the resident from her room to the dining room. CNA O stated to the surveyor seated at the resident's table in the small dining room "This is the feeder table" and told the surveyor she could sit at the "feeder table." CNA O stated the facility had "a few feeders" that sit there to eat their meals and staff assisted them to eat.

On 12/02/24 at 12:22 PM, observation revealed CNA N stood beside R29 and assisted her in eating her pureed meal for approximately eight minutes. Administrative Nurse F came into the dining room and told CNA N she needed to sit down when she assisted the resident in eating. Approximately five minutes later Administrative Nurse D came to the dining room table and counseled CNA N, in front of the residents, staff, and survey team, that she needed to sit when she assisted the residents to eat because it was a dignity issue to stand beside the resident.

On 12/02/24 at 03:10 PM, Administrative Nurse D stated the staff should not have called R29 "a feeder" as that was not dignified. Administrative

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F 550	Continued From page 3 Nurse D said she would educate the staff about not calling the residents "feeders." The facility's "Resident Rights" policy, dated 12/08/23, documented each resident had the right and would be afforded the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility without interference, coercion, discrimination, or reprisal. No staff member or contracted provider of care would hamper, compel, treat differently, or retaliate against a resident for exercising Resident Rights. Each resident would be treated with dignity, would be allowed, and encouraged to make choices and to be free from neglect and misappropriation of personal property. The facility failed to promote care for R29 in a manner to maintain and enhance dignity and respect. This placed R29 at risk for 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	F 582		

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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 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:

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The facility had a census of 79 residents. The sample included 20 residents with three residents reviewed for Center for Medicare and Medicaid Services (CMS) Beneficiary Liability notices. Based on record review and interview, the facility failed to provide the CMS Form 10055, "Advanced Beneficiary Notice" (ABN), to the resident or their representative for Resident (R) 429. This placed the residents at risk for uninformed decisions regarding skilled services.

Findings included:

- The Medicare ABN form informed the beneficiaries Medicare may not pay for future skilled therapy and did not provide an estimated cost to continue their services. The form included options for the beneficiary to "(1) receive specified services listed, and bill Medicare for an official decision on payment. I understand if Medicare does not pay, I will be responsible for payment, but can appeal to Medicare. (2) receive therapy listed, but do not bill Medicare, I am responsible for payment for payment of services. (3) I do not want the listed services."

R429's clinical record lacked evidence the facility provided CMS form 10055 when the resident's skilled services ended on 09/15/24.

On 12/02/24 at 02:35 PM, Administrative Staff B stated R429 was admitted to the facility on skilled care; when it was time for him to be discharged from skilled care, Administrative Staff B contacted the resident's representative by phone. Administrative Staff B stated that R429's representative wanted R429 to stay in the facility for a few more days due to a death in the family. Administrative Staff B said she told R429's

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F 582	Continued From page 6 representative the room price would increase but verified the room prices and provision of information was not provided on the CMA ABN 10055. On 12/04/24 at 09:40 AM, Administrative Staff A verified that R429 was not provided the ABN 10055. Upon request, the facility did not provide an ABN Policy. The facility failed to provide R429 with the ABN form CMS 10055 as required. This placed the residents at risk for uninformed decisions regarding skilled services.	F 582		
F 623 SS=D	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	F 623		

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

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

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(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information 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(k).
This REQUIREMENT is not met as evidenced by:
The facility had a census of 79 residents. The sample included 20 residents, with one reviewed for hospitalization. Based on observation, record

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review, and interview, the facility failed to notify the State Long Term Care Ombudsman (LTCO) for Resident (R) 31's facility-initiated discharge to the hospital. This placed R31 at risk for impaired rights.

Findings included:

- The Electronic Medical Record (EMR) for R31 documented diagnoses of depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), osteomyelitis (local or generalized infection of the bone and bone marrow), pain, atrial fibrillation (rapid, irregular heartbeat), and peripheral vascular disease (PVD- slow and progressive circulation disorder causing narrowing, blockage, or spasms in a blood vessel).

The "Medicare 5-Day Minimum Data Set" (MDS), dated 05/28/24, documented R31 had intact cognition and was dependent upon staff for transfers. R31 required substantial assistance with toileting, showers, dressing, and mobility, and was independent with transfers. The MDS further documented R31 received antidepressant (a class of medications used to treat mood disorders), opioid (a class of controlled drugs used to treat pain), and hypoglycemic (less than normal amount of sugar in the blood) medications. R31 was depressed for seven to 11 days and did not have any behaviors.

The "Quarterly MDS," dated 09/25/24, documented R31 had intact cognition. R31 was dependent upon staff for transfers. R31 required substantial assistance with toileting, bathing,

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dressing, and mobility. The MDS further documented R31 received antidepressant and diuretic (a medication to promote the formation and excretion of urine) medications and had no behaviors.

R31's "Care Plan" dated 07/08/24, documented R31 was at risk for medication adverse reactions related to Black Box Warning (BBW-highest safety-related warning that medications can be assigned by the Food and Drug Administration) medications and directed staff to administer medication as ordered, and document and monitor for side effects and effectiveness. The care plan directed staff to encourage R31 to express her feelings as needed, determine if problems seem to be related to external causes, and monitor for targeted behaviors. The care plan further directed staff to educate the resident and family of the risks of side effects and potential adverse effects of the medication.

The "Nurse's Notes," dated 06/25/24 at 01:12 PM, documented the nurse entered R31's room and saw R31's head lying on her meal tray. The nurse attempted to wake up R31 and she had a blank stare, mumbled words, and was limp. The note further documented the nurse informed the physician and obtained R31's blood sugar, and it was 71 milligrams per deciliters (. The family requested R31 to be seen at the hospital.

R31's EMR lacked documentation staff notified the LTCO of the resident's discharge from the facility.

On 12/03/24 at 01:48 PM, Social Service X stated she had not been employed in June when R31 was sent to the hospital. Social Service X

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F 623	Continued From page 11 supplied documentation sent to the LTCO of the residents who had been discharged for the last few months and verified R31's discharge was not sent to the LTCO. On 12/03/24 at 02:00 PM, Administrative Nurse D stated that R31's hospital discharge should have been sent to the LTCO and the person responsible for sending information to the LTCO no longer worked at the facility. The facility's "Notifying Resident of Facility-Initiated Discharge" policy, dated 07/31/24, documented the facility would notify the State Long Term Care Ombudsman of a facility-initiated transfer/discharge at the same time the resident/representative was notified by providing the LTCO of a copy of the transfer/discharge letter. The facility failed to notify the LTCO of R31's facility-initiated discharge to the hospital. This placed the resident at risk for impaired rights.	F 623		
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 79 residents. The sample included 20 residents. Based on	F 689		

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observation, record review, and interview the facility failed to ensure an environment free from accident hazards when staff left a container of toilet bowl cleaner, a container of Comet, two aerosol spray deodorants, and a container of Virex in an unlocked wooden cabinet. This placed the two cognitively impaired, independently mobile residents at risk for preventable accidents or injuries.

Findings included:

- On 12/02/24 at 11:10 AM, observation in the 200-hall quiet area located by the visitor bathroom revealed three unlocked bottom doors of a wooden cabinet that contained the following:
A one-quart container of the Works toilet bowl cleaner. Observation revealed the label read: causes skin burns and irreversible eye damage. Harmful if swallowed or absorbed through the skin. Do not get in the eyes, on skin, or on clothing. Wear goggles or safety glasses, protective clothing, and rubber (or chemical-resistant) gloves. Wash thoroughly with soap and water after handling and before eating, drinking, chewing gum, using tobacco, or using the toilet. Remove contaminated clothing and wash clothing before reuse. Do not breathe vapor or fumes. Keep out of reach of children.
A 1.31-pound (lb.) container of Comet (powdered disinfectant cleaner). Further observation revealed the label read: moderately irritating to eyes, skin, and mucous membranes. Avoid contact with eyes, skin, or clothing. Harmful if swallowed or inhaled. Avoid breathing vapor. Remove and wash contaminated clothing before reuse. Wash thoroughly with soap and water after handling and before eating, drinking, chewing gum, or using tobacco. Do not mix with products

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F 689	Continued From page 13 that contain ammonia or dangerous fumes. Two aerosol spray deodorants. Observation revealed the label read: For external use only. Keep out of reach of children. If accidentally swallowed get medical help or contact a Poison Control Center right away. Do not use it on broken skin or irritated skin. A half-full 946 milliliter (ml) container of Virex (disinfectant cleaner). Further observation revealed the label read keep out of reach of children. On 12/02/24 at 11:15 AM, Maintenance Staff (MS) V verified the above findings and stated the chemicals should be kept in a locked housekeeping cart. MS V removed the items and gave them to the housekeeper, who locked them in her cart. On 12/04/24 at 10:10 AM, Administrative Staff A stated he expected staff to store chemicals in a locked cabinet. The facility's "Chemical Storage Policy," revised 03/12/24, documented that all chemicals that are deemed hazardous to residents would be stored in a locked area or used under supervision. This is defined as any chemical that would cause harm or stated to keep away from children. The facility failed to ensure an environment free from accident hazards when staff stored harmful chemicals in an unlocked cabinet. This placed the two cognitively impaired, independently mobile residents at risk for preventable accidents or injuries.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3)	F 690		

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F 690	Continued From page 14 §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: The facility had a census of 79 residents. The sample included 20 residents in which two	F 690		

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residents were reviewed for urinary tract infections (UTI-an infection in any part of the urinary system). Based on observation, record review, and interview, the facility failed to provide services consistent with the standards of care for Resident (R) 7's urinary catheter (a tube inserted into the bladder to drain the urine into a collection bag). This placed R7 at risk for catheter-related complications and UTI.

Findings included:

- R7's Electronic Medical Record (EMR) documented diagnoses of multiple sclerosis (MS-progressive disease of the nerve fibers of the brain and spinal cord), 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), and a history of UTIs.

The "Quarterly Minimum Data Set" (MDS), dated 10/01/24, documented a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. The MDS documented R7 was dependent on staff for toilet hygiene and transfers and had a urinary catheter.

R7's "Care Plan," dated 05/21/24, stated R7 had a suprapubic catheter (urinary bladder catheter inserted through the abdomen into the bladder) related to a neurogenic bladder. The care plan directed staff to provide acetic acid (vinegar) flushes per physician orders initiated on 10/10/24. The plan directed staff to change the catheter as ordered and monitor and document for pain or discomfort due to the catheter, initiated 05/21/24. Staff were to monitor, record, and report signs and symptoms of UTI to the physician, initiated

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05/21/24. The plan directed staff to perform catheter care per facility policy every shift and provide a privacy bag for gravity bag when appropriate, initiated 05/21/24. The care plan lacked guidance to use Enhanced Barrier Precautions (EBP-infection control interventions designed to reduce transmission of resistant organisms which employ targeted gown and glove use during high contact care).

The "Physician Order" dated 05/02/24, directed staff to change the suprapubic catheter every month.

The "Physician Order" dated 07/03/24, directed staff to provide catheter care every shift and as needed.

The "Physician Order" dated 10/29/24 directed staff to continue precautions per facility protocol and await the final lab culture report. Due to symptoms, start Rocephin (an antibiotic) 1 gram (gm), intermuscular (IM) for three days; change catheter after R7 had been on antibiotics for a day, and provide catheter care per facility protocol.

The "Advanced Registered Nurse Practitioner Progress Note," dated 11/05/24, documented a history of multiple sclerosis, overactive bladder, and frequent UTIs. The note recorded that a catheter was in place with dark urine for a neurogenic bladder. The note directed to provide catheter care per facility protocol and continue precautions per facility protocol.

On 12/02/24 at 01:42 PM, observation revealed Certified Nurse Aide (CNA) Q washed her hands and applied gloves but did not don a gown. CNA

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Q emptied R7's urinary drainage bag into a urinal. CNA Q allowed the drainage port tip to touch the urine in the container. The urine output measured 2000 millimeters (ml). CNA Q removed the gloves and washed her hands, gloved them again, then unattached the drainage port and wiped it with a moist wipe. CNA Q stated they did not have alcohol wipes.

On 12/02/24 at 04:18 PM, observation revealed R7 sat in a wheelchair in the dining room with the catheter drainage bag in a privacy bag. R7's catheter tubing rested on the floor.

On 12/03/24 at 07:40 AM, observation revealed R7 sat in a wheelchair at a dining table with the catheter drainage bag under her chair in a privacy bag. Approximately five inches of the catheter tubing was touching the bare floor. At 08:13 AM, R7 self-propelled her wheelchair from the dining room to her room with approximately five to six inches of catheter tubing dragging on the floor.

On 12/03/24 at 01:10 PM, observation revealed R7 sat in a wheelchair in her room with approximately five inches of catheter tubing on the floor.

On 12/03/24 at 12:30 PM, CNA Q stated the facility had not instructed her to use personal protective equipment (PPE) for EBP when providing catheter care.

On 12/03/24 at 02:22 PM, Administrative Nurse E, Consultant GG, and Administrative Nurse D verified the facility had not initiated EBP due to a lack of understanding regarding the requirements.

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F 690	Continued From page 18 The facility's "Foley Catheter Care" policy, dated 12/07/23, stated the purpose of catheter care was to prevent possible urinary tract infections from bacteria. The policy stated the catheter and drainage bag should be kept as a closed system with the drainage bag kept at a lower level than the bladder and the drainage bag should be emptied at the end of each shift and as needed. The facility failed to provide services consistent with the standards of care for R7's urinary catheter. This placed R7 at risk for catheter-related complications and UTI.	F 690		
F 699 SS=D	Trauma Informed Care CFR(s): 483.25(m) §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is not met as evidenced by: The facility had a census of 79 residents. The sample included 20 residents, with five reviewed for behaviors. Based on observation, record review, and interview, the facility failed to complete a trauma-informed care assessment and develop a trauma-informed plan of care for Resident (R) 52 and R71, who had a diagnosis of post-traumatic stress disorder (PTSD-psychiatric disorder characterized by an acute emotional response to a traumatic event or situation involving severe environmental stress). This	F 699		

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placed the residents at risk for unmet behavioral and mental health needs.

Findings included:

- The Electronic Medical Record (EMR) for R52 documented diagnoses of PTSD, depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and obsessive-compulsive disorder (OCD- an anxiety disorder characterized by recurrent and persistent thoughts, ideas, and feelings of obsessions severe enough to cause marked distress, consume considerable time, or significantly interfere with the resident's occupational, social, or interpersonal functioning).

The "Admission Minimum Data Set" (MDS), dated 11/14/24, documented R52 had intact cognition and was dependent upon staff for toileting. R52 required set-up assistance for ambulation, eating, and bathing. R52 was independent with mobility, dressing, personal hygiene, and transfers. R52 had no behaviors and received antidepressant medication. The MDS documented the resident had depression, anxiety, and PTSD.

R52's EMR lacked evidence a trauma-informed care assessment was completed for R52.

R52's "Care Plan," dated 11/12/24, documented R52 was at risk for medication adverse reactions related to Black Box Warning (BBW-highest safety-related warning that medications can be assigned by the Food and Drug Administration) medications and directed staff to administer

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medication as ordered, and document and monitor for side effects and effectiveness. The care plan directed staff to monitor and document targeted behaviors, actions taken, and effectiveness and document in the progress notes. The care plan lacked interventions related to R52's PTSD to identify triggers and prevent re-traumatization.

The "Physician's Order," dated 11/08/24, directed staff to administer hydroxyzine (an antihistamine), 25 milligrams (mg), by mouth every 12 hours, as needed, for anxiety.

The "Physician's Order," dated 11/09/24, directs staff to administer sertraline (an antidepressant medication), 50 mg, by mouth, daily for depression.

On 12/03/24 at 12:47 PM, observation revealed R52 propelled her wheelchair from the dining room and stopped to hug a staff member before she continued down the hall to her room.

On 12/03/24 at 02:03 PM, Administrative Nurse D stated she was unaware that R52 had PTSD and did not know what assessments were required. Administrative Nurse D further stated she would make sure an assessment was completed and the triggers placed on the resident's care plan.

On 12/03/24 at 02:10 PM, Administrative Nurse E stated she did not know a trauma-informed care assessment needed to be completed for R52 and stated she would make sure R52's triggers were placed on her care plan.

On 12/03/24 at 02:25 PM, Licensed Nurse (LN) G stated she was unaware if there were any

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residents in the facility that had PTSD and stated she would like to know if there were any so she could find out what the triggers were for that resident or residents.

On 12/03/24 at 02:45 PM, Certified Nurse Aide (CNA) M stated she thought R52 had PTSD but did not know what the triggers were or if there were any other residents in the facility with PTSD.

The facility's "Trauma Informed Care" policy, dated 07/12/16, documented that, as an organization, the facility was committed to implementing trauma-informed approaches to the care provided and the organizational culture created for the residents of this facility. The policy documented incorporating a trauma-informed approach in the of the residents offers all residents a high quality of life, health, and well-being. Assessments would be completed by staff members or residents themselves to determine the history of past traumatic life events.

The facility failed to complete a trauma-informed care assessment and develop a trauma-informed plan of care for R52, who had a diagnosis of PTSD. This placed R52 at risk for unmet behavioral and mental health needs.

- The Electronic Medical Record (EMR) for R71 documented diagnoses of PTSD, depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear, auditory hallucinations (sensing things while awake that appear to be real, but the mind created), and schizophrenia (a mental disorder

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characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought).

The "Admission Minimum Data Set" (MDS), dated 10/22/24, documented that R71 had intact cognition and required partial assistance from staff for personal hygiene, mobility, and dressing. R71 required supervision with toileting, transfers, and ambulation. R71 had no behaviors, had hallucinations and delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue), and sometimes isolated herself. The assessment documented R71 received antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) and antidepressant medications daily. The MDS documented the resident had depression, anxiety, schizophrenia, and PTSD.

R71's EMR lacked evidence a trauma-informed care assessment was completed for R71 after admission.

R71's "Care Plan," dated 10/29/24, documented R71 was at risk for medication adverse reactions related to a Black Box Warning (BBW-highest safety-related warning that medications can have assigned by the Food and Drug Administration) medications and directed staff to administer medication as ordered, and document and monitor for side effects and effectiveness. The care plan directed staff to monitor and document any changes in behaviors, mood, and cognition. The care plan directed staff to consult with the pharmacy and physician to consider dosage reduction when clinically appropriate at least quarterly. The care plan lacked interventions

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related to R52's PTSD to identify triggers and prevent re-traumatization.

The "Physician's Order," dated 10/17/24, directed staff to administer Trintellix (an antidepressant), 20 milligrams mg), by mouth, daily, for depression.

The "Physician's Order," dated 11/18/24, directed staff to administer clozapine (an antipsychotic), 100 mg, by mouth, daily, and 150 mg, at bedtime, for schizophrenia.

On 12/03/24 at 08:30 AM, observation revealed R71 ambulated with the use of her walker in the hallway after breakfast.

On 12/03/24 at 02:03 PM, Administrative Nurse D stated she was unaware that R71 had PTSD and did not know what assessments were required. Administrative Nurse D further stated she would make sure an assessment was completed and the triggers placed on the resident's care plan.

On 12/03/24 at 02:10 PM, Administrative Nurse E stated she did not know a trauma-informed care assessment needed to be completed for R71 and stated she would make sure R71's triggers were placed on her care plan.

On 12/03/24 at 02:25 PM, Licensed Nurse (LN) G stated she was unaware if there were any residents in the facility that had PTSD and stated she would like to know if there were any so she could find out what the triggers were for that resident or residents.

On 12/03/24 at 02:45 PM, Certified Nurse Aide (CNA) M stated she did not know if R71 had

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F 699	Continued From page 24 PTSD. The facility's "Trauma Informed Care" policy, dated 07/12/16, documented that, as an organization, the facility was committed to implementing trauma-informed approaches to the care provided and the organizational culture created for the residents of this facility. The policy documented incorporating a trauma-informed approach in the of the residents offers all residents a high quality of life, health, and well-being. Assessments would be completed by staff members or residents themselves to determine the history of past traumatic life events. The facility failed to complete a trauma-informed care assessment and develop a trauma-informed plan of care for R71, who had a diagnosis of PTSD. This placed R71 at risk for unmet behavioral and mental health needs.	F 699		
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.	F 756		

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(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.
(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.

§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 79 residents. The sample included 20 residents, with eight reviewed for unnecessary medications. Based on observation, record review, and interview, the facility failed to ensure the Consultant Pharmacist (CP) identified and reported the lack of the required stop date for Resident (R) 31, R37, R52 and R68s' as-needed (PRN) antianxiety (a class of medications that calm and relax people with excessive anxiety, nervousness, or tension) medication. The facility failed to acknowledge and follow up on the CP's request for a diagnosis for R17's Effexor (an antidepressant medication) and Haldol (an antipsychotic medication). This placed the residents at risk for inappropriate or

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unnecessary use of medications and related side effects.

Findings included:

- The Electronic Medical Record (EMR) for R31 documented diagnoses of depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), osteomyelitis (local or generalized infection of the bone and bone marrow), pain, atrial fibrillation (rapid, irregular heartbeat), and peripheral vascular disease (PVD- slow and progressive circulation disorder causing narrowing, blockage, or spasms in a blood vessel).

The "Medicare 5-Day Minimum Data Set" (MDS), documented R31 had intact cognition and was dependent upon staff for transfers. R31 required substantial assistance with toileting, showers, dressing, and mobility, and was independent with transfers. The MDS further documented R31 received antidepressant (a class of medications used to treat mood disorders), opioid (a class of controlled drugs used to treat pain), and hypoglycemic (less than normal amount of sugar in the blood) medications. R31 was depressed for seven to 11 days and did not have any behaviors.

The "Quarterly MDS," dated 09/25/24, documented R31 had intact cognition. R31 was dependent upon staff for transfers. R31 required substantial assistance with toileting, bathing, dressing, and mobility. The MDS further documented R31 received antidepressant and diuretic (a medication to promote the formation and excretion of urine) medications and had no

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behaviors.

R31's "Care Plan" dated 07/08/24, documented R31 was at risk for medication adverse reactions related to Black Box Warning (BBW-highest safety-related warning that medications can be assigned by the Food and Drug Administration) medications and directed staff to administer medication as ordered, and document and monitor for side effects and effectiveness. The care plan directed staff to encourage R31 to express her feelings as needed, determine if problems seem to be related to external causes, and monitor for targeted behaviors. The care plan further directed staff to educate the resident and family of the risks of side effects and potential adverse effects of the medication.

The "Physician's Order," dated 06/28/24, directed staff to administer Ativan (an antianxiety medication), 0.5 milligrams (mg), 1 tablet, every four hours, PRN, for anxiety. The order lacked a stop date.

The CP's "Medication Regimen Review," dated August, September, October, and November 2024, documented the CP had no recommendations related to R31's PRN Ativan.

On 12/03/24 at 08:30 AM, observation revealed R31 propelled her wheelchair down the hall to her room.

On 12/03/24 at 03:00 PM, Administrative Nurse D stated the Consultant Pharmacist had not reported that the Ativan did not have a stop date.

The facility's "Medication Administration" policy, dated 03/13/24, documented the Consultant

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Pharmacist would review each resident's medication regimen monthly. The Consultant Pharmacist would document in each resident's clinical record the findings, conclusions, and recommendations that result from monitoring the medication regimen. The Consultant Pharmacist would communicate to the physician prescriber, if different from the primary physician, and those involved in the resident's care any findings, conclusions, and recommendations that result from monitoring the medication regimen.

The facility failed to ensure the CP identified and reported that R31's PRN Ativan lacked a stop date. This placed the resident at risk for inappropriate or unnecessary use of medications and related side effects.

- The Electronic Medical Record (EMR) for R37 documented diagnoses of anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), hypertension (high blood pressure), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and atrial fibrillation (rapid, irregular heartbeat).

The "Medicare 5-Day Minimum Data Set" (MDS), documented R37 had severely impaired cognition and was dependent upon staff for showers and transfers. R37 required substantial assistance from staff for eating, toileting, dressing, and mobility. R31 had no behaviors and did not receive any medications.

The "Quarterly MDS," dated 09/16/21, documented R37 had severely impaired cognition, and was dependent upon staff for

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toileting, personal hygiene, dressing, and transfers. R37 required substantial assistance from staff with oral hygiene and partial assistance with mobility. The MDS documented R37 had verbal behaviors for one to three days, rejection of care for one to three days, other behaviors for one to three days, and did not receive any medications.

R37's "Care Plan," dated 06/24/24, documented R37 was at risk for medication adverse reactions related to Black Box Warning (BBW-highest safety-related warning that medications can have assigned by the Food and Drug Administration) medications and directed staff to administer medication as ordered, and document and monitor for side effects and effectiveness. The care plan further directed staff to educate the resident and family of the risks of side effects and potential adverse effects of the medication, encourage her to express her feelings, and monitor for sedation.

The "Physician's Order," dated 06/18/24, directed staff to administer Ativan (an antianxiety medication), 0.5 milligrams (mg), 1 tablet, every four hours, PRN, for restlessness. The order lacked a stop date.

The "Medication Regimen Review," dated July, August, September, October, and November 2024, documented the CP had no recommendations related to the PRN Ativan.

On 12/03/24 at 08:45 AM, observation revealed R37 was in bed. She hollered for help> She had removed her oxygen tubing and held it in her hands.

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On 12/03/24 at 02:25 PM, Licensed Nurse (LN) G stated R37 was cognitively impaired and would often call her roommate names and holler out. LN G said R37 received antianxiety medication as needed.

On 12/03/24 at 03:00 PM, Administrative Nurse D stated the Consultant Pharmacist had not reported that R37's Ativan did not have a stop date.

The facility's "Medication Administration" policy, dated 03/13/24, documented the Consultant Pharmacist would review each resident's medication regimen monthly. The Consultant Pharmacist would document in each resident's clinical record the findings, conclusions, and recommendations that result from monitoring the medication regimen. The Consultant Pharmacist would communicate to the physician prescriber, if different from the primary physician, and those involved in the resident's care any findings, conclusions, and recommendations that result from monitoring the medication regimen.

The facility failed to ensure the CP identified and reported that R37's PRN Ativan lacked a stop date. This placed the resident at risk for inappropriate or unnecessary use of medications and related side effects.

- The Electronic Medical Record (EMR) for R52 documented diagnoses of depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), posttraumatic stress disorder (PTSD- a mental disorder characterized by an acute emotional response to a traumatic event or situation involving severe

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environmental stress), hypertension (high blood pressure), and obsessive-compulsive disorder (OCD- an anxiety disorder characterized by recurrent and persistent thoughts, ideas, and feelings of obsessions severe enough to cause marked distress, consume considerable time, or significantly interfere with the resident's occupational, social, or interpersonal functioning).

The "Admission Minimum Data Set" (MDS), dated 11/14/24, documented R52 had intact cognition and was dependent upon staff for toileting. R52 required set-up assistance for ambulation, eating, and bathing. R52 was independent with mobility, dressing, personal hygiene, and transfers. R52 had no behaviors and received antidepressant medication.

R52's "Care Plan," dated 11/12/24, documented R52 was at risk for medication adverse reactions related to Black Box Warning (BBW-highest safety-related warning that medications can be assigned by the Food and Drug Administration) medications and directed staff to administer medication as ordered, and document and monitor for side effects and effectiveness. The care plan directed staff to monitor and document targeted behaviors, actions taken, and effectiveness and document in the progress notes.

The "Physician's Order," dated 11/08/24, directed staff to administer hydroxyzine (an antihistamine), 25 milligrams (mg), by mouth every 12 hours, as needed, for anxiety. The order lacked a stop date.

The CP's "Medication Regimen Review," dated November 2024 documented the CP had no recommendations related to R52's PRN

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hydroxyzine use.

On 12/03/24 at 12:47 PM, observation revealed R52 propelled her wheelchair from the dining room and stopped to hug a staff member before she continued down the hall to her room.

On 12/03/24 at 02:25 PM, Licensed Nurse (LN) G stated that R52 did not have any behaviors that she was aware of. LN G said R52 took the hydroxyzine if she had anxiety.

On 12/04/24 at 10:00 AM Consultant GG stated he was unable to find a physician rationale for the as-needed hydroxyzine and stated they would have the physician provide the additional information.

On 12/03/24 at 03:00 PM, Administrative Nurse D stated the Consultant Pharmacist had not reported the as-needed hydroxyzine and did not have a rationale or stop date.

The facility's "Medication Administration" policy, dated 03/13/24, documented the Consultant Pharmacist would review each resident's medication regimen monthly. The Consultant Pharmacist would document in each resident's clinical record the findings, conclusions, and recommendations that result from monitoring the medication regimen. The Consultant Pharmacist would communicate to the physician prescriber, if different from the primary physician, and those involved in the resident's care any findings, conclusions, and recommendations that result from monitoring the medication regimen.

The facility failed to ensure the CP identified and reported that R52 lacked a physician rationale for

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the use of PRN hydroxyzine for R52's anxiety with no stop date. This placed the resident at risk for inappropriate or unnecessary use of medications and related side effects.
- R68's Electronic Medical Record (EMR) documented R68 had a diagnosis of anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear).

R68's "Admission Minimum Data Set"(MDS) dated 10/29/24 documented that R68 had a Brief Interview of Mental Status (BIMS) score of seven which indicated severely impaired cognition. The MDS documented that R68 received an antianxiety (a class of medications that calm and relax people) medication during the observation period.

R68's "Care Plan," revised 10/24/24, instructed staff to administer medication as ordered. Staff were to monitor and document the side effects and effectiveness of the medications and monitor for symptoms of anxiety including excessive worry, angry outbursts, concerns that become overly distressful, the inability to rest or relax, perseveration of ideas, or repetitive statements.

R68's "Physician Order," dated 10/23/24 at 09:30 PM instructed staff to administer Ativan (antianxiety medication), 1 milligram (mg) every six hours as needed (PRN) for anxiety with an indefinite end date.

The "Consultant Pharmacist (CP) Regimen Review" on 11/20/24 lacked evidence the pharmacist identified R68's PRN Ativan order did not have the required stop date.

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On 12/02/24 at 12:02 PM, observation revealed R68 sat quietly in a wheelchair in front of the activity room.

On 12/03/24 at 03:50 PM, Administrative Nurse D verified the CP had not alerted the facility of the lack of a stop date for R68's PRN Ativan.

The facility's "Medication Administration Policy," revised 03/12/24, documented the CP would review each resident's medication regimen monthly and documented in each resident's clinical record the findings, conclusions, and recommendations that resulted from monitoring the medication regimen. The CP would communicate to the physician and those involved in the resident's care the findings, conclusions, and recommendations from monitoring the medication regimen.

The facility failed to ensure the CP identified and reported to the facility that R68's PRN Ativan lacked the required stop date. This placed the resident at risk for unnecessary medication side effects.

- R17's Electronic Medical Record (EMR) documented diagnoses of general muscle weakness, anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear) disorder, asthma (a disorder of narrowed airways that causes wheezing and shortness of breath), major depressive disorder (major mood disorder that causes persistent feelings of sadness), hypertension (HTN-elevated blood pressure), insomnia (inability to sleep), schizoaffective disorder (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought), diabetes mellitus

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(DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), and acute kidney failure.

The "Quarterly Minimum Data Set" (MDS), dated 09/03/24, documented R17 had moderately impaired cognition, disorganized thinking, and inattention which occurred continually. The MDS documented that R17 required supervision to partial/moderate assistance with self-care and mobility. The MDS further documented R17 received an antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality), antianxiety (a class of medications that calm and relax people), and antidepressant (a class of medications used to treat mood disorders).

R17's "Care Plan" dated 05/22/24, documented R17 had a mood disorder related to anxiety, depression, and hallucinations (sensing things while awake that appear to be real, but the mind created). The plan directed staff to administer medications as ordered and monitor and document side effects and effectiveness. The plan further documented R17 used the antipsychotic medication, Haldol, for hallucinations. R17's "Care Plan" dated 06/10/24, directed staff to monitor for any depressive, anxiety, or psychosis symptoms.

The "Physician Orders" dated 04/19/24 directed staff to administer haloperidol 1 milligram (mg) at bedtime for antipsychotics and venlafaxine extended release (Effexor) 150 mg every day for an antidepressant.

The "Consultant Pharmacist Review" dated 04/24/24, 05/21/24, and 10/20/24 requested an

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F 756	Continued From page 36 update of diagnosis for the use of haloperidol and venlafaxine. R17's medical record lacked the physician's response to the Consultant Pharmacist's recommendation to address the lack of diagnoses for the use of haloperidol and venlafaxine. On 12/02/24 at 04:15 PM, observation revealed R17 in the dining room participating in a board game with another resident and staff member. On 12/04/24 at 07:50 AM, Administrative Nurse D and Consultant GG verified the physician had not written a proper diagnosis for haloperidol and venlafaxine or rationale for continued use of the psychotropic drug use. The facility's "Medication Administration" policy, dated 03/13/2024, stated the consultant pharmacist would review each resident's medication regimen monthly and communicate recommendations to the physician or prescriber. The facility failed to acknowledge and respond to the CP's recommendation to add an indication of use for R17's haloperidol and venlafaxine. This placed R17 at risk of inappropriate use of psychotropic medication and related side effects.	F 756		
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following	F 758		

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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 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

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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 79 residents. The sample included 20 residents, with eight reviewed for unnecessary medications. Based on observation, record review, and interview, the facility failed to ensure a 14-day stop date or specified duration for Resident (R) 31, R37, R52, R68 and R391's ongoing as-needed (PRN) antianxiety (a class of medications that calm and relax people with excessive anxiety, nervousness, or tension) medication and failed to get an appropriate diagnosis for R17's Effexor (an antidepressant medication) and Haldol (an antipsychotic medication). This placed the residents at risk for unnecessary medications and related complications.

Findings included:

- The Electronic Medical Record (EMR), for R31 documented diagnoses of depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), osteomyelitis (local or generalized infection of the bone and bone marrow), pain, atrial fibrillation (rapid, irregular heartbeat), and peripheral vascular disease (PVD- slow and progressive circulation disorder causing narrowing, blockage, or spasms in a blood vessel).

The "Medicare 5-Day Minimum Data Set" (MDS), dated 05/28/24, documented R31 had intact cognition and was dependent upon staff for

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transfers. R31 required substantial assistance with toileting, showers, dressing, and mobility, and was independent with transfers. The MDS further documented R31 received antidepressant (a class of medications used to treat mood disorders), opioid (a class of controlled drugs used to treat pain), and hypoglycemic (less than normal amount of sugar in the blood) medications. R31 was depressed for seven to 11 days and did not have any behaviors.

The "Quarterly MDS," dated 09/25/24, documented R31 had intact cognition. R31 was dependent upon staff for transfers. R31 required substantial assistance with toileting, bathing, dressing, and mobility. The MDS further documented R31 received antidepressant and diuretic (a medication to promote the formation and excretion of urine) medications and had no behaviors.

R31's "Care Plan" dated 07/08/24, documented R31 was at risk for medication adverse reactions related to Black Box Warning (BBW-highest safety-related warning that medications can be assigned by the Food and Drug Administration) medications and directed staff to administer medication as ordered, and document and monitor for side effects and effectiveness. The care plan directed staff to encourage R31 to express her feelings as needed, determine if problems seem to be related to external causes, and monitor for targeted behaviors. The care plan further directed staff to educate the resident and family of the risks of side effects and potential adverse effects of the medication.

The "Physician's Order," dated 06/28/24, directed staff to administer Ativan (an antianxiety

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medication), 0.5 milligrams (mg), 1 tablet, every four hours, PRN, for anxiety. The order lacked a stop date.

On 12/03/24 at 08:30 AM, observation revealed R31 propelled her wheelchair down the hall to her room.

On 12/03/24 at 02:25 PM, Licensed Nurse (LN) G stated R31 did not have any behaviors, was on hospice, and may need Ativan for her anxiety.

On 12/03/24 at 02:45 PM, Certified Nurse Aide (CNA) M stated R31 had no behaviors and was very nice.

On 12/03/24 at 03:00 PM, Administrative Nurse D stated she was unaware R31's Ativan did not have a 14-day stop date and said she would make sure that she contacted the physician to obtain an order for a stop date or rationale for continued use.

The facility's "Psychotropic Medication" policy, dated 07/3124, documented the attending physician must certify that a psychotropic medication was necessary to treat a specific condition or behavior. Any resident admitted with a PRN psychoactive medication would have a 14-day stop date.

The facility failed to ensure R31's Ativan had a 14-day stop date or specified duration with physician rationale for extended use. This placed the resident at risk for adverse medication side effects.

- The Electronic Medical Record (EMR) for R37

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documented diagnoses of anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), hypertension (high blood pressure), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and atrial fibrillation (rapid, irregular heartbeat).

The "Medicare 5-Day Minimum Data Set" (MDS), documented R37 had severely impaired cognition and was dependent upon staff for showers and transfers. R37 required substantial assistance from staff for eating, toileting, dressing, and mobility. R31 had no behaviors and did not receive any medications.

The "Quarterly MDS," dated 09/16/21, documented R37 had severely impaired cognition, and was dependent upon staff for toileting, personal hygiene, dressing, and transfers. R37 required substantial assistance from staff with oral hygiene and partial assistance with mobility. The MDS documented R37 had verbal behaviors for one to three days, rejection of care for one to three days, other behaviors for one to three days, and did not receive any medications.

R37's "Care Plan," dated 06/24/24, documented R37 was at risk for medication adverse reactions related to Black Box Warning (BBW-highest safety-related warning that medications can have assigned by the Food and Drug Administration) medications and directed staff to administer medication as ordered, and document and monitor for side effects and effectiveness. The care plan further directed staff to educate the resident and family of the risks of side effects and potential adverse effects of the medication,

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encourage her to express her feelings, and monitor for sedation.

The "Physician's Order," dated 06/18/24, directed staff to administer Ativan (an antianxiety medication), 0.5 milligrams (mg), 1 tablet, every four hours, PRN, for restlessness. The order lacked a stop date.

On 12/03/24 at 08:45 AM, observation revealed R37 was in bed. She hollered for help. She had removed her oxygen tubing and held it in her hands.

On 12/03/24 at 08:5 AM, Certified Medication Aide (CMA) R stated R37 had a lot of behaviors, was combative with staff, and often yelled at her roommate for no reason. CMA R further stated that when R37 had behaviors she would notify the nurse.

On 12/03/24 at 02:25 PM, Licensed Nurse (LN) G stated R37 was cognitively impaired and would often call her roommate names and holler out. LN G said R37 received antianxiety medication as needed.

On 12/03/24 at 03:00 PM, Administrative Nurse D stated she was unaware R37's Ativan did not have a 14-day stop date and said she would make sure that she contacted the physician to obtain an order for a stop date or rationale for continued use. Administrative Nurse D further stated that R37's roommate's family had requested a room move due to R37's behavior.

The facility's "Psychotropic Medication" policy, dated 07/3124, documented the attending physician must certify that a psychotropic

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medication was necessary to treat a specific condition or behavior. Any resident admitted with a PRN psychoactive medication would have a 14-day stop date.

The facility failed to ensure R37's Ativan had a 14-day stop date or specified duration with a physician rationale for extended use. This placed the resident at risk for adverse medication side effects.

- The Electronic Medical Record (EMR) for R52 documented diagnoses of depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), posttraumatic stress disorder (PTSD- a mental disorder characterized by an acute emotional response to a traumatic event or situation involving severe environmental stress), hypertension (high blood pressure), and obsessive-compulsive disorder (OCD- an anxiety disorder characterized by recurrent and persistent thoughts, ideas, and feelings of obsessions severe enough to cause marked distress, consume considerable time, or significantly interfere with the resident's occupational, social, or interpersonal functioning).

The "Admission Minimum Data Set" (MDS), dated 11/14/24, documented R52 had intact cognition and was dependent upon staff for toileting. R52 required set-up assistance for ambulation, eating, and bathing. R52 was independent with mobility, dressing, personal hygiene, and transfers. R52 had no behaviors and received antidepressant medication.

R52's "Care Plan," dated 11/12/24, documented R52 was at risk for medication adverse reactions

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related to Black Box Warning (BBW-highest safety-related warning that medications can be assigned by the Food and Drug Administration) medications and directed staff to administer medication as ordered, and document and monitor for side effects and effectiveness. The care plan directed staff to monitor and document targeted behaviors, actions taken, and effectiveness and document in the progress notes.

The "Physician's Order," dated 11/08/24, directed staff to administer hydroxyzine (an antihistamine), 25 milligrams (mg), by mouth every 12 hours, as needed, for anxiety. The order lacked a stop date.

On 12/03/24 at 12:47 PM, observation revealed R52 propelled her wheelchair from the dining room and stopped to hug a staff member before she continued down the hall to her room.

On 12/03/24 at 02:25 PM, Licensed Nurse (LN) G stated that R52 did not have any behaviors that she was aware of. LN g said R52 took the hydroxyzine if she had anxiety.

On 12/03/24 at 02:45 PM, Certified Nurse Aide (CNA) M stated R52 had no behaviors.

On 12/04/24 at 10:00 AM Consultant GG stated he was unable to find a physician rationale for the as-needed hydroxyzine and stated they would have the physician provide the additional information.

On 12/03/24 at 03:00 PM, Administrative Nurse D stated she would ensure the required information for the hydroxyzine would be obtained from the physician along with a rationale for the use of the

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antihistamine for R52's anxiety.

The facility's Psychotropic Medication Use" policy, dated 02/22/24, documented that Psycho-pharmacologic medications are drugs that affect brain activities associated with mental processes and behaviors, Psychotropic medications are divided into four broad categories: anti-psychotic, anti-depressant, anti-anxiety, antihistamine, anti-convulsant, mood-altering drugs, and hypnotic drugs. Licensed nurses would be aware of the potential side effects of psychotropic medications and report any side effects to the resident's attending physician. The physician would have a documented clinical rationale for the medication.

The facility failed to ensure a stop date for the PRN hydroxyzine used for its psychotropic qualities. This placed the resident at risk for unnecessary medications and related complications.
- R68's Electronic Medical Record (EMR) documented R68 had a diagnosis of anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear).

R68's "Admission Minimum Data Set"(MDS) dated 10/29/24 documented that R68 had a Brief Interview of Mental Status (BIMS) score of seven which indicated severely impaired cognition. The MDS documented that R68 received an antianxiety (a class of medications that calm and relax people) medication during the observation period.

R68's "Care Plan," revised 10/24/24, instructed staff to administer medication as ordered. Staff

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were to monitor and document the side effects and effectiveness of the medications and monitor for symptoms of anxiety including excessive worry, angry outbursts, concerns that become overly distressful, the inability to rest or relax, perseveration of ideas, or repetitive statements.

R68's "Physician Order," dated 10/23/24 at 09:30 PM instructed staff to administer Ativan (antianxiety medication), 1 milligram (mg) every six hours as needed (PRN) for anxiety with an indefinite end date.

On 12/02/24 at 12:02 PM, observation revealed R68 sat quietly in a wheelchair in front of the activity room.

On 12/03/24 at 03:50 PM, Administrative Nurse D verified that R68's PRN Ativan had a stop date of indefinite and she was unaware it required a specified stop date.

The facility's "Psychotropic Medication Use" policy, dated 07/31/2024, stated the use of non-pharmacological interventions for psychiatric disorders and problem behaviors related to dementia would be attempted prior to and during the administration of antipsychotic medications. The physician's order for a psychotropic drug would include both a qualifying diagnosis for the drug and a list of specific target behaviors that the staff would monitor during the drug administration. The attending physician must certify that a psychotropic medication was necessary to treat a specific condition or behavior. The drug dosage must be periodically reduced with the goal of discontinuing it or replacing it with another less potent prescription.

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The facility failed to ensure R68's PRN Ativan had the required stop date. This placed the resident at risk for unnecessary medication side effects.
- R391's Electronic Health Record (EHR) revealed diagnoses of dementia (a progressive mental disorder characterized by failing memory, confusion), Down's syndrome (chromosomal abnormality characterized by varying degrees of mental retardation and multiple defects), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear).

R391's "Admission Minimum Data Set" (MDS), dated 11/22/24, recorded R391 had severely impaired cognition. The MDS recorded she required extensive assistance from two staff with bed mobility and transfers. The MDS lacked documentation that R391 received an antianxiety medication during the observation period.

R391's "Care Plan," dated 12/02/24, recorded that R391 required extensive assistance with most activities of daily living (ADL) care. R391's "Care Plan" documented the resident received lorazepam (antianxiety medication) for anxiety.

R391's "Physician's Order," dated 11/16/24, directed the staff to administer lorazepam 0.5 milligrams (mg) via gastrostomy tube (G-tube: tube surgically placed through an artificial opening into the stomach) every four hours as needed (PRN) for anxiety. The order lacked a stop date.

R391's EMR lacked evidence of a specified duration which included a physician's rationale for the extended use of the PRN lorazepam.

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On 12/03/24 at 08:55 AM, observation revealed R391 lying in bed with the head of the bed elevated 30 degrees. Licensed Nurse (LN) I loosened the resident's abdominal binder and administered the resident's medication via the G-tube.

On 12/03/24 at 03:00 PM, Administrative Nurse D verified R391 received lorazepam PRN, with a physician order date of 11/16/24. Administrative Nurse D verified the facility did not obtain the 14-day stop date or a reason for the continued use with a rationale and a specified duration.

The "Psychotropic Medication Use" policy dated 5/31/2024, recorded the resident's need for the psychotropic medication would be monitored, as well as when the resident has received optional benefits from the medication and when the medication dose can be lowered or discontinued. Both the physician and the nursing staff would evaluate the effectiveness of PRN or as-needed orders for psychotropic drugs to manage behaviors. Any resident admitted to the facility with an order for psychotropic medication would be accompanied by a taper order for a specific date within the first four months of admission. Any resident with a PRN psychotropic medication would have a 14-day stop date. Prior to the end of the 14-day period, the ordering practitioner would assess the resident's response to the PRN medication and would document a thoughtful risk-benefit rationale statement for continued use of the medication. If the assessment indicates continued use of the medication, a specific duration would be included in the re-order of the medication. The physician's order for the medication would include both a qualifying diagnosis for the drug and a list of targeted

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behaviors that the staff would monitor during the drug administration.

The facility failed to obtain a stop date for R391's use of PRN lorazepam. This placed R391 at risk for adverse side effects from the continued use of psychotropic medications.
- R17's Electronic Medical Record (EMR) documented diagnoses of general muscle weakness, anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear) disorder, asthma (a disorder of narrowed airways that causes wheezing and shortness of breath), major depressive disorder (major mood disorder that causes persistent feelings of sadness), hypertension (HTN-elevated blood pressure), insomnia (inability to sleep), schizoaffective disorder (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), and acute kidney failure.

The "Quarterly Minimum Data Set" (MDS), dated 09/03/24, documented R17 had moderately impaired cognition, disorganized thinking, and inattention which occurred continually. The MDS documented that R17 required supervision to partial/moderate assistance with self-care and mobility. The MDS further documented R17 received an antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality), antianxiety (a class of medications that calm and relax people), and antidepressant (a class of medications used to treat mood disorders).

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R17's "Care Plan" dated 05/22/24, documented R17 had a mood disorder related to anxiety, depression, and hallucinations (sensing things while awake that appear to be real, but the mind created). The plan directed staff to administer medications as ordered and monitor and document side effects and effectiveness. The plan further documented R17 used the antipsychotic medication, Haldol, for hallucinations. R17's "Care Plan" dated 06/10/24, directed staff to monitor for any depressive, anxiety, or psychosis symptoms.

The "Physician Orders" dated 04/19/24 directed staff to administer haloperidol 1 milligram (mg) at bedtime for "antipsychotics" and venlafaxine (Effexor) extended-release 150 mg every day for "antidepressant."

R17's medical record lacked physician documentation of diagnoses for the use of haloperidol and venlafaxine.

On 12/02/24 at 04:15 PM, observation revealed R17 in the dining room participating in a board game with another resident and staff member.

On 12/04/24 at 07:50 AM, Administrative Nurse D and Consultant GG verified the physician had not written an actual diagnosis for haloperidol and venlafaxine or a rationale for continued use of the psychotropic drugs.

The facility's "Psychotropic Medication Use" policy, dated 07/31/2024, stated the use of non-pharmacological interventions for psychiatric disorders and problem behaviors related to dementia would be attempted before and during the administration of antipsychotic medications.

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F 758	Continued From page 51 The physician's order for a psychotropic drug would include both a qualifying diagnosis for the drug and a list of specific target behaviors that the staff would monitor during the drug administration. The attending physician must certify that a psychotropic medication was necessary to treat a specific condition or behavior. The drug dosage must be periodically reduced with the goal of discontinuing it or replacing it with another less potent prescription. The facility failed to ensure an appropriate indication and the required physician documentation for the continued use of R7's haloperidol and venlafaxine, placing the resident at risk for unnecessary adverse side effects.	F 758		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of	F 761		

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the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 79 residents. The sample included 20 residents. Based on observation, record review, and interview, the facility failed to store and label biologicals as required when staff failed to identify and discard six expired vials of Prevnar (a vaccine that protects against 20 different strains of the Streptococcus pneumoniae bacteria) in one of three medication rooms. The facility further failed to place an open date on insulin (a hormone that lowers the level of glucose in the blood) pens in one of three treatment carts. This placed the affected residents at risk of receiving an expired and ineffective dose of Prevnar and insulin.

Findings included:

- On 12/02/24 at 08:20 AM, observation in the 100-hall medication room revealed six vials of Prevnar 0.5 milliliter syringes with an expiration date of August 2024.

On 12/02/24 at 08:20 AM, Licensed Nurse (LN) K verified the expired Prevnar and stated expired medications were to be placed into a bin on 900 Hall and were to be destroyed with the pharmacy.

On 12/02/24 at 09:23 AM, Administrative Nurse D verified expired medications should be disposed of appropriately.

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The facility's "Medication Storage and Labeling" policy, dated 05/03/24, stated medication containers having soiled, damaged, incomplete, or illegible labels would be returned to the issuing pharmacy for relabeling or destroyed by facility policy.

The facility failed to dispose of six expired Prevnar syringes. This placed the residents at risk of receiving an ineffective dose of the medication.
- On 12/02/24 at 08:15 AM, observation revealed in the 300-400 treatment cart Resident (R)17's Basaglar (long-acting) insulin pen, R26 and R36s' Lantus Solostar (long-acting insulin), and R46's insulin glargine (long-acting) insulin pens lacked an open date and a discard date.

On 12/02/24 at 08:15 AM, Licensed Nurse (LN) J verified the above findings and stated staff should place an open date on insulin pens when they open a new one.

On 12/04/24 at 10:20 AM, Administrative Nurse D stated she expected staff to place an open date on an insulin pen when they open a new one.

The facility's "Medication Storage and Labeling" policy, dated 05/03/24, stated medication containers having soiled, damaged, incomplete, or illegible labels would be returned to the issuing pharmacy for relabeling or destroyed in accordance with facility policy.

The facility failed to place an open date on R17, R26, R36, and R46s' insulin pens. This placed the residents at risk of receiving ineffective doses of insulin.

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LAKEPOINT WICHITA, LLC	1315 N WEST STREET WICHITA, KS 67203

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F 849 SS=D	Hospice Services CFR(s): 483.70(n)(1)-(4) §483.70(n) Hospice services. §483.70(n)(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(n)(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	F 849		

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communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day.
(E) A provision that the LTC facility immediately notifies the hospice about the following:
(1) A significant change in the resident's physical, mental, social, or emotional status.
(2) Clinical complications that suggest a need to alter the plan of care.
(3) A need to transfer the resident from the facility for any condition.
(4) The resident's death.
(F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided.
(G) An agreement that it is the LTC facility's 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

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of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility.
(J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation.
(K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.

§483.70(n)(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

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and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family.
(iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians.
(iv) Obtaining the following information from the hospice:
(A) The most recent hospice plan of care specific to each patient.
(B) Hospice election form.
(C) Physician certification and recertification of the terminal illness specific to each patient.
(D) Names and contact information for hospice personnel involved in hospice care of each 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(n)(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

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practicable physical, mental, and psychosocial well-being, as required at §483.24.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 79 residents. The sample included 20 residents with two reviewed for hospice (a type of health care that focuses on the terminally ill patient's pain and symptoms and attending to their emotional and spiritual needs at the end of life) services. Based on observation, record review, and interview, the facility failed to ensure coordinated care and services provided by the facility with the care and services provided by hospice for Resident (R) 39 and R31. This placed the residents at risk for inadequate end-of-life care.

Findings included:

- R39's Electronic Health Record (EHR) revealed diagnoses of severe protein-calorie malnutrition (does not eat enough protein and calories to meet nutritional needs), acute kidney failure (the kidneys lose the ability to remove waste and balance fluids,) and dysphagia (swallowing difficulty).

R39's "Quarterly Minimum Data Set" (MDS), dated 11/07/24, recorded R39 had a Brief Interview for Mental Status score of three which indicated severe cognitive impairment. The MDS recorded he required extensive assistance from two staff with bed mobility, transfers, and activities of daily living (ADLs). The MDS documented the resident received hospice services.

R39's "Care Plan," dated 11/20/24, recorded R39 required extensive assistance with most ADL

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care. R39's "Care Plan" documented the resident was admitted to [hospice services] on 08/09/24. The care plan directed the staff to administer the medications ordered and notify the physician if there is breakthrough pain. The care plan lacked instruction on the services provided by hospice including the frequency and type of support visits, supplies and medical equipment provided by hospice, medications covered by hospice, and the hospice contact information.

A review of R39's clinical record revealed the resident was admitted to hospice care on 08/09/24. The facility had a plan of care provided by the hospice in a communication book.

On 12/03/24 at 10:30 AM, R39 was dressed and sat in a Broda (specialized wheelchair with the ability to tilt and recline) chair in his room.

On 12/03/24 at 01:50 PM, Administrative Nurse D and Nurse Consultant GG verified the facility lacked specific information on the facility care plan that coordinated with the hospice care plan.

The "End of Life Palliative Care and Hospice Care" policy, dated 12/07/2023, documented bereavement counseling provided by hospice providers would be supervised by the hospice social worker or Chaplin for provision of "pre-death" assessment and counseling for residents and family members with bereavement staff providing support following death in collaboration with facility social service, chaplain, and nursing staff. A comprehensive and timely interdisciplinary assessment of the resident and family forms the basis of end-of-life care (palliative). The interdisciplinary team completes an initial comprehensive assessment and

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subsequent re-evaluation through the resident and family interviews, review of medical and other available records, discussion with other providers, physical examinations and assessment, along with relevant laboratory and/or diagnostic tests or procedures. The comprehensive assessment reoccurs on a regular basis and at least quarterly and with any significant change in the resident's status or change in the resident and/or family's goals. The care plan is based on the identified and expressed preferences, values, goals, and needs of the resident and family and is developed with professional guidance and support for resident-family decision-making. The care plan is based on an ongoing assessment and reflects goals set by the resident, family, or resident's physician. The Interdisciplinary Team (IDT) provides services to the resident and the family consistent with the care plan. In addition to Chaplin's, nurses, physicians, and social workers, other therapeutic disciplines who provide palliative care services to residents and family members may include but are not limited to nursing assistants, Nutrition and Registered Dieticians, Occupational therapists, Respiratory Therapist, Pharmacists, Physical therapist, Psychologist, Speech and language pathologist. The IDT team communicates (at least weekly or more often as required by the clinical situation) to plan, review, evaluate, and update the care plan, with input from both the resident and family.

The facility failed to coordinate care between the facility and the hospice provider for R39, who received hospice services. This deficient practice placed him at risk for inadequate end-of-life care.
- The Electronic Medical Record (EMR) for R31 documented diagnoses of depression (a mood disorder that causes a persistent feeling of

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sadness and loss of interest), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), osteomyelitis (local or generalized infection of the bone and bone marrow), pain, atrial fibrillation (rapid, irregular heartbeat), and peripheral vascular disease (PVD- slow and progressive circulation disorder causing narrowing, blockage, or spasms in a blood vessel).

The "Medicare 5-Day Minimum Data Set" (MDS), dated 05/28/24, documented R31 had intact cognition and was dependent upon staff for transfers. R31 required substantial assistance with toileting, showers, dressing, and mobility, and was independent with transfers. The MDS further documented R31 received antidepressant (a class of medications used to treat mood disorders), opioid (a class of controlled drugs used to treat pain), and hypoglycemic (less than normal amount of sugar in the blood) medications. R31 was depressed for seven to 11 days and was not on hospice.

The "Quarterly MDS," dated 09/25/24, documented R31 had intact cognition. R31 was dependent upon staff for transfers. R31 required substantial assistance with toileting, bathing, dressing, and mobility. The MDS further documented R31 received antidepressant and diuretic (a medication to promote the formation and excretion of urine) medications and was on Hospice services.

R31's "Care Plan," dated 07/01/24, documented R31 was admitted to hospice and directed staff to anticipate and meet her needs and communicate with the hospice and the physician. The care plan directed the staff to work together as a team and

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ensure the resident was comfortable and free of pain. The care plan documented the hospice nurse and charge nurse would work together to ensure R31 was comfortable and pain-free; the hospice staff would bathe R31. The hospice would assist in setting palliative goals and directed staff to notify the hospice and the physician of changes in condition. The care plan lacked instruction on the services provided by hospice including the frequency and type of support visits, supplies and medical equipment provided by hospice, medications covered by hospice, and the hospice contact information.

A review of R31's clinical record revealed the resident was admitted to hospice care on 06/28/24. The facility had a plan of care provided by the hospice in a communication book.

On 12/03/24 at 08:30 AM, observation revealed R31 propelled her wheelchair down the hall to her room.

On 12/03/24 at 02:00 PM, Administrative Nurse D and Nurse Consultant GG verified the facility lacked specific information on the facility care plan that coordinated with the hospice care plan.

The "End of Life Palliative Care and Hospice Care" policy, dated 12/07/2023, documented bereavement counseling provided by hospice providers would be supervised by the hospice social worker or Chaplin for provision of "pre-death" assessment and counseling for residents and family members with bereavement staff providing support following death in collaboration with facility social service, chaplain, and nursing staff. A comprehensive and timely interdisciplinary assessment of the resident and

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family forms the basis of end-of-life care (palliative). The interdisciplinary team completes an initial comprehensive assessment and subsequent re-evaluation through the resident and family interviews, review of medical and other available records, discussion with other providers, physical examinations, and assessment, along with relevant laboratory and/or diagnostic tests or procedures. The comprehensive assessment reoccurs on a regular basis and at least quarterly and with any significant change in the resident's status or change in the resident and/or family's goals. The care plan is based on the identified and expressed preferences, values, goals, and needs of the resident and family and is developed with professional guidance and support for resident-family decision-making. The care plan is based on an ongoing assessment and reflects goals set by the resident, family, or resident's physician. The Interdisciplinary Team (IDT) provides services to the resident and the family consistent with the care plan. In addition to Chaplin's, nurses, physicians, and social workers, other therapeutic disciplines who provide palliative care services to residents and family members may include but are not limited to nursing assistants, Nutrition and Registered Dieticians, Occupational therapists, Respiratory therapist, Pharmacist, Physical therapist, Psychologist, Speech and language pathologist. The IDT team communicates (at least weekly or more often as required by the clinical situation) to plan, review, evaluate, and update the care plan, with input from both the resident and family.

The facility failed to coordinate care between the facility and the hospice provider for R31, who received hospice services. This deficient practice placed him at risk for inadequate end-of-life care.

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F 851 SS=F	Payroll Based Journal CFR(s): 483.70(p)(1)-(5) §483.70(p) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(p)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(p)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as	F 851		

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applicable), and hours worked for each individual).

§483.70(p)(3) Distinguishing employee from agency and contract staff.
When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency.

§483.70(p)(4) Data format.
The facility must submit direct care staffing information in the uniform format specified by CMS.

§483.70(p)(5) Submission schedule.
The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 79 residents. Based on record review and interviews, the facility failed to submit complete and accurate staffing information through the Payroll-Based Journal (PBJ) as required. This deficient practice placed the residents at risk for unidentified and ongoing inadequate nurse staffing.

Findings included:

- The PBJ report provided by the Centers for Medicare & Medicaid Services (CMS) for Fiscal Year (YR) 2023 Quarter (Q) 4 indicated excessively low weekend staffing and FY 2024 Q1 indicated excessively low weekend staffing and no Registered Nurse (RN) hours for 10 days in January 2024, seven days in February 2024

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F 851	Continued From page 66 and one day in March 2024. A review of the facility's weekend staffing and RN hours of the dates listed PBJ revealed appropriate weekend staff and RN coverage. On 12/04/24 at 09:22 AM, Administrative Nurse D reported that the discrepancy may be related to the previous company owners' incorrect submission of information. The facility's undated "Mandatory Submission of Uniform Format Staffing Information (PBJ)" policy documented the facility will submit to CMS complete and accurate direct care staffing data, including the category of work for each person on direct care staff, including but not limited to if the individual is a registered nurse (RN), licensed practical nurse (LPN), licensed vocational nurse (LVN), certified nursing assistant, therapist, or other type of medical personnel as specified by CMS. The facility will distinguish employees from agency and contract workers. The facility will submit as directed by CMS to CMS during the established staffing reporting periods but no less frequently than quarterly. The facility failed to submit accurate PBJ data, placing the residents at risk for unidentified and ongoing inadequate staffing.	F 851		
F 880 SS=F	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	F 880		

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development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 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.

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	175466	A. BUILDING _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEPOINT WICHITA, LLC	1315 N WEST STREET WICHITA, KS 67203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 68 (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: The facility had a census of 79 residents. The sample included 20 residents. Based on observation, record review, and interview, the facility failed to use appropriate barriers while sorting soiled laundry, failed to maintain an ongoing waterborne pathogen prevention program to address and mitigate the risk for Legionella (Legionella is a bacterium which can cause pneumonia in vulnerable populations), and failed to implement Enhanced Barrier Precautions (EBP-infection control interventions designed to reduce transmission of resistant organisms which employ targeted gown and glove use during high contact care) for Resident (R)7, R385 and R391. This placed the residents at risk of infectious diseases.	F 880		

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Findings included:

- On 12/02/24 at 12:35 PM observation revealed License Nurse (LN) H entered the room of R385 and donned gloves but no gown. LN H unclamped the end of the gastrostomy tube (G-tube: tube surgically placed through an artificial opening into the stomach) and attached a 60-milliliter (ml) syringe to the end of the G-tube and administered 60 ml of water, followed by one carton of Jevity (a liquid nutritional supplement that is high in calories, protein, and fiber) 1.5 calorie, followed by 60 ml water then administered 100 ml of free water. LN H removed the 60-ml syringe and clamped the end of the tube. LN H lowered the resident's bed to a low position.

On 12/02/24 at 01:42 PM, observation revealed Certified Nurse Aide (CNA) Q washed hands, and applied gloves but did not don gown. CNA Q emptied R7's urinary drainage bag into a urinal. CNA Q allowed the drainage port tip to touch the urine in the container. The urine output measured 2000 millimeters (ml). CNA Q removed the glove and washed hands, gloved again, then unattached the drainage port and wiped it with a moist wipe. CNA Q stated they did not have alcohol wipes.

On 12/03/24 at 07:52 AM, while on tour of the laundry department, Maintenance Staff U stated the soiled laundry was sorted by laundry staff using only gloves for personal protective equipment (PPE). Maintenance Staff U stated the laundry personnel did not wear a barrier gown or apron while sorting soiled laundry. Maintenance Staff U stated there could be the possibility of cross-contamination of soiled material to the

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clean laundry which was folded by the same laundry staff.

On 12/03/24 at 08:55 AM, LN I entered the room of R391 and donned gloves but no gown. LN I elevated the head of the resident's bed approximately 30 degrees and loosened the resident's abdominal binder. LN I unclamped the end of the G-tube and injected 10 ml of air to listen for placement with a stethoscope (a medical instrument for listening to the action of someone's heart or breathing). LN I then attached a 60-ml syringe to the end of the G-tube and administered 30 ml of water, then the resident's medication, followed by 30 ml of water. LN I removed the 60 ml syringe, clamped the end of the G-tube, and placed it under the binder.

On 12/03/24 at 12:30 PM, CNA Q stated the facility had not instructed her to use personal protective equipment (PPE) for EBP when providing catheter care.

On 12/03/24 at 02:22 PM, Administrative Nurse E, Consultant GG, and Administrative Nurse D verified the facility had not initiated EBP due to a lack of understanding regarding the requirements.

On 12/03/24 at 03:00 PM interview with Administrative Nurse D and Nurse Consultant GG verified the residents' rooms lacked EBP signs and PPE in the rooms to inform staff they should use EBP when providing care for R385 and R391 due to the G-tubes. Administrative Nurse D said the facility would do some education with the staff regarding EBP and wearing PPE for resident care and get the residents' rooms set up with the appropriate PPE equipment and signs.

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On 12/04/24 at 09:48 AM, Maintenance Staff U reported that the prevention waterborne pathogen procedure was to flush toilets and run facets and showers weekly in areas where there were not many residents. Maintenance Staff U stated he had not logged or documented the weekly flushing of the toilets, faucets, and showers.

The facility was unable to provide any evidence of an ongoing water management plan upon request.

The facility's "Laundry" policy, dated 12/04/24, documented it was the policy of the facility to prevent the spread of infection by appropriate separation, collection, laundry, and storage of laundry. Facility staff will handle, store, process, and transport linens in a method to prevent the spread of infection.

The facility's undated "Water Management Policy" documented it was the policy of this facility to ensure the appropriate precautions for the control of Legionella (Legionella is a bacterium which can cause pneumonia in vulnerable populations) bacteria are identified through a "Legionella" risk assessment process and appropriate control measures implemented to ensure, so far as is reasonably practicable, the health, safety, and welfare of residents, visitors, staff members, and volunteers. The minimum standards to be met include but are not limited to a description of building water systems, identification of areas where Legionella could grow and spread, the implementation, management, monitoring, and recording of precautions to include regular inspection, microbiological monitoring, temperature checks, and flushing where

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appropriate, and documentation of all monitoring.

The facility's Enhanced Barrier Precautions (EBP)" policy, dated 04/01/2024, stated the facility would follow recommendations from The Centers for Disease Control to keep residents safe from healthcare-acquired infections. The policy stated EBP would be used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high contact resident care activities in the resident's room that provide opportunities for transfer of organisms to staff hands and clothing. Residents with the following conditions require EBP for all high-contact care including chronic wounds, urinary catheters, hemodialysis access sites, and feeding tubes. the policy directed staff to post clear signage stating EBP precautions and make PPE available near or inside the resident's room.

The facility failed to handle soiled laundry in a manner to prevent the spread of possible infectious material without using the appropriate barriers. The facility failed to implement a water management program for waterborne pathogens placing the residents who reside in the facility at risk of contracting Legionella pneumonia. This placed the residents at increased risk for infections. The facility failed to implement EBP for three residents. These failures placed the residents at risk for increased infections.