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F 000	INITIAL COMMENTS The following citations represent the findings of a health resurvey. The 2567 was sent electronically on 12/30/24.	F 000		
F 558 SS=E	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: The facility had a census of 58 residents. The sample included 15 residents with five reviewed for accommodation of needs. Based on observation, record review, and interview, the facility failed to ensure the residents were provided foot pedals during wheelchair transports for Resident (R) 23, R36, R46, R34, R40, and R33. This placed the residents at risk for preventable accidents and injuries due to unmet care needs. Findings Included: - On 12/16/24 at 08:16 AM, R23, a severely cognitively impaired resident, sat upright in his Broda chair (specialized wheelchair with the ability to tilt and recline). R23 had socks on both feet. Certified Nurse Aide (CNA) O pushed R23 in his Broda chair and R23's feet slid along the floor before he lifted his legs.	F 558		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 12/30/2024

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

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On 12/17/24 at 07:18 AM, Staff pushed R36 in her wheelchair with no foot pedals. Staff repeatedly told R36 to keep her feet up.

On 12/17/24 at 07:20 AM, Staff pushed R46, a cognitively impaired resident, in her wheelchair with no foot pedals. Staff repeatedly asked R46 to keep her feet up.

On 12/17/24 at 09:47 AM, R23 sat upright in his Broda chair as Licensed Nurse (LN) J pushed his chair. R23's feet bumped up and down. R23 picked his feet up and held them out after LN J asked him to pick them up as she pushed him to the dining room.

On 12/17/24 at 11:00 AM, R34, a severely cognitively impaired resident, sat upright in her Broda chair in the hallway outside the TV room with socks on her feet and no heel protectors in place. Certified Nurse Aide (CNA) N pushed R34 in the Broda chair to the dining room with R34's feet sliding on the floor.

On 12/17/24 at 11:13 AM, R23 sat upright in his Broda chair as CNA O pushed him from the dining room down the hallway. R23's feet slid along the floor. R23 wore only socks on his feet.

On 12/18/24 at 08:08 AM, R40, a severely cognitively impaired resident, was wheeled to the main dining room by Licensed Nurse (LN) G without any foot pedals. R40 had socks on as her feet slid on the floor as she was pushed to the back dining room table.

On 12/18/24 at 08:14 AM, R33, a severely cognitively impaired resident with lower extremity limitation, sat in his Broda chair at the dining

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room table next to the piano. LN H wheeled R33 from his dining room table to the front window. R33's right foot was not on a foot pedal and slid on the ground as he was pushed to the window.

On 12/18/24 at 11:37 AM, CNA M stated that all the residents had foot pedals for their wheelchairs, but staff would only apply them for residents who could not lift their legs up. She stated that the resident's legs should never slide or touch the ground while being pushed. She stated that staff would ask the residents if they could hold their legs up and apply them if needed. She stated that foot pedals would only be applied if they were needed.

On 12/18/24 at 11:45 AM, Licensed Nurse (LN) H stated staff know which residents can hold their feet up. She stated the foot pedals were left off the wheelchairs to promote independence. She stated staff should never allow the resident's feet to slide on the floor as they push them.

On 12/18/24 at 12:34 PM, Administrative Nurse D stated staff should always apply wheelchair foot pedals for high fall risk residents. She stated staff were expected to apply the pedals when pushing the residents long distances.

The facility's "Assistive Devices and Equipment" policy revised 01/2024 indicated the facility will supervise the use of assistive devices including grab bars, walkers, canes, and foot pedals. The policy indicated staff will ensure the safe use of all assistive devices.

The facility failed to utilize and ensure foot pedals were provided and used during wheelchair transports for R23, R36, R46, R34, R40, and

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F 558	Continued From page 3 R33. This placed the residents at risk for preventable accidents and injuries due to unmet care needs.	F 558		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(h)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State	F 583		

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law.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 58 residents. The sample included 15 residents. Based on observation, record review, and interview, the facility failed to keep Resident (R) 112's protected health information (PHI) private on a medication cart parked in the main dining room. This placed R112 at risk for impaired privacy.

Findings included:

- On 12/17/24 at 07:37 AM, an observation revealed a medication cart parked in the main dining room with a laptop computer sitting on the top, Licensed Nurse (LN) G walked away from the medication cart and into the dining room. LN G left the computer screen unlocked and open and R112's PHI was on the screen, visible to all who passed by the medication cart. The information visualized included R112's medications, date of birth, allergy information, and code status.

On 12/18/24 at 11:55 AM, Licensed Nurse (LN) H stated the medication cart should be double locked, the computer screen should be closed, or the PHI should be hidden from view.

On 12/18/24 at 12:20 PM, Administrative Nurse D stated she expected the nursing staff to close the computer screen before walking away from the medication cart. Administrative Nurse D stated the resident's PHI should never be left on the computer screen for unintended viewing.

The facility's "Confidentiality of Information and Personal Privacy" policy last reviewed 08/2024

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F 583	Continued From page 5 documented that the facility would protect and safeguard resident confidentiality and personal privacy. The facility failed to keep and maintain R112's privacy regarding PHI. This placed the resident at risk for impaired privacy.	F 583		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced	F 657		

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by:
The facility reported a census of 58 residents. The sample included 15 residents with 15 reviewed for care plan revisions. Based on interviews, observations, and record reviews, the facility failed to revise Resident (R) 33's "Care Plan" to reflect his increased behavioral episodes. The facility additionally failed to revise R32's "Care Plan" to reflect her sleeping preferences. This deficient practice placed both residents at risk for impaired care due to uncommunicated care needs.

Findings Included:

- The "Diagnosis" section within R33's Electronic Medical Records (EMR) included diagnoses of epilepsy (brain disorder characterized by repeated seizures), seizures (violent involuntary series of contractions of a group of muscles), spinal stenosis (degenerative condition of the spine that could cause weakness and loss of use of extremities), insomnia (difficulty sleeping), aphasia (difficulty speaking), major depressive disorder (major mood disorder), and cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain).

R33's "Quarterly Minimum Data Set" (MDS) dated 11/04/24 documented a Brief Interview for Mental Status (BIMS) score of three indicating severe cognitive impairment. The MDS documented episodes of wandering behaviors one to three days during observation. The MDS documented upper and lower extremity impairments on one side of his body. The MDS documented he was dependent on staff assistance for oral hygiene,

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toileting, transfers, bed mobility, dressing, and bathing.

R33's "Cognitive Loss Area Assessment" (CAA) completed 03/07/24 documented he had poor memory and recall. The CAA documented poor decision-making thought processes. The CAA documented he had impaired hearing requiring the use of sign language and electronic adaptive equipment.

R33 was not triggered for behavioral CAA.

R33's "Care Plan" initiated on 11/04/24 documented he was at risk for falls, cognitive decline, and activities of daily living (ADLs) deficit. The plan documented he required moderate to maximal assistance for his bed mobility, toileting, dressing, eating, personal hygiene, and bathing. The plan documented he required a sit-to-stand mechanical lift and staff assistance with transfers. The plan documented he was unable to ambulate in his Broda chair (specialized wheelchair with the ability to tilt and recline) without staff assistance. The plan documented he had a history of wandering but had no exit-seeking behaviors. The plan instructed staff to keep his routine consistent to prevent confusion.

