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	175379	A. BUILDING _____ B. WING _____	01/15/2025

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MENNONITE FRIENDSHIP COMMUNITIES INC	600 W BLANCHARD AVENUE SOUTH HUTCHINSON, KS 67505

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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey and Complaint Investigation 190332 and 191511. The 2567 was sent electronically on 1/28/25	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-	F 580		

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

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

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(A) A change in room or roommate assignment as specified in §483.10(e)(6); or
(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).
This REQUIREMENT is not met as evidenced by:
The facility had a census of 65 residents. The sample included 16 residents, with six reviewed for unnecessary medications. Based on observation, record review, and interview, the facility failed to notify the physician for blood sugars outside of physician ordered parameters for one resident, Resident (R) 34. This placed the resident at risk for hyperglycemic (greater than normal amount of glucose in the blood) and hypoglycemic (less than normal amount of sugar in the blood) episodes related to delayed physician involvement.

Findings included:

- The Electronic Medical Record (EMR) for R34 documented diagnoses of diabetes mellitus (DM - when the body cannot use glucose type 2, not

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

The "Annual Minimum Data Set" (MDS), dated 11/29/24, documented R34 had intact cognition. R34 was independent with all activities of daily living, except for supervision with showers. R34 received insulin (a hormone that lowers the level of glucose in the blood) daily.

R34's "Care Plan," dated 12/17/24, initiated on 12/04/24, directed staff to obtain Accu-checks (blood glucose monitoring test) as ordered, observe, and monitor for any signs and symptoms of hyperglycemia and or hypoglycemia. The care plan directed staff to administer medications as ordered. The update, dated 09/19/24, documented R34 was very active in managing his blood sugar routines and had a Dexcom blood glucose monitoring machine (a continuous glucose monitor that tracked your blood sugar without finger pricks). The nurses would help change Dexcom as needed and ordered.

R34's "Physician's Order," dated 07/02/24, directed staff to notify the physician if his blood sugar was less than 90 milliliters (ml) per deciliter (dl) or greater than 300 ml/dl, at 07:30 AM, 11:30 AM, 05:30 PM, and at hour of sleep (HS) for a total of four times per day for diabetes mellitus, type 2.

The "Physician's Order," dated 08/1/24 directed staff to administer Humalog (a rapid-acting insulin

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used to lower blood glucose) insulin sliding scale with meals:
131-180-2U
181-240-4U
241-300-6U
301-350-8U
351-400-10U for dm type 2

R34's "Nurse Treatment Record," dated December 2024, documented the following days R34's blood sugar was out of parameters and the physician was not notified:
12/03/24 at HS- 301 ml/dl
12/06/24 at 0530 PM- 302 ml/dl
12/15/24 at 11:30 AM- 376 ml/dl
12/15/24 at HS- 303 ml/dl
12/16/24 at 11:30 AM- 320 ml/dl
12/16/24 at 05:30 PM- 312 ml/dl
12/21/24 at HS- 343 ml/dl
12/28/24 at HS- 354 ml/dl

R34's "Nurse Treatment Record," dated January 2025, documented the following days R34's blood sugar was out of parameters and the physician was not notified:
01/06/25 at 11:30 AM- 303
01/06/25 at HS- 316
01/09/25 at 11:30 AM- 302
01/14/25 at 1130 AM- 310

On 01/14/25 at 11:00 AM, R34 was at the treatment cart with his glucometer and it read 310 ml/dl. Licensed Nurse (LN) G administered 8 units of Humulog insulin to R34.

On 01/14/25 at 12:15 PM, LN G stated that R34 did have orders to notify the physician if his blood sugars were out of the ordered parameters. LN G verified that she should have contacted the

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F 580	Continued From page 4 physician when R34's blood sugar was out of parameters. LN G further stated R34 liked to be in control of his blood sugars. LN G stated the physician felt R34 was on too much insulin, but the family did not want anything changed at this time. On 01/15/25 at 11:02 AM, Administrative Nurse D stated nursing staff should follow the physician's orders and notify the physician when the blood sugars were out of parameters. The facility's "Guidelines For Notifying Physician of Clinical Problems", dated 01/23, documented, clinical care problems and significant changes in condition of residents must be communicated to the resident's physician, the resident's physician's designee or the facility medical director in a timely efficient and effective manner. Staff are to notify the physician whenever there is a need to alter treatment significantly, a significant change in resident's condition, and should a resident develop a clinical problem that required physician intervention. The facility failed to notify the physician as ordered when R34's blood sugar was out of the physician-ordered parameters. This placed the resident at risk for hyperglycemic and hypoglycemic episodes related to delayed physician involvement.	F 580		
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a	F 640		

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facility must encode the following information for each resident in the facility:
(i) Admission assessment.
(ii) Annual assessment updates.
(iii) Significant change in status assessments.
(iv) Quarterly review assessments.
(v) A subset of items upon a resident's transfer, reentry, discharge, and death.
(vi) Background (face-sheet) information, if there is no admission assessment.

§483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.

§483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following:
(i)Admission assessment.
(ii) Annual assessment.
(iii) Significant change in status assessment.
(iv) Significant correction of prior full assessment.
(v) Significant correction of prior quarterly assessment.
(vi) Quarterly review.
(vii) A subset of items upon a resident's transfer, reentry, discharge, and death.
(viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment.

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§483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 65 residents. The sample included 16 residents. Based on record review and interview the facility failed to verify the Center for Medicare and Medicaid Services (CMS) received transmissions of the Minimum Data Set (MDS) containing the Resident Assessment Instruments (RAI) for two of 65 residents, R34 and R37.

Findings included:

- R34's Comprehensive MDS, dated 12/09/24, was completed and signed but not submitted to CMS.

R37's Quarterly MDS, dated 09/27/24, was submitted but not received by CMS.

On 01/14/25 at 01:00 PM, Licensed Nurse (LN) K verified the two resident's MDS had not been received by CMS and stated she was responsible to ensure they were submitted and accepted.

The facility's "MDS Process" policy, dated 11/2022, stated staff were to transmit the MDS within seven days of completion.

The facility failed to verify CMS received transmissions of the MDS containing the Resident Assessment Instruments for R34 and R37.

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F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689		

§483.25(d) Accidents.
The facility must ensure that -
§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and

§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 65 residents. The sample included 16 residents. Based on observation, record review, and interview the facility failed to ensure an environment free from accident hazards when staff left an activated steam table in an unlocked closet, with an unsecured gate, and the coffee station left accessible to residents with an unclosed gate. This placed the eight cognitively impaired independently mobile residents at risk for preventable accidents or injuries.

Findings included:

- On 01/13/25 at 10:10 AM observation revealed an activated steam table located in the 100-hall dining room in an unlocked open bifold door closet, with an unlocked combination padlock on the left-hand side of the trifold wooden white gate, in front of the closet.

On 01/13/25 at 10:11 AM, Certified Nurse Aide (CNA) M verified that there was an activated steam table located in the 100-hall dining room in an unlocked bifold door closet, with an unlocked combination padlock on the left-hand side of the

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trifold wooden white gate. CNA M stated she was unaware who was responsible for keeping the gate locked, she never messed with it. CNA M stated it was probably dietary staff.

01/13/25 at 10:18 AM, Certified Dietary Manager (CDM) BB verified the left side of the gate should be secured with the combination padlock when the steam table was activated but she did not know the combination. CDM BB checked the water temperature in the first steam table pan on the left and it was 158.5 degrees Fahrenheit (F). The water temperature of the middle steam table pan was 160.1F. The third pan was empty. The CDM BB checked the top metal part of the steam table around the pans, and it was 98F. CDM BB stated she would not want a resident to touch it. CDM BB turned off the steam table and locked the gate.

On 01/13/25 at 11:46 AM, an activated steam table was located in the southwest 100 hall dining room closet with the left-hand side of the white gate unlocked, without staff present. Resident (R) 31 sat in a chair at a table on the far side of the dining room. Observation revealed at 11:52 AM Dietary Staff (DS) DD propelled R22 into the dining room in a wheelchair to the same table, then left the dining room. At 11:55 AM R50 ambulated into the dining room and sat at the same table. At 11:58 AM R28 ambulated with a walker with an aide, sat at the same table, then left the dining room, with the gate still unlocked. Further observation revealed DS DD returned to the dining room and served the residents their noon meals.

On 01/15/25 at 10:40 AM, Administrative Nurse D stated she expected staff to lock the gate in the

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southwest 100 hall dining room, when the steam table was activated or remain in the dining room when the steam table was activated.

The facility's "Use of Steam Table in Dining Area Policy," revised in 2020, documented that once the steam table is in the serving location, it is plugged in to help maintain food temperatures and must be continually staffed by an employee. A steam table is never left unattended in an area readily accessible to residents.

The facility failed to ensure the resident environment remained free from accident hazards when staff left an activated steam table unsupervised and unlocked. This placed the eight cognitively impaired independently mobile residents at risk for preventable accidents or injuries.

- On 01/14/25 at 03:55 PM, observation revealed no staff in the area or sight of the beverage station with the gate open. The beverage station area included a hot chocolate machine and a coffee dispensing machine with two push-button spigots. The kitchen door was closed and only one resident was at the very far end of the large room.

On 01/14/25 at 04:00 PM, CDM BB obtained coffee temperatures from the coffee dispensers at 157F and 160F. CDM BB verified staff should place the security gate to close access to the beverage station area when they were not in the area to monitor access.

The facility's " Precautions for Handling Hot Beverages Policy, revised in 2020, documented that coffee and hot beverage equipment should

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F 689	Continued From page 10 be placed in areas that would be safe for residents. If self-serve stations are available, consider a dispenser to minimize spillage. The facility failed to ensure an environment free from accident hazards when staff left the beverage station gate open. This placed the eight cognitively impaired independently mobile residents at risk for preventable accidents or injuries.	F 689		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: The facility had a census of 65 residents. The	F 693		

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sample included 16 residents of which one was reviewed for the G-Tube (Gastrostomy- surgical creation of an artificial opening into the stomach through the abdominal wall) feeding management. Based on observation, record review, and interview, the nurse failed to listen for the placement of the G-tube before administering medications and nutritional feeding for Resident (R)45. This placed the resident at risk for complications related to the feeding tube.

Finding included:

- R45's Electronic Health Record (EHR) revealed diagnoses of recorded a diagnosis of dysphasia (swallowing disorder), and cerebral infarct (damage to tissue in the brain due to loss of oxygen in the area).

R 45's "Quarterly Minimum Data Set" (MDS), dated 12/04/24, recorded R45 had short- and long-term memory loss with severely impaired cognition. The MDS recorded R45 required extensive assistance with transfers, bed mobility, dressing, toilet use, and personal hygiene. The MDS recorded the resident had a feeding tube.

R45's "Care Plan," dated 11/29/24, recorded R45 required a tube feeding for nutritional maintenance. The care plan directed the staff to administer tube feedings per physician order, assess tube placement, patency, and residual every shift including before and after meals and after administration of any fluids. The care plan documented staff could give medications as "cocktail" per physician order. The care plan recorded staff would report to the physician any side effects of abdominal pain from the abdominal binder, abdominal distention

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constipation or diarrhea.

R45's "Physician Order" dated 12/26/24, directed the staff to administer Isosource (liquid nutritional supplement), 1.5 calorie per milliliter (ml), six ounces (oz) per G-Tube four times a day. The order directed staff to crush medications, and dissolve in water, then administer the medication with a total of 200 ml of water per feeding and medication administration.

On 01/13/24 at 04:00 PM, Licensed Nurse (LN) I crushed the resident medications and added a small amount of water to dissolve the medications before administering per G-tube. LN I administered 50 ml of water followed by the following medications; Cyclobenzaprine (muscle relaxant) 5 milligram (mg) one tablet, Pepcid (antiacid) 40 mg, one tablet, Lopressor (lowers blood pressure) 100 mg one tablet, Tramadol (pain relief) 500 mg, one tablet. Then administer 6 oz of Isorsource 1.5 calorie per ml nutritional supplement followed by 50 ml of water, and approximately 100 ml of water with the nutritional supplement. LN G failed to listen for placement or check stomach residual prior to administration of medications and nutritional supplements.

On 01/15/25 at 09:10 AM, Administrative Nurse D verified the nursing staff were to check placement prior to administering medication and feedings. Administrative Nurse D verified she would have a mini-in-service to re-educate the staff regarding the G-tube protocol including how and when to check placement.

The facility's "Enteral Tube Use and Care" policy, dated 11/2022, documented the policy of the facility is to utilize feeding tubes in accordance

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F 693	Continued From page 13 with physician orders and current clinical standards of practice, with interventions to prevent complications to the extent possible. The policy documented to initiate bolus tube feeding clamp or pinch the distal end of gastrostomy tube, minimize the air flow potential until the syringe was attached. The policy documented to attach the syringe to the end of the tube, elevate the tube above the resident's abdomen, fill the syringe with formula, and allow the syringe to empty gradually, refilling until the prescribed amount has been delivered, and then flush with the prescribed amount of lukewarm water as ordered. The policy documented if the resident has continuous feeding to check for residual if the physician ordered it, and verify placement of tube by aspirating stomach contents. The Nurse failed to check R45's G-tube placement, prior to medication administration and nutritional feeding, as ordered, placing the resident at risk for complications related to the G-tube.	F 693		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.	F 756		

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F 756	Continued From page 14 (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 had a census of 65 residents. The sample included 16 residents, with six reviewed for unnecessary medications. Based on observation, record review, and interview, the facility failed to ensure the Consultant Pharmacist (CP) identified and reported the lack of an appropriate indication or required physician documentation for Resident (R) 38's and R27's use of an antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) medication and for the lack of a specific 14-day stop date for R38's as	F 756		

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needed (PRN) Ativan (an antianxiety medication). This placed the residents at risk for inappropriate use of medication and related complications.

Findings included:

- The Electronic Medical Record (EMR) for R38 documented diagnoses of dementia without behavior disturbance (a progressive mental disorder characterized by failing memory and confusion), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest).

The "Quarterly Minimum Data Set" (MDS), dated 12/05/24, documented R38 had moderately impaired cognition. R38 was dependent upon staff for toileting, lower body dressing, mobility, and transfers. R38 was always incontinent of bladder and frequently incontinent of bowel and had rejected care one to three days of the seven-day look-back period. R38 received an antipsychotic, an antianxiety (a class of medications that calm and relax people), an antidepressant (a class of medication used to treat mood disorders), and an opioid (a class of controlled drugs used to treat pain).

R38's "Care Plan," dated 12/17/24, initiated on 04/23/21, directed staff to administer medication as ordered, observe for nonverbal signs of anxiety, and determine any behavior cycles or events. The update, dated 02/14/23, directed staff to offer visits to a mental health center, and involve family. The update, dated 01/18/24, directed staff to listen to her frustrations and concerns, provide reassurance, and provide all

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care with two staff members. The update, dated 04/29/24, directed staff to offer reassurance if tearful or upset, and to encourage R38 to attend activities. R38's care plan directed staff to smile and compliment R38 to promote feelings of belonging and importance.

The "Physician's Order," dated 08/12/24, directed staff to administer Ativan (an antianxiety medication), 1 milligram (mg), one to two tablets, by mouth, every four to six hours, as needed, for anxiety. The EMR documented a stop date of 01/01/2035.

The "Physician's Order," dated 08/21/24, directed staff to administer Seroquel (an atypical antipsychotic medication), 100 mg, by mouth, twice per day, for depression.

R38's EMR lacked evidence of a physician documented rationale which included the risks versus benefits for R38's Seroquel.

The CP's monthly medication review (MMR) for R38 recorded on 07/15/24 documented R38 received PRN Ativan and did not have a specific stop date which was required, the physician responded with "none." The 07/29/24 MRR documented R38 had a diagnosis of depression for her Seroquel which was not acceptable and asked the physician if there was a different diagnosis he wanted to use and if he wanted to reduce the medication. The physician documented "do not reduce" and had not provided an appropriate diagnosis or indication for the use of the Seroquel. The MRR dated 08/30/24 documented R38 received PRN Ativan and to please provide a specific stop date as the surveyors could question it if it was over six

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months to a year, due to the patient needing to be reassessed on a regular basis. The physician documented "lifetime." The MRR for 09/29/24, 10/30/24, 11/28/24, and 12/30/24 did not make any recommendation or indication for continued use of Seroquel or a 14-day stop date for the PRN Ativan.

On 01/14/25 at 07:45 AM, R38 received her medication without concern and was very pleasant and joked with staff.

On 0/14/25 at 08:00 AM, Certified Nurse Aide (CNA) O stated R38 could be rude at times if staff failed to get what R38 wanted right away. CNA O further stated two staff go to her room to provide cares as she has accused staff of not providing care.

On 01/15/25 at 09:55 AM, Licensed Nurse (LN) I stated, R38 had some behaviors and could be rude to staff. LN I stated R38 received Seroquel twice per day and had as needed anxiety medication if she needed it. LN I stated R38 went to a mental health professional every couple of months and staff charted if she had behaviors.

On 01/15/25 at 10:47 AM, Administrative Nurse D stated she was unaware the diagnosis for R38's Seroquel was not an approved diagnosis, and would work with the physician to obtain a rationale for the diagnosis. Administrative Nurse D further stated, that the stop date for the as needed Ativan was not correct and was unsure if it was entered incorrectly. Administrative Nurse D stated the pharmacy had not reported any recommendations for the Seroquel diagnosis or the stop date for the PRN Ativan after the August 2024 review.

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The facility's "Medication Review and Pharmacist Notification to Physician" policy, dated 03/17/23, documented the consultant pharmacist documents in the resident's clinical record that the drug regimen review had been performed including a review of unnecessary drugs. The pharmacist provides monitoring of the resident's response to treatment and care, complications of adverse consequences of the treatments, irregularity of any event that was inconsistent with approaches to providing pharmaceutical services, and duration of medication. The licensed pharmacist reviewed each resident's medical and drug regimen at least monthly for skilled and long-term care residents. The licensed pharmacist would report any irregularities to the attending physician, the medical director, and the director of nursing. The physicians and director of nursing should provide timely responses to irregularities identified as a result of the resident's medication regimen review.

The facility failed to ensure the CP identified and reported the lack of an appropriate indication for the use of Seroquel, an antipsychotic medication, and for the lack of a specific 14-day stop date for R38's PRN Ativan. This placed the resident's at risk for inappropriate use of medication and related complications.
- R27's "Electronic Medical Record" documented diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure) and recurrent major depressive disorder (MDD - mood disorder that causes a persistent feeling of sadness and loss of interest).

The "Quarterly Minimum Data Set" (MDS), dated

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10/08/24, documented a Brief Interview for Mental Status (BIMS) score of 10, indicating moderately impaired cognition. The MDS documented R27 had verbal behaviors, was independent with eating, wheelchair mobility, required supervision for walking, and moderate staff assistance for dressing and transfers. The MDS documented R27 received an antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) medication, and the physician documented a dose reduction was clinically contra-indicated.

The "Psychotropic Drug Use Care Plan," dated 10/22/24, directed staff to observe for nonverbal signs of anxiety, restlessness, trembling, or pacing. Administer Risperdal as ordered. See the Black Box Warning (BBW- highest safety-related warning that medications can have assigned by the Food and Drug Administration) in the physician orders and follow pharmacy recommendations. R27's disruptive behavior problems related to inappropriate statements or questions towards staff and residents such as "Are you a man or a woman," repetitive questions, yelling at staff, and taunting other residents. The care plan directed staff to remind R27 that this type of talk is inappropriate, reapproach him as needed, or try using different staff members. Staff were to assess whether R27 understood what he was doing, and all staff were to be consistent with the handling of behaviors. R27's care plan directed staff to have R27 sit with other men in the dining room, notify the provider of increased behaviors, and document the behaviors. Staff were to escort R27 to and from the dining room to help ensure that R27 did not make comments to other residents that were upsetting to them.

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The "Physician Order," dated 08/28/23, directed staff to administer Risperdal (an antipsychotic drug), 0.5 milligrams (mg) (½ tab) at bedtime for recurrent MDD.

The "Consultant Pharmacist Recommendation," dated 08/28/23, requested clarification of the diagnosis for Risperdal and if using for a non-approved diagnosis requested thorough documentation describing what has been tried and failed and why the severity of the symptoms justified the use of the drug. The provider wrote the patient was admitted on these medications for dementia with behaviors and they were actively working on dose reduction as they had not seemed to be necessary at this time. No rationale for the continued use of Risperdal was written.

The fax note to the physician, dated 12/02/23, stated R27 had some behaviors in the last month such as repetitively asking if you are a man or woman, looking down staff shirts, and saying, "I can tell you're a woman." The spouse stated his psychotropic medications were decreased and she would like them changed back or changed to something a different medication.

The "Physician Order," dated 12/13/23, increased Risperdal to 0.5 mg twice daily for MDD.

The "Consultant Pharmacist Recommendation," dated 06/29/24, requested an approved diagnosis for Risperdal, or a GDR (gradual dose reduction). The physician had not provided a rationale for the continued use of Risperdal for dementia with behaviors.

The "Physician Order," dated 07/07/24,

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decreased Risperdal to 0.25 mg, twice daily, for dementia (progressive mental disorder characterized by failing memory, and confusion) with behaviors.

The facility's fax to the physician, dated 09/06/24 fax to PCP stated no behaviors of psychosis, hallucinations, or harmful behaviors were documented. Do you want to re-evaluate if Risperdal should be continued? PCP responded- had been decreased in the past, and no rationale was written.

Review of progress notes from 06/01/24 to 01/10/25 revealed one note documented personal sexual behavior on 09/02/24 at 01:29 AM, and a behavior note regarding a sexual comment on 12/07/24. The progress notes lacked any other behavior incidents.

The "Consultant Pharmacist Recommendation," dated 12/30/24, requested a GDR for Risperdal. The physician wrote that Risperdal was decreased.

The "Physician Order," dated 01/10/25, directed staff to decrease Risperdal to 0.5 mg (1/2 tab) at bedtime. The order was documented to be noted by a facility nurse on 01/10/25.

The January 2025 Medication Administration Record (MAR) did not show any change in the dose of Risperdal starting 01/10/25 to 01/14/25. The MAR had documentated staff administered 0.5 mg (1/2 tab) twice daily on 01/11/25, 01/12/25, 01/13/25, and 01/14/25, which was four doses more than the physician ordered.

The fax note to the physician, dated 01/14/25,

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stated R27's spouse would like to decline the Risperdal change, and stated she did not like the aggressive comments he has made.

The "Physician Order," dated 01/14/25, Risperdal 0.5 mg tablet 1/2 tab (0.25 mg) by mouth daily, twice daily For Dementia with Behaviors

January 2025 Point of Care documentation for verbal behavioral symptoms directed toward others was all 0s. Physical hitting, kicking, pushing, scratching, grabbing, and sexual were all 0s. Other physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, verbal/vocal symptoms like screaming, disruptive sounds, and or rejection of care. All shifts documented no behaviors in January.

On 01/13/25 at 02:52 PM, R27 sat in a recliner in his room. He asked the surveyor questions about education and religion but was not upset, angry, or confrontational.

On 01/14/25 at 04:12 PM, Certified Nurse Aide (CNA) P assisted R27 to stand with a gait belt and walker. She provided incontinence care, changed gloves, and placed a clean brief on R27. The resident sat back down in his recliner to wait for his wife. The resident was pleasant and very cooperative.

On 01/14/25 at 12:10 PM, Administrative Nurse D stated when the pharmacist consultant recommended documentation of behaviors the staff sent the request to the physician to reduce or discontinue the Risperdal due to a lack of behaviors.

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On 01/14/25 at 01:55 PM, Licensed Nurse (LN) H stated she had not observed the resident display angry or harmful behaviors. LN H stated the spouse reported the resident became verbally aggressive when visiting her at the independent living facility. LN H verified staff had not changed the MAR to reflect the 01/10/24 physician order to decrease the Risperdal. The order to keep the Risperdal dose at twice daily came on 01/14/25. She verified the resident had received Risperdal twice daily from 01/11/25 through 01/14/25 and should not have.

On 01/15/25 at 09:55 AM, Administrative Nurse D verified staff should have followed the physician's order of 01/10/25 to decrease the dose of Risperdal.

The facility's "Psychotropic Medication Use" policy, dated 11/2022, stated residents who used psychotropic drugs would receive a gradual dose reduction and behavioral interventions unless clinically contraindicated. This was to ensure the elder did not receive unnecessary medications and the lowest possible dose would be administered for the shortest amount of time. The elder's need for psychotropic medication would be monitored and when the medication could be lowered or discontinued. The attending physician must certify that a psychotropic medication was necessary to treat a specific condition or behavior. Behaviors for which these drugs are used must present a danger for elders or others, interfere with the staff's ability to provide care or cause the elder "frightful distress" due to paranoia, hallucinations, or delusions. The consultant pharmacist would review the appropriateness of all medication orders for

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medications to be administered by staff. The drug dosage must be periodically reduced with the goal of discontinuing it or replacing it with another less potent prescription. All antipsychotics would be tapered as a gradual dose reduction unless clinically contraindicated. After the first year a GDR would be attempted annually unless clinically contraindicated. For any elder receiving an antipsychotic to treat behavioral symptoms related to dementia, the GDR may be clinically contraindicated if the elder's target symptoms returned or worsened after the most recent attempt at a GDR and the physician has documented the clinical rationale for why any additional attempted dose reduction would be likely to impair the resident's function or increase distressed behavior.

The "Consultant Pharmacist Medication Review" policy, dated 03/17/23, stated the consultant pharmacist would document in the resident's clinical record that the drug regimen review has been performed including a review of unnecessary drugs. The pharmacist would provide monitoring of the resident's response to treatment and care, complications of adverse consequences of the treatments, irregularity of any event that was inconsistent with approaches to providing pharmaceutical services, and duration of medication. The licensed pharmacist reviewed each resident's medical and drug regimen at least monthly for skilled and long-term care residents. The licensed pharmacist would report any irregularities to the attending physician, the medical director, and the director of nursing. The physicians and director of nursing should provide timely responses to irregularities identified as a result of a resident's medication regimen review.

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F 756	Continued From page 25 The facility failed to follow the consultant pharmacist's recommendation to obtain the physician's rationale for the continued use of the antipsychotic Risperdal for R27 who had a diagnosis of Alzheimer's dementia, placing R27 at risk for adverse effects of the antipsychotic medication.	F 756		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: The facility had a census of 65 residents. The sample included 16 residents, with six reviewed for unnecessary medications. Based on	F 757		

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observation, record review, and interview, the facility failed to notify the physician of blood sugars outside of physician ordered parameters for one resident, Resident (R) 34. This placed the resident at risk for hyperglycemic (greater than normal amount of glucose in the blood) and hypoglycemic (less than normal amount of sugar in the blood) episodes and adverse effects related to medications.

Findings included:

- The Electronic Medical Record (EMR) for R34 documented diagnoses of diabetes mellitus (DM - when the body cannot use glucose type 2, not enough insulin made, or the body cannot respond to the insulin), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and anxiety (a mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear).

The "Annual Minimum Data Set" (MDS), dated 11/29/24, documented R34 had intact cognition. R34 was independent with all activities of daily living, except for supervision with showers. R34 received insulin (a hormone that lowers the level of glucose in the blood) daily.

R34's "Care Plan," dated 12/17/24, initiated on 12/04/24, directed staff to obtain Accu-checks (blood glucose monitoring test) as ordered, observe, and monitor, any signs and symptoms of hyperglycemia and hypoglycemia. The care plan directed staff to administer medications as ordered. The update, dated 09/19/24, documented R34 was very active in managing his own blood sugar routines and had a Dexcom blood glucose monitoring machine (a continuous

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glucose monitor that tracked your blood sugar without finger pricks). The nurses would help change Dexcom as needed and ordered.

R34's "Physician's Order," dated 07/02/24, directed staff to notify the physician if his blood sugar was less than 90 milliliters (ml) per deciliter (dl) or greater than 300 ml/dl, at 07:30 AM, 11:30 AM, 05:30 PM, and at hour of sleep (HS) for a total of four times per day for diabetes mellitus, type 2.

The "Physician's Order," dated 08/1/24 directed staff to administer Humalog (a rapid-acting insulin used to lower blood glucose) insulin sliding scale with meals:
131-180-2U
181-240-4U
241-300-6U
301-350-8U
351-400-10U for dm type 2

R34's "Nurse Treatment Record," dated December 2024, documented the following days R34's blood sugar was out of parameters and the physician was not notified:
12/03/24 at HS- 301 ml/dl
12/06/24 at 0530 PM- 302 ml/dl
12/15/24 at 11:30 AM- 376 ml/dl
12/15/24 at HS- 303 ml/dl
12/16/24 at 11:30 AM- 320 ml/dl
12/16/24 at 05:30 PM- 312 ml/dl
12/21/24 at HS- 343 ml/dl
12/28/24 at HS- 354 ml/dl

R34's "Nurse Treatment Record," dated January 2025, documented the following days R34's blood sugar was out of parameters and the physician was not notified:

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F 757	Continued From page 28 01/06/25 at 11:30 AM- 303 01/06/25 at HS- 316 01/09/25 at 11:30 AM- 302 01/14/25 at 1130 AM- 310 On 01/14/25 at 11:00 AM, R34 was at the treatment cart with his glucometer and it read 310 ml/dl. Licensed Nurse (LN) G administered 8 units of Humulog insulin to R34. On 01/14/25 at 12:15 PM, Licensed Nurse G stated R34 had orders to notify the physician if his blood sugars were out of the ordered parameters and verified that she should have contacted the physician when R34's blood sugar was out of parameters. Licensed Nurse G further stated R34 liked to be in control of his blood sugars. R34's physician felt he was on too much insulin but the family did not want anything changed at this time. On 01/15/25 at 11:02 AM, Administrative Nurse D stated nursing staff should follow the physician's orders and notify the physician when the blood sugars were out of parameters. The facility's "Guidelines For Notifying Physician of Clinical Problems", dated 01/23, documented clinical care problems and significant changes in condition of residents must be communicated to the resident's physician, the resident's physician's designee, or the facility medical director in a timely efficient and effective manner. Staff are to notify the physician whenever there is a need to alter treatment significantly, a significant change in resident's condition, and should a resident develop a clinical problem that required physician intervention. The facility's "Blood Glucose Monitoring" policy,	F 757		

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F 757	Continued From page 29 revised on 03/23, documented if the resident's test result was outside acceptable parameters, whether as ordered by the ordering physician or less than 50 ml/dl or greater than 400 ml/dl, by glucometer, and the resident is symptomatic requiring immediate intervention, care would be provided in accordance with the physician orders or standard, best practice procedure. If the resident had a diagnosis of hyperglycemia, insulin would be administered only upon the order of a physician. The facility failed to notify the physician as ordered when R34's blood sugar was out of the physician-ordered parameters. This placed the resident at risk for complications and adverse effects related to medications.	F 757		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented	F 758		

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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 the appropriateness of that medication.
This REQUIREMENT is not met as evidenced by:
The Facility had a census of 65 residents. The sample included 16 residents, with six reviewed for unnecessary medications. Based on observation, record review, and interview, the facility failed to ensure Resident (R)38 and R27 had an approved diagnosis or a physician-documented rationale which included risks versus benefits for R38's use of Seroquel (antipsychotic - class of medications used to treat

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major mental conditions which cause a break from reality) and for R27's use of Risperdal (an antipsychotic medication) The facility further failed to ensure a 14-day stop date to be reassessed on a regular basis for R38. This placed the residents at risk for unnecessary medications and related complications.

Findings included:

- The Electronic Medical Record (EMR) for R38 documented diagnoses of dementia without behavior disturbance (a progressive mental disorder characterized by failing memory and confusion), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and depression (depression (a mood disorder that causes a persistent feeling of sadness and loss of interest).

The "Quarterly Minimum Data Set" (MDS), dated 12/05/24, documented R38 had moderately impaired cognition. R38 was dependent upon staff for toileting, lower body dressing, mobility, and transfers. R38 was always incontinent of bladder and frequently incontinent of bowel and had rejected care one to three days of the seven-day look-back period. R38 received an antipsychotic, an antianxiety (a class of medications that calm and relax people, an antidepressant (a class of medications used to treat mood disorders), and an opioid (a class of controlled drugs used to treat pain).

R38's "Care Plan," dated 12/17/24, initiated on 04/23/21, directed staff to administer medication as ordered, observe for nonverbal signs of anxiety, and determine any behavior cycles or events. The update, dated 02/14/23, directed staff

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to offer visits to a mental health center, and involve family. The update, dated 01/18/24, directed staff to listen to her frustrations and concerns, provide reassurance, and provide all care with two staff members. The update, dated 04/29/24, directed staff to offer reassurance if tearful or upset. R38's care plan directed staff to encourage R38 to attend activities, smile, and compliment R38 to promote feelings of belonging and importance

The "Physician's Order," dated 08/12/24, directed staff to administer Ativan (an antianxiety medication), 1 milligram (mg), one to two tablets, by mouth, every four to six hours, as needed, for anxiety. The EMR documented a stop date of 01/01/2035.

The "Physician's Order," dated 08/21/24, directed staff to administer Seroquel, 100 mg, by mouth, twice per day, for depression.

R38's EMR lacked evidence of a physician-documented rrationalewhich included the risks versus benefits for R38's Seroquel.

On 01/14/25 at 07:45 AM, R38 received her medication without concern and was very pleasant and joked with staff.

On 0/14/25 at 08:00 AM, Certified Nurse Aide O stated R38 could be rude at times if you don't get what she wants right away. CNA O further stated two staff go to her room to provide care as she has accused staff of not providing care.

On 01/15/25 at 09:55 AM, Licensed Nurse (LN) I stated, R38 had some behaviors and could be rude to staff. LN I stated R38 received Seroquel

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twice per day, and did have as needed (PRN) anxiety medication if she needed it. LN I stated R38 did go to a mental health professional every couple of months and staff chart if she had behaviors.

On 01/15/25 at 10:47 AM, Administrative Nurse D stated she was unaware the diagnosis for R38's Seroquel was not an approved diagnosis and would work with the physician to obtain a rationale for the diagnosis. Administrative Nurse D further stated, that the stop date for the PRN Ativan was not correct and was unsure if it was entered incorrectly.

The facility's "Psychotropic Medication Use" policy, dated 11/22, documented residents would not receive psychotropic drugs pursuant to a PRN order unless that medication was necessary to treat a diagnosed specific condition that was documented in the clinical record. PRN orders for psychotropic drugs are limited to 14 days, except as provided, if the attending physician or prescribing practitioner believed that it is appropriate for the PRN order to be extended beyond 14 days. The physician was required to document their rationale in the resident's medical record and indicate the duration of the PRN order. All physician orders for antipsychotic medications would be clear and accurate and would include a diagnosis, condition, or indication for use; and the consultant pharmacist would review the appropriateness of all medication orders for medications to be administered by clinical staff. The
attending physician must certify that a psychotropic medication was necessary to treat a specific condition/behavior the antipsychotic medication would be prescribed only when

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indicated by assessment and medical necessity and after nonpharmacological interventions or alternatives have been considered or used all orders would be clear, and accurate and would in include a diagnosis, condition or indication for use, and the pharmacist would review the appropriateness of all medication orders.

The facility failed to obtain an appropriate physician rationale or indication of the use of R38's Seroquel and failed to ensure a stop date for the PRN Ativan. This placed the resident at risk for unnecessary medications and related complications.
- R27's "Electronic Medical Record" documented diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure) and recurrent major depressive disorder (MDD- mood disorder that causes a persistent feeling of sadness and loss of interest).

The "Quarterly Minimum Data Set" (MDS), dated 10/08/24, documented a Brief Interview for Mental Status (BIMS) score of 10, indicating moderately impaired cognition. The MDS documented R27 had verbal behaviors, was independent with eating, wheelchair mobility, required supervision for walking, and moderate staff assistance for dressing and transfers. The MDS documented R27 received antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) medication, and the physician documented a dose reduction was clinically contra-indicated