R33's EMR under "Progress Notes" revealed a note on 11/22/24. The note documented that R33 became physically aggressive while staff attempted to transfer him from his Broda chair to the shower chair. The note documented he was resistant to care and hitting staff.

R33's EMR under "Progress Notes" revealed a note on 11/27/24. The note documented that R33 was resistive towards care. The note documented

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he began to hit, slap, and kick staff. The note documented that staff made several attempts to perform care with no success. The note documented that R33's representative was notified and requested to be called each time he refused care or became aggressive.

R33's EMR under "Progress Notes" revealed a note on 12/07/24. The note documented staff attempted to get R33 up for the day and he became physically aggressive. The note documented that R33 began to hit, kick, and twist staff members' arms. The note documented that R33's representative was notified. R33's representative requested his neurologist be notified of his behaviors.

R33's EMR under "Progress Notes" revealed a note on 12/08/24. The note documented that R33 was hitting, punching, and grabbing staff when they attempted to get him up for the morning. The note documented staff gave him more time and he eventually allowed them to assist him.

On 12/17/24 at 08:20 AM, R33 sat in his Broda chair in the dining room. R33 was assisted by staff during his breakfast.

On 12/18/24 at 11:37 AM, Certified Nurse's Aide (CNA) M stated R33 could get aggressive during care and transfers. She stated he could be resistant to care and had decreased awareness due to his cognitive impairment and inability to hear. She stated staff should explain what was going to happen to him before treatment or care and allow him to express his opinions. She stated that usually, his refusal is in the morning time. She stated staff contacted his representative to assist during behaviors.

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On 12/18/24 at 11:54 AM, Licensed Nurse (LN) H stated R33 sometimes had behaviors. She stated staff were to communicate clearly with him at eye level. She stated that staff should give him time to process and explain what would happen to him, before attempting to move him. She stated he could be aggressive, and staff should give R33 time and reapproach him at a later time if he was agitated. She stated that staff should offer him choices and listen to his frustrations. She stated he has been known to be physically aggressive and the care plan should reflect interventions and triggers related to his behaviors.

On 12/18/24 at 12:23 PM, Administrative Nurse D stated R33 behaviors were not frequent and more sporadic. She stated he occasionally had behaviors, but staff were usually able to calm him down and get the care completed. She stated the care plan should reflect behavioral interventions and possible triggers to assist with behaviors.

The facility's "Care Plans" policy revised 03/2024 documented a comprehensive assessment would be completed to identify treatment goals and interventions based on the assessment findings. The policy documented that each resident's care plan would reflect the resident's current conditions and changes toward their care goals.

The facility failed to revise R33's "Care Plan" to reflect increased behavioral concerns and interventions. This deficient practice placed R33 at risk for impaired care due to uncommunicated care needs.
- The "Diagnosis" tab of R32's Electronic Medical Record (EMR) documented diagnoses of anemia (an inadequate number of healthy red blood cells

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to carry adequate oxygen to body tissues), dementia (a progressive mental disorder characterized by failing memory and confusion), protein-calorie malnutrition, bipolar disorder (a major mental illness that causes people to have episodes of severe high and low moods), delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue), chronic pain, hypertension (high blood pressure), major depressive disorder (major mood disorder that causes persistent feelings of sadness), insomnia (inability to sleep), chronic pain, anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and dysuria (painful urination).

The "Annual Minimum Data Set" (MDS) dated 12/09/24 documented a Brief Interview of Mental Status (BIMS) score of three which documented severely impaired cognition. The MDS documented R32 required substantial to maximum assistance for eating, bathing, and dressing; R32 was dependent on staff for oral hygiene.

The "Cognitive Loss/Dementia Care Assessment Area" (CAA) dated 12/09/24 triggered secondary to R32's BIMs score. Contributing factors included dementia. Risk factors included self-care deficits, falls and injuries, incontinence, decreased socialization, skin breakdown, and weight loss. The care plan would be reviewed to maintain cognitive status, activities of daily living (ADLs) status, continence status, mobility, encourage activity participation, maintain communication, decrease fall, pressure ulcer risk, and maintain weight.

R32's "Care Plan" revised 12/13/24 documented

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she had a psychosocial well-being problem related to lack of motivation. R32 would verbalize feelings related to emotional state. Staff was to allow R32 time to answer questions and to verbalize feelings perceptions and fears as needed. Staff were to encourage participation from the resident, who depended on others to make own decisions. Nursing staff were to monitor R32's feelings relative to unhappiness, anxiousness, and crying, and provide opportunities for the resident and family to participate in care. Staff were to remove the resident to a calm safe environment and allow R32 to vent and share feelings.

R32's "Care Plan" lacked preferences or indications for sleeping and napping on the couches in areas other than R32's room and when R32 yelled out for help.

On 12/16/24 at 07:15 AM, R32 lay on the couch in the Northeast hallway. R32 had a blanket and pillow. R32 was yelling out help me.

On 12/16/24 at 01:12 PM, R32 lay on the couch in the Northeast hallway. R32 had a blanket and was reaching out her hand and asking for help.

On 12/16/24 at 11:33 AM, R32 lay on the couch in the hallway next to the dining room. R32 had her eyes shut and was covered with a blanket.

On 12/18/24 at 11:37 AM, Certified Nurses Aid (CNA) M stated she did not have access to the Kardex (a nursing tool that gives a brief overview of the care needs of each resident). CNA M stated the nurse in charge keeps all the CNAs updated on any changes with each resident. CNA M stated all the nursing staff know R32 likes to

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sleep on the couches, and at times yells for help. CNA M said staff could check on R32 to ensure she did not need help. CNA M stated she was unsure if R32's preferences were on her care plan.

On 12/18/24 at 11:55 AM, Licensed Nurse (LN) H stated all nursing staff have access to the care plan and said the care plan identifies resident-specific information. LN H stated that R32 liked to take naps on couches and would occasionally yell out. She stated she did not believe R32's preferences were part of her care plan.

On 12/18/24 at 12:18 PM, Administrative Nurse D stated the care plans were updated by the MDS coordinator; she stated the core group of administrative staff discussed what should be placed on the care plans. She stated she saw R32 sleeping on the couch at times and yelling for help. Administrative Nurse D stated she did not believe R32's preference of sleeping on the couch or yelling was care planned.

The facility's "Comprehensive Care Plan" policy revised March 2024 documented a comprehensive, person-centered care plan that includes objectives and timetables to meet the resident's physical, psychosocial, and functional needs was developed and implemented for each resident. The interdisciplinary team (IDT) in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS assessment (Admission, Annual or

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F 657	Continued From page 13 Significant Change in Status), and no more than 21 days after admission. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. The facility failed to revise R32's "Care Plan" with preferred preferences for napping on the couches in common areas or for the behavior of yelling out for help. This deficient practice placed R32 at risk for impaired care due to uncommunicated care needs.	F 657		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: The facility identified a census of 58 residents. The sample included 15 residents with two residents reviewed for pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, because of pressure, or pressure in combination with shear and/or friction). Based on observation, record review,	F 686		

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and interviews, the facility failed to ensure pressure-reducing heel protectors or boots were in place for Resident (R) 34 who had a pressure-related injury on her left heel. These deficient practices placed R34 at risk for complications related to further skin breakdown and worsening of pressure ulcers.

Findings included:

- R34's Electronic Medical Record (EMR) from the "Diagnosis" tab documented diagnoses of a pressure ulcer of the left heel, dementia (a progressive mental disorder characterized by failing memory and confusion), major depressive disorder (major mood disorder that causes persistent feelings of sadness), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear).

The "Significant Change Minimum Data Set" (MDS) dated 11/04/24 documented a Brief Interview of Mental Status (BIMS) score of three which indicated severely impaired cognition. The MDS documented R34 was at risk of developing pressure ulcers and currently had an unhealed pressure ulcer. The MDS documented R34 had a pressure-reducing device on her bed, nutritional or hydration interventions in place to manage skin problems, and pressure ulcer care in place.

R34's "Pressure Ulcer Care Area Assessment" (CAA) dated 11/08/24 documented R34 had developed a new pressure ulcer related to mobility impairment.

R34's "Care Plan" dated 11/04/24 documented staff would apply bilateral heel protectors to R34's feet when she was out of bed. The plan of care

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also documented staff would apply bilateral Thera-boots when she was in bed.

R34's EMR under the "Orders" tab revealed the following physician orders:
Ensure R34 was wearing bilateral heel protectors during the day and bilateral Thera-boots at night, dated 11/08/24.

On 12/17/24 at 11:00 AM, R34 sat upright in her Broda chair (specialized wheelchair with the ability to tilt and recline) in the hallway outside the TV room with socks on her feet and no heel protectors in place. Certified Nurse Aide (CNA) N pushed her in the Broda chair with her feet sliding on the floor to the dining room.

On 12/17/24 at 04:07 PM, R34 lay awake on her bed. She was not wearing Thera-boots and her heels laid directly on the bed. A pressure-reducing boot laid on the floor of her open closet.

On 12/18/24 at 11:37 AM, CNA M stated she would know which residents were to have pressure-reducing measures in place by the Kardex (a nursing tool that gives a brief overview of the care needs of each resident), the charge nurse information, and if the heel protectors were in the room.

On 12/18/24 at 11:55 AM, Licensed Nurse (LN) H stated the pressure-reducing devices were listed on the "Treatment Administration Record" (TAR) and staff would sign off every shift that the items were in place. LN H said usually the CNAs would apply the heel protectors or boots.

On 12/18/24 at 12:20 PM, Administrative Nurse D

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F 686	Continued From page 16 stated she expected R34's heel protectors and boots to be in place. Administrative Nurse D stated she expected the nurse to ensure the pressure-reducing devices were in place as ordered. The facility's "Support Surface Guidelines" policy last revised September 2024 documented that the purpose of this procedure was to provide guidelines for the assessment of appropriate pressure-reducing and relieving devices for residents at risk of skin breakdown. The facility failed to ensure pressure-reducing heel protectors and boots were in place for R34 who had a pressure injury on her left heel. This deficient practice placed R34 at risk for complications related to skin breakdown and worsening pressure ulcers.	F 686		
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 reported a census of 58 residents. The sample included 15 residents with five reviewed for accidents. Based on interviews, observations, and record review, the facility failed to ensure a safe care environment related to the use of Resident (R)35's fall prevention	F 689		

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interventions for his wheelchair. This deficient practice placed R35 at risk for preventable falls and injuries.

Findings included:

- The "Diagnosis" tab within R35's Electronic Medical Records (EMR) included diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion) restlessness, agitation, major depressive disorder (major mood disorder), muscle spasms, muscle weakness, and repeated falls.

R35's "Quarterly Minimum Data Set" (MDS) dated 11/04/24 documented a Brief Interview for Mental Status (BIMS) score of three indicating severe cognitive impairment. The MDS documented he required partial to moderate assistance with dressing, transfers, bed mobility, bathing, personal hygiene, and personal hygiene. The MDS documented he could independently use his wheelchair. The MDs documented two or more non-injury falls since his last assessment.

R35's "Falls Care Area Assessment" (CAA) completed 05/01/24 documented he had a significant history of falls and required assistance. The CAA documented he did not always comply with asking for assistance. The CAA documented he had difficulty maintaining a standing position, even with a mobility aid or personal assistance. The CAA documented a care plan will be implemented to address his fall risks and provide interventions.

R35's "Care Plan" initiated 07/23/24 documented he was at risk for a decline in his activities of daily living (ADLs) and falls related to his medical

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diagnoses. The plan documented he required touch assistance and supervision when transferring between surfaces. The plan documented he could not safely transfer himself without staff assistance, and chair alarms were put into place. The plan documented he used a wheelchair for mobility. The plan instructed staff to ensure a Dycem (non-slip mat used for stabilization and gripping to prevent slipping) was placed in his recliner and wheelchair to prevent slips and falls.

On 12/17/24 at 10:20 AM, R35 sat in his room in the recliner. His fall alarm was in place in the chair and was functioning. His recliner had a Dycem mat directly underneath him. An inspection of his wheelchair revealed a pressure relieving mat but lacked a Dycem mat.

On 12/17/24 at 01:25 PM, R35 sat in his wheelchair in the small dining area next to the main dining room eating his meal. R35's wheelchair had his pressure mat but lacked a Dycem mat.

On 12/18/24 at 12:03 PM, R35 sat in his room in his wheelchair. R35 removed the blanket and Dycem mat from his recliner. He stated he was going to lunch. R35 folded the Dycem mat and placed it on his bed. An inspection of his wheelchair revealed no Dycem mat in place under him.

On 12/18/24 at 11:37 AM, Certified Nurse's Aide (CNA) N stated R35 was impulsive and would often transfer himself without staff knowing. She stated he was a fall risk due to his cognitive impairment and limited mobility. She stated he could wheel himself but needed assistance with

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F 689	Continued From page 19 transfers. She stated he should have a Dycem mat in his recliner but was not sure about his wheelchair. She was not sure if he had one for each or if it was moved every time he transferred. On 12/18/24 at 12:23 PM, Administrative Nurse D stated she was not sure if R35 had two Dycem mats but stated staff were expected to ensure the Dycem mats were in place every time he transferred or moved. The facility's "Assessing Falls" policy revised August 2024 documented the facility would assess each resident's functional abilities and identify pertinent interventions to prevent subsequent falls. The policy documented the facility would provide ongoing monitoring and assessment of individuals at risk for falls. The facility failed to ensure R35's care-planned fall inventions were in place, related to his wheelchair's Dycem mat. This deficient practice placed R35 at risk for preventable falls and injuries.	F 689		
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,	F 756		

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and these reports must be acted upon.
(i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.
(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.
(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.

§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 58 residents. The sample included 15 with five residents reviewed for drug regimen review. Based on interviews, observations, and record review, the facility failed to ensure the Consulting Pharmacist (CP) identified and made recommendations related to Residents (R) 55, R8, R52, and R32's indications for their antipsychotic medications (a class of medications used to treat major mental conditions that cause a break from reality). This placed the residents at risk for unnecessary

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psychotropic (alters mood or thoughts) medications and related complications.

Findings Included:

- The "Diagnosis" tab within R55's Electronic Medical Records (EMR) included diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), fatigue, and pain.

R55's "Quarterly Minimum Data Set" (MDS) dated 10/21/24 documented a Brief Interview for Mental Status (BIMS) score of eleven indicating moderate cognitive impairment. The MDS documented she was independent with meals, oral hygiene, toileting, bathing, dressing, transfers, and bed mobility. The MDS documented no behaviors were exhibited during the observed period. The MDS documented she took antipsychotic medication. The MDS documented a gradual dose reduction (GDR) was not completed and documented as clinically contraindicated on 09/06/24.

R55's "Psychotropic Drug Use Area Assessment" (CAA) completed 08/05/24 documented she took antipsychotics and was at risk for adverse effects related to her Seroquel medication (an antipsychotic medication).

R55's "Care Plan" initiated on 09/11/24 documented she was at risk for a cognitive decline due to her medical diagnosis. The plan documented she was independent when completing her activities of daily living (ADLs). The plan documented she was at risk for adverse reactions related to her medications; and took medications with Black Box Warnings (BBW- the

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highest safety-related warning that medications can be assigned by the Food and Drug Administration). The plan instructed staff to monitor for changes and notify her medical provider. R55's plan lacked documentation showing she had behaviors and non-pharmacological interventions to address those behaviors. The plan lacked documentation related to her antipsychotic medication.

R55's EMR under the "Orders" tab indicated an order for staff to administer 50 milligrams (mg) of Seroquel three times a day for behavioral disturbances and paranoia related to dementia. The EMR revealed she had the medication upon her admission on 07/31/24.

A review of R25's EMR revealed no documented rationale for the indicated use of Seroquel for dementia-related behaviors.

A review of the facility's "Monthly Medication Reviews" (MMR) from 08/2024 to 12/2024 revealed no recommendations noting the inappropriate indication of use related to R55's Seroquel medication.

On 12/18/24 at 07:30 AM, Licensed Nurse (LN) G administered R55's morning medications. R55 received her morning dose of Seroquel without behaviors or refusals. R55 reported she felt fine and had no concerns.

On 12/18/24 at 12:23 PM, Administrative Nurse D stated the pharmacist did not recognize or report issues related to medication indications. Administrative Nurse D stated she would meet with them to ensure they did in the future.

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The facility's "Medication Regimen Reviews" policy last revised May 2024 documented the Consultant Pharmacist reviewed the medication regimen of each resident at least monthly. Medication regimen reviews (MRR) are done upon admission (or as close to admission as possible) and at least monthly thereafter, or more frequently if indicated. The policy documented that the Consulting Pharmacist would identify, and report medication irregularities found during the monthly review.

The facility failed to ensure the CP identified and made recommendations related to R55's inappropriate indication for her Seroquel medication. This placed R55 at risk for unnecessary psychotropic medications and related complications.a

- R8's Electronic Medical Record (EMR) from the "Diagnosis" tab documented diagnoses of diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear).

The "Significant Change Minimum Data Set" (MDS) dated 07/01/24 documented a Brief Interview of Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS documented R8 received antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) medication, antidepressant (a class of medications used to treat mood disorders) medication, diuretic (a medication to promote the formation and

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excretion of urine) medication, and opioid (a class of controlled drugs used to treat pain) medication during the observation period.

The "Quarterly MDS" dated 12/09/24 documented a BIMS score of 14 which indicated intact cognition. The MDS documented that R8 had received antianxiety (a class of medications that calm and relax people) medication, antipsychotic medication, opioid medication, and antidepressant medication during the observation period.

R8's "Psychotropic Drug Use Care Area Assessment" (CAA) dated 07/05/24 documented she had received multiple psychotropic and opioid medications. The nursing staff continued to monitor for effectiveness and side effects every shift.

R8's "Care Plan" dated 08/25/24 documented the nursing staff would monitor R8 for possible signs and symptoms of side effects of her medications. The plan lacked documentation related to her antipsychotic medication.

R8's EMR under the "Orders" tab revealed the following physician orders:
Quetiapine fumarate (antipsychotic) oral tablet extended release 24 hour (Seroquel) 150 milligram (mg) give one tablet by mouth at bedtime related to major depressive disorder dated 07/12/24.

Review of R8's EMR lacked documentation of non-pharmaceutical interventions tried and failed prior to the antipsychotic medication. The EMR lacked evidence of documentation related to informed consent for the use of antipsychotic

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medication.

R8's "Monthly Medication Review" (MMR) reviewed from May 2024 through December 2024 lacked evidence the CP identified and reported R8's antipsychotic medication did not have a physician-documented rationale or risk versus benefit for continued use of an antipsychotic without a CMS-approved indication.

On 12/17/24 at 07:17 AM, R8 lay asleep on her bed. R8's oxygen cannula was in her nostrils; she was covered with a blanket and the head of her bed was elevated.

On 12/18/24 at 12:23 PM, Administrative Nurse D stated the pharmacist did not recognize or report issues related to medication indications. Administrative Nurse D stated she would meet with them to ensure they did in the future.

The "Medication Regimen Reviews" policy last revised May 2024 documented the Consultant Pharmacist reviewed the medication regimen of each resident at least monthly. Medication regimen reviews (MRR) are done upon admission (or as close to admission as possible) and at least monthly thereafter, or more frequently if indicated. The goal of the MRR was to promote positive outcomes while minimizing adverse consequences and potential risks associated with medication. An "irregularity" refers to the use of medication that was inconsistent with accepted pharmaceutical services standards of practice; was not supported by medical evidence; and/or impedes or interferes with achieving the intended outcomes of pharmaceutical services. It may also include the use of medication without indication, without adequate monitoring, in excessive doses,

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and or in the presence of adverse consequences. If the identified irregularity represents a risk to a person's life, health, or safety; the consultant pharmacist contacts the physician immediately (within one hour) to report the information to the physician verbally and document the notification.

The facility failed to ensure the CP had identified and reported irregularities with R8's antipsychotic medication. This deficient practice placed R8 at risk for unnecessary medication administration, ineffective benefits of the medication, and possible adverse side effects.
- The "Diagnosis" tab of R52's Electronic Medical Record (EMR) documented diagnoses of cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), aphasia (condition with disordered or absent language function), hemiparesis/hemiplegia (weakness and paralysis on one side of the body) affecting right dominant side, anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), dysphagia (swallowing difficulty), hypertension (high blood pressure), vascular dementia (a progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain), and major depressive disorder (major mood disorder that causes persistent feelings of sadness).

The "Quarterly Minimum Data Set" (MDS) dated 10/28/24, documented a Brief Interview of Mental Status (BIMS) score of four which indicated severely impaired cognition. The MDS documented R52 had an impairment on one side of her body. The MDS documented R52 needed

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partial to moderated assistance with dressing, toileting, and setting up for eating. The MDS documented R52 received an antidepressant (a class of medications used to treat mood disorders) and antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) during the observation period.

R52's "Psychotropic Drug Use Care Area Assessment" (CAA) dated 05/16/24 documented R52 admitted to the facility with a psychotropic medication and the physician would monitor R52's medication routinely. The MDS documented staff would monitor the side effects of medication for R52.

R52's "Care Plan" dated 08/05/2024 documented R52 had impaired cognitive function, dementia, or impaired thought processes related to dementia. R52 would be able to communicate basic needs daily. R52's plan of care documented staff would administer medications as ordered and monitor and document for side effects and effectiveness. Staff were to keep the R52's routine consistent and try to provide consistent caregivers as much as possible to decrease confusion.

R52's EMR under the "Orders" tab documented the following physician's order:
Quetiapine fumarate (antipsychotic) 25 milligrams (mg) oral tablet give 0.5 tablet by mouth one time a day for behavioral disorders associated with dementia dated 07/17/24.

R52's EMR revealed no physician-documented rationale for the continued use of quetiapine fumarate for dementia-related behaviors.

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A review of the CP's "Monthly Medication Reviews (MMR)" from 08/2024 to 12/2024 revealed no recommendations noting the inappropriate indication of use related to R52's quetiapine fumarate medication.

On 12/16/24 at 07:32 AM R52 sat at the dining room table eating her breakfast.

On 12/18/24 at 12:23 PM Administrative Nurse D stated the pharmacist did not recognize or report issues related to medication indications, but she stated she would meet with them to ensure they did in the future.

The facility's "Medication Regimen Reviews" policy last revised May 2024 documented the Consultant Pharmacist reviewed the medication regimen of each resident at least monthly. Medication regimen reviews (MRR) are done upon admission (or as close to admission as possible) and at least monthly thereafter, or more frequently if indicated. The policy documented the Consulting Pharmacist would identify and report medication irregularities found during the monthly review.

The facility failed to ensure the CP identified and made recommendations related to R52's inappropriate indication for her quetiapine fumarate medication. This placed R52 at risk for unnecessary psychotropic medications and related complications.

- The "Diagnosis" tab of R32's Electronic Medical Record (EMR) documented diagnoses of anemia (an inadequate number of healthy red blood cells to carry adequate oxygen to body tissues),

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dementia (a progressive mental disorder characterized by failing memory and confusion), protein-calorie malnutrition, bipolar disorder (a major mental illness that causes people to have episodes of severe high and low moods), delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue), chronic pain, hypertension (high blood pressure), major depressive disorder (major mood disorder that causes persistent feelings of sadness), insomnia (inability to sleep), chronic pain, anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and dysuria (painful urination),

The "Annual Minimum Data Set" (MDS) dated 12/09/24 documented a Brief Interview of Mental Status (BIMS) score of three which indicated severely impaired cognition. The MDS documented R32 required substantial to maximum assistance for eating, bathing, and dressing, and was dependent on staff for oral hygiene. The MDS documented R32 received antipsychotics during the observation period.

R32's "Psychotropic Drug Use Care Area Assessment" (CAA) dated 12/09/24 documented R32 triggered secondary to the use of psychotropic medication to manage psychiatric illness and conditions. A licensed nurse monitored for side effects every shift, and the physician was to be notified of any abnormal findings. A pharmacist consultant would review medications monthly, and the physician would review medications with each visit. Contributing factors included current history of depression, anxiety, and bipolar disease. Risk factors included increased falls, impaired balance, and a potential for adverse effects of medication. The

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care plan would be reviewed to monitor the effectiveness of psychotropic medication and any adverse effects of medication.

R32's "Care Plan" revised 12/13/24 documented R32 received psychotropic medications related to bipolar disorder (a major mental illness that causes people to have episodes of severe high and low moods), depression, and anxiety. R32 would be free of psychotropic drug-related complications including movement disorder, discomfort, hypotension, gait disturbance, constipation, or cognitive and behavioral impairment. Nursing staff were to administer psychotropic medications as ordered by the physician and monitor for side effects and effectiveness every shift. Nurses were to consult with the pharmacy and physician to consider dosage reduction when clinically appropriate at least quarterly. Nursing staff were to monitor and record the occurrence of target behavior symptoms every shift.

R32's EMR under the "Orders" tab documented the following physician's order:
Risperidone (antipsychotic) oral tablet 0.5 milligrams (mg) give one tablet by mouth two times a day for delusions dated 07/24/24.

R32's EMR revealed no physician-documented rationale for the continued use of risperidone for delusions.

A review of the CP's "Monthly Medication Reviews" (MMR) from 08/2024 to 12/2024 revealed no recommendations noting the inappropriate indication of use related to R32's risperidone medication.

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F 756	Continued From page 31 On 12/16/24 at 07:15 AM, R32 lay on the couch in the Northeast hallway. R32 had a blanket and pillow. On 12/18/24 at 12:23 PM, Administrative Nurse D stated the pharmacist did not recognize or report issues related to medication indications, but she stated she would meet with them to ensure they did in the future. The facility's "Medication Regimen Reviews" policy last revised 05/2024 documented the consultant pharmacist reviews the medication regimen of each resident at least monthly. Medication regimen reviews (MRR) are done upon admission (or as close to admission as possible) and at least monthly thereafter, or more frequently if indicated. The policy documented the Consulting Pharmacist would identify and report medication irregularities found during the monthly review. The facility failed to ensure the CP identified and made recommendations related to R32's inappropriate indication for her risperidone medication. This placed R32 at risk for unnecessary psychotropic medications and related complications.	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 categories: (i) Anti-psychotic;	F 758		

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F 758	Continued From page 32 (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 renewed unless the attending physician or prescribing practitioner evaluates the resident for	F 758		

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the appropriateness of that medication.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 58 residents. The sample included 15 with five residents reviewed for unnecessary medications. Based on interviews, observations, and record review, the facility failed to ensure an appropriate indication or documented physician rationale for Resident (R) 55, R8, R32, and R52s' antipsychotic medications (a class of medications used to treat major mental conditions that cause a break from reality). This placed the residents at risk for unnecessary psychotropic (alters mood or thoughts) medications and related complications.

Findings Included:

- The "Diagnosis" tab within R55's Electronic Medical Records (EMR) included diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), fatigue, and pain.

R55's "Quarterly Minimum Data Set" (MDS) dated 10/21/24 documented a Brief Interview for Mental Status (BIMS) score of eleven indicating moderate cognitive impairment. The MDS documented she was independent with meals, oral hygiene, toileting, bathing, dressing, transfers, and bed mobility. The MDS documented no behaviors were exhibited during the observed period. The MDS documented she took antipsychotic medication. The MDS documented a gradual dose reduction (GDR) was not completed and documented as clinically contraindicated on 09/06/24.

R55's "Psychotropic Drug Use Area Assessment"

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(CAA) completed 08/05/24 documented she took antipsychotics and was at risk for adverse effects related to her Seroquel (antipsychotic medication).

R55's "Care Plan" initiated on 09/11/24 documented she was at risk for a cognitive decline due to her medical diagnosis. The plan documented she was independent with her activities of daily living (ADLs). The plan documented she was at risk for adverse reactions related to her medications and took medications with Black Box Warnings (BBW- the highest safety-related warning that medications can be assigned by the Food and Drug Administration). The plan instructed staff to monitor for changes and notify her medical provider. R55's plan lacked documentation showing she had behaviors and non-pharmacological interventions to address those behaviors. The plan lacked documentation related to her antipsychotic medication.

R55's EMR under the "Orders" tab documented an order for staff to administer 50 milligrams (mg) of Seroquel three times a day for behavioral disturbances and paranoia related to dementia. The EMR revealed she had the medication upon her admission on 07/31/24.

A review of R25's EMR revealed no documented rationale for the documented use of Seroquel for dementia-related behaviors.

On 12/18/24 at 07:30 AM, Licensed Nurse (LN) G administered R55's morning medications. R55 received her morning dose of Seroquel without behaviors or refusals. R55 stated she felt fine and had no concerns.

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On 12/18/24 at 11:54 AM, LN H stated the appropriate indication for antipsychotic medication did not include dementia-related indications unless the resident had schizophrenia (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought), Huntington's disease (a rare abnormal hereditary condition characterized by progressive mental deterioration, a disabling central nervous system movement disorder), or Tourette's syndrome (condition of the nervous syndrome causing uncontrollable repetitive movements or unwanted sounds).

On 12/18/24 at 12:23 PM, Administrative Nurse D stated only CMS-approved indications should be used for antipsychotic medications. She stated that dementia was not an appropriate indication for Seroquel.

The facility's "Psychotropic Drug Use" policy revised July 2024 documented residents would not receive medications that were not clinically documented to treat specific conditions. The policy documented monthly medication reviews would be completed to show psychotropic monitoring to ensure appropriate indication, effectiveness, and the need for a gradual dose reduction.

The facility failed to ensure an appropriate indication or a documented physician rationale for R55's Seroquel medication. This placed R55 at risk for unnecessary psychotropic medications and related complications.
- R8's Electronic Medical Record (EMR) from the "Diagnosis" tab documented diagnoses of diabetes mellitus (DM - when the body cannot

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use glucose, not enough insulin is made, or the body cannot respond to the insulin), depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear).

The "Significant Change Minimum Data Set" (MDS) dated 07/01/24 documented a Brief Interview of Mental Status (BIMS) score of 15 which documented intact cognition. The MDS documented R8 received antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) medication, antidepressant (a class of medications used to treat mood disorders) medication, diuretic (a medication to promote the formation and excretion of urine) medication, and opioid (a class of controlled drugs used to treat pain) medication during the observation period.

The "Quarterly MDS" dated 12/09/24 documented a BIMS score of 14 which documented intact cognition. The MDS documented that R8 had received antianxiety (a class of medications that calm and relax people) medication, antipsychotic medication, opioid medication, and antidepressant medication during the observation period.

R8s "Psychotropic Drug Use Care Area Assessment" (CAA) dated 07/05/24 documented she had received multiple psychotropic and opioid medications. The nursing staff continued to monitor for effectiveness and side effects every shift.

R8's "Care Plan" dated 08/25/24 documented

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nursing staff would monitor R8 for possible signs and symptoms of side effects of her medications. The plan lacked documentation related to her antipsychotic medication.

R8's EMR under the "Orders" tab revealed the following physician orders:
Quetiapine fumarate (antipsychotic) oral tablet extended release 24 hour (Seroquel) 150 milligram (mg) give one tablet by mouth at bedtime related to major depressive disorder dated 07/12/24.

Review of R8's EMR lacked documentation of non-pharmaceutical interventions tried and failed prior to the administration of antipsychotic medication. The EMR lacked evidence of documentation related to informed consent for the use of antipsychotic medication.

On 12/17/24 at 07:17 AM, R8 lay asleep on her bed. R8's oxygen cannula was in her nostrils; she was covered with a blanket and the head of her bed was elevated.

On 12/18/24 at 11:54 AM, LN H stated the appropriate indication for antipsychotic medication did not include dementia-related indications unless the resident had schizophrenia (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought), Huntington's disease (a rare abnormal hereditary condition characterized by progressive mental deterioration, a disabling central nervous system movement disorder), or Tourette's syndrome (condition of the nervous syndrome causing uncontrollable repetitive movements or unwanted sounds).

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On 12/18/24 at 12:23 PM, Administrative Nurse D stated only CMS-approved indications should be used for antipsychotic medications. She stated that dementia was not an appropriate indication for Seroquel.

The facility's "Psychotropic Drug Use" policy revised July 2024 documented residents would not receive medications that were not clinically documented to treat a specific condition Residents, families, and/or the representative were involved in the medication management process. Residents who had not used psychotropic medications were not prescribed or given those medications unless the medication was determined to be necessary to treat a specific condition that was diagnosed and documented in the medical record. Medications not classified as anti-psychotic, anti-depressant, anti-anxiety, and hypnotic medication were not prescribed or administered as a substitution for another psychotropic medication unless there was a documented clinical indication consistent with clinical standard of practice. Consideration of the use of any psychotropic medication was based on a comprehensive review of the resident. That included an evaluation of the resident's signs and symptoms to identify underlying causes.

The facility failed to ensure an appropriate indication or a documented physician rationale for R8's Seroquel medication. This placed R8 at risk for unnecessary psychotropic medications and related complications.
- The "Diagnosis" tab of R32's Electronic Medical Record (EMR) documented diagnoses of anemia (an inadequate number of healthy red blood cells

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to carry adequate oxygen to body tissues), dementia (a progressive mental disorder characterized by failing memory and confusion), protein-calorie malnutrition, bipolar disorder (a major mental illness that causes people to have episodes of severe high and low moods), delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue), chronic pain, hypertension (high blood pressure), major depressive disorder (major mood disorder that causes persistent feelings of sadness), insomnia (inability to sleep), chronic pain, anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and dysuria (painful urination),

The "Annual Minimum Data Set" (MDS) dated 12/09/24 documented a Brief Interview of Mental Status (BIMS) score of three which documented severely impaired cognition. The MDS documented R32 required substantial to maximum assistance for eating, bathing, and dressing, and was dependent on staff for oral hygiene. The MDS documented R32 received antipsychotics during the observation period.

R32's "Psychotropic Drug Use Care Area Assessment" (CAA) dated 12/09/24 documented R32 triggered secondary to the use of psychotropic medication to manage psychiatric illness and conditions. A licensed nurse monitored for side effects every shift, and the physician was to be notified of any abnormal findings. A pharmacist consultant would review medications monthly, and the physician would review medications with each visit. Contributing factors included current history of depression, anxiety, and bipolar disease. Risk factors included increased falls, impaired balance, and a

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potential for adverse effects of medication. The care plan would be reviewed to monitor the effectiveness of psychotropic medication and any adverse effects of medication.

R32's "Care Plan" revised 12/13/24 documented R32 received psychotropic medications related to bipolar disorder (a major mental illness that causes people to have episodes of severe high and low moods), depression, and anxiety. R32 would be free of psychotropic drug-related complications including movement disorder, discomfort, hypotension, gait disturbance, constipation, or cognitive and behavioral impairment. Nursing staff were to administer psychotropic medications as ordered by the physician and monitor for side effects and effectiveness every shift. Nurses were to consult with the pharmacy and physician to consider dosage reduction when clinically appropriate at least quarterly, Nursing staff were to monitor and record the occurrence of target behavior symptoms every shift.

R32's EMR under the "Orders" tab documented the following physician's order:
Risperidone (antipsychotic) oral tablet 0.5 milligrams (mg) give one tablet by mouth two times a day for delusions dated 07/24/24.

A review of R32's EMR revealed no physician-documented rationale for the continued use of risperidone for delusions.

On 12/16/24 at 07:15 AM, R32 lay on the couch in the Northeast hallway. R32 had a blanket and pillow.

On 12/18/24 at 11:54 AM, LN H stated the

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appropriate indication for antipsychotic medication did not include dementia-related indications unless the resident had schizophrenia (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought), Huntington's disease (a rare abnormal hereditary condition characterized by progressive mental deterioration, a disabling central nervous system movement disorder), or Tourette's syndrome (condition of the nervous syndrome causing uncontrollable repetitive movements or unwanted sounds).

On 12/18/24 at 12:23 PM, Administrative Nurse D stated only CMS-approved indications should be used for antipsychotic medications. She stated delusions were not an appropriate indication for risperidone.

The facility's "Psychotropic Drug Use" policy revised July 2024 documented residents would not receive medications that were not clinically documented to treat a specific condition Residents, families, and/or the representative were involved in the medication management process. Residents who had not used psychotropic medications were not prescribed or given those medications unless the medication was determined to be necessary to treat a specific condition that was diagnosed and documented in the medical record. Medications not classified as anti-psychotic, anti-depressant, anti-anxiety, and hypnotic medication were not prescribed or administered as a substitution for another psychotropic medication unless there was a documented clinical indication consistent with clinical standard of practice. Consideration of the use of any psychotropic medication was

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based on a comprehensive review of the resident. This included evaluation of the resident's signs and symptoms to identify underlying causes.

The facility failed to ensure an appropriate indication or a documented physician rationale for R32's risperidone fumarate medication. This placed R32 at risk for unnecessary psychotropic medications and related complications.

- The "Diagnosis" tab of R52's Electronic Medical Record (EMR) documented diagnoses of cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), aphasia (condition with disordered or absent language function), hemiparesis/hemiplegia (weakness and paralysis on one side of the body) affecting right dominant side, anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), dysphagia (swallowing difficulty), hypertension (high blood pressure), vascular dementia (a progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain), and major depressive disorder (major mood disorder that causes persistent feelings of sadness).

The "Quarterly Minimum Data Set" (MDS) dated 10/28/24 documented a Brief Interview of Mental Status (BIMS) score of four which documented severely impaired cognition. The MDS documented R52 had an impairment on one side of her body. The MDS documented R52 needed partial to moderated assistance with dressing, toileting, and set up for eating. The MDS

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documented R52 received an antidepressant (a class of medications used to treat mood disorders) and antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) during the observation period.

R52's "Psychotropic Drug Use Care Area Assessment" (CAA) dated 05/16/24 documented R52 was admitted to the facility with a psychotropic medication and the physician would monitor R52's medication routinely. The MDS documented staff would monitor side effects of the medication for R52.

R52's "Care Plan" dated 08/05/2024 documented R52 had impaired cognitive function, dementia, or impaired thought processes related to dementia. R52 would be able to communicate basic needs daily. R52's plan of care documented staff would administer medications as ordered and monitor and document for side effects and effectiveness. Staff were to keep the R52's routine consistent and tried to provide consistent caregivers as much as possible to decrease confusion.

R52's EMR under the "Orders" tab documented the following physician's order:
Quetiapine fumarate (antipsychotic) 25 milligrams (mg) oral tablet give 0.5 tablet by mouth one time a day for behavioral disorders associated with dementia dated 07/17/24.

A review of R52's EMR revealed no physician-documented rationale for the continued use of quetiapine fumarate for behavior disorders with dementia.

On 12/16/24 at 07:32 AM, R52 sat at the dining

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room table eating her breakfast.

On 12/18/24 at 11:54 AM, Licensed Nurse (LN) H stated the appropriate indication for antipsychotic medication did not include dementia-related indications unless the resident had schizophrenia (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought), Huntington's disease (a rare abnormal hereditary condition characterized by progressive mental deterioration, a disabling central nervous system movement disorder), or Tourette's syndrome (condition of the nervous syndrome causing uncontrollable repetitive movements or unwanted sounds).

On 12/18/24 at 12:23 PM, Administrative Nurse D stated only CMS-approved indications should be used for antipsychotic medications. She stated that dementia was not an appropriate indication for quetiapine.

The facility's "Psychotropic Drug Use" policy revised July 2024 documented residents would not receive medications that were not clinically documented to treat a specific condition Residents, families, and/or the representative were involved in the medication management process. Residents who had not used psychotropic medications were not prescribed or given those medications unless the medication was determined to be necessary to treat a specific condition that was diagnosed and documented in the medical record. Medications not classified as anti-psychotic, anti-depressant, anti-anxiety, and/or hypnotic medication were not prescribed or administered as a substitution for another psychotropic medication unless there

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F 758	Continued From page 45 was a documented clinical indication consistent with the clinical standard of practice. Consideration of the use of any psychotropic medication was based on a comprehensive review of the resident. This included evaluation of the resident's signs and symptoms to identify underlying causes. The facility failed to ensure an appropriate indication or a documented physician rationale for R52's quetiapine fumarate medication. This placed R52 at risk for unnecessary psychotropic medications and related complications.	F 758		
F 801 SS=F	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization	F 801		

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recognized for this purpose.
(ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional.
(iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section.
(iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law.

§483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services.
(i) The director of food and nutrition services must at a minimum meet one of the following qualifications-
(A) A certified dietary manager; or
(B) A certified food service manager; or
(C) Has similar national certification for food service management and safety from a national certifying body; or
D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; or

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(E) Has 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, 2023, that includes topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving; and
(ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and
(iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 58 residents and one kitchen. Based on record review and interviews, the facility failed to provide the services of a full-time certified dietary manager for the 58 residents who resided in the facility and received their meals from the kitchen. This placed the residents at risk for inadequate nutrition.

Findings included:

- On 12/16/24 at 07:26 AM, during the initial tour of the kitchen, Dietary Staff BB stated she had started the certified dietary manager course three years ago. Dietary Staff BB stated she had completed three months of the course before staffing shortages at the facility required her to return full-time in dietary. Dietary Staff BB stated the Registered Dietician (RD) came to the facility monthly.

On 12/18/24 at 01:10 PM, Administrative Staff A

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F 801	Continued From page 48 stated he was aware Dietary Staff BB was not certified. Administrative Staff A stated that was something that he would investigate. The Facility's "Dietitian" policy revised November 2024 documented that a qualified, competent, and skilled dietitian would help oversee the food and nutrition services in the facility. The facility failed to employ a full-time certified dietary manager to evaluate residents' nutritional concerns and oversee the ordering, preparing, and storage of food for the 58 residents in the facility, placing the residents at risk for inadequate nutrition.	F 801		
F 838 SS=F	Facility Assessment CFR(s): 483.71(a)(1)(3)(b)(1)(c)(1)-(5) §483.71 Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations (including nights and weekends) and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. §483.71(a) The facility assessment must address or include the following: §483.71(a)(1) The facility's resident population, including, but not limited to: (i) Both the number of residents and the facility's resident capacity;	F 838		

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F 838	Continued From page 49 (ii) The care required by the resident population, using evidence-based, data-driven "methods" that considering the types of diseases, conditions, physical and behavioral health needs, cognitive disabilities, overall acuity, and other pertinent facts that are present within that population, consistent with and informed by individual resident assessments as required under § 483.20; (iii) The staff competencies and skill sets that are necessary to provide the level and types of care needed for the resident population; (iv)The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.71(a)(2) The facility's resources, including but not limited to the following: (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, behavioral health, and specific rehabilitation therapies; (iv) All personnel, including managers, nursing and other direct care staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and	F 838		

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(vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations.

§483.71(a)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach as required in §483.73(a)(1).

§ 483.71(b) In conducting the facility assessment, the facility must ensure:
§ 483.71(b)(1) Active involvement of the following participants in the process:
(i) Nursing home leadership and management, including but not limited to, a member of the governing body, the medical director, an administrator, and the director of nursing; and
(ii) Direct care staff, including but not limited to, RNs, LPNs/LVNs, NAs, and representatives of the direct care staff, if applicable.
(iii) The facility must also solicit and consider input received from residents, resident representatives, and family members.

§483.71(c) The facility must use this facility assessment to:
§483.71(c)(1) Inform staffing decisions to ensure that there are a sufficient number of staff with the appropriate competencies and skill sets necessary to care for its residents' needs as identified through resident assessments and plans of care as required in § 483.35(a)(3).

§483.71(c)(2) Consider specific staffing needs for each resident unit in the facility and adjust as necessary based on changes to its resident population.

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§483.71(c)(3) Consider specific staffing needs for each shift, such as day, evening, night, and adjust as necessary based on any changes to its resident population.

§483.71(c)(4) Develop and maintain a plan to maximize recruitment and retention of direct care staff.

§483.71(c)(5) Inform contingency planning for events that do not require activation of the facility's emergency plan, but do have the potential to affect resident care, such as, but not limited to, the availability of direct care nurse staffing or other resources needed for resident care.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 58 residents. The sample included 15 residents. Based on observations, interviews, and record reviews, the facility failed to conduct a thorough facility-wide assessment to determine the resources necessary to care for residents competently during day-to-day operations and emergencies. This failure affected all 58 residents residing in the facility.

Findings Included:

- On 12/18/24 an inspection of the "Facility Assessment" was completed. The assessment was revised on 06/28/2024. A review of the evaluation revealed the following:

The assessment identified the average daily staffing required for the facility but failed to identify the specific staffing levels needed and the

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F 838	Continued From page 52 number of Registered Nurses (RN), Licensed Nurses (LPN/LVN), Certified Medication Aides (CMA), and Certified Nurse's Aides (CNA) needed for each unit, shift, and per census. The assessment lacked staffing levels required for each shift, including evenings and weekends. On 12/18/24 at 12:45 AM, Administrative Staff A stated the facility assessment was just revised. He stated he worked with Administrative Nurse A to complete the assessment based on the resident population, acuity, census, and needs of each resident to provide staffing. He stated the assessment was completed yearly based on the required guidelines. The facility's "Facility Assessment" policy revised October 2024 indicated the facility would complete an annual assessment to determine and update the capacity to meet the needs and competency of each resident. The facility failed to conduct a thorough, updated facility-wide assessment to determine what resources were necessary to care for residents competently during day-to-day operations and emergencies. This failure affected all 88 residents residing in the facility.	F 838		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880		

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§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.
(v) The circumstances under which the facility must prohibit employees with a communicable

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disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

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

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

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 58 residents. The facility identified one resident on 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). Based on record review, observations, and interviews, the facility failed to ensure the blood pressure cuff, pulse monitor, and oxygen saturation equipment were sanitized after each resident's use. This deficient practice placed the residents at risk for infectious diseases.

Findings included:

- On 12/16/24 at 07:47 AM, License Nurse (LN) I obtained a resident's blood pressure and pulse in the main dining room. LN I did not sanitize the pulse monitor or blood pressure cuff before or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175376	A. BUILDING _____ B. WING _____	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APOSTOLIC CHRISTIAN HOME	511 PARAMOUNT STREET SABETHA, KS 66534

(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 55	F 880		

after resident use.

On 12/17/24 at 07:18 AM, LN G obtained a resident's blood pressure, oxygen saturation, and pulse in the main dining room. LN G did not sanitize the blood pressure cuff, oxygen saturation monitor, or pulse monitor before or after resident use.

On 12/18/24 at 07:42 AM, LN G obtained the resident's blood pressure and pulse monitoring in the main dining room. LN G did not sanitize the blood pressure cuff or the pulse monitor before and after resident use.

On 12/18/24 at 11:55 AM, LN H stated all shared equipment was to be sanitized between resident use. LN H stated the facility had a sanitizer spray all staff could use.

On 12/18/24 at 12:18 PM, Administrative Nurse D stated it was the facility's expectation was all nursing staff sanitize shared equipment after each resident's use.

The facility's "Sanitizing Shared Equipment" dated September 2024 documented Resident-care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current CDC. Critical items consist of items that carry a high risk of infection if contaminated with any microorganism. Semi-critical items consist of items that may encounter mucous membranes or non-intact. Non-critical items are those that encounter intact skin but not mucous membranes. Non-critical items require cleaning followed by either low- or intermediate-level disinfection following manufacturers' instructions.

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F 880	Continued From page 56 The facility failed to ensure the blood pressure cuff, pulse monitor, and oxygen saturation equipment was sanitized after each resident's use. These deficient practices placed the residents at risk for infectious diseases.	F 880		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure	F 883		

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F 883	Continued From page 57	F 883		

that-
(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;
(iii) The resident or the resident's representative has the opportunity to refuse immunization; and
(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and
(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 58 residents. The sample included 15 residents, with five reviewed for immunization status. Based on record reviews and interviews, the facility failed to offer and administer or obtain informed declinations for the Pneumococcal Conjugate Vaccine (PCV20 - vaccination for bacterial pneumonia infections) vaccination for Resident (R) 32 and R52. This placed the residents at increased risk for complications related to pneumonia.

Findings included:

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F 883	Continued From page 58	F 883		

- Review of R32's clinical record revealed the PCV13 was administered on 11/30/17, and the PSV23 was administered on 08/30/13. R31's clinical record lacked documentation the PCV20 was offered or declined and lacked documentation of a historical administration or a physician-documented contraindication.

Review of R53's clinical record revealed the PCV13 was administered on 09/27/18, and the PSV23 was administered on 09/02/19. R53's clinical record lacked documentation the PCV20 was offered or declined and lacked documentation of a historical administration or a physician-documented contraindication.

On 12/18/24 at 12:18 PM, Administrative Nurse D stated the facility relied on WEB IZ (database-driven immunization registry system) to prompt the facility when an immunization needed to be given. She stated the facility did not offer the PCV20 if a resident had the PCV13 and PCV23. Administrative Nurse D stated R32 and R53 were not offered the PCV20.

The facility did not provide an immunization policy.

The facility failed to offer the PCV20 or obtain informed declinations for R32 and R53. This placed the residents at increased risk for complications related to pneumonia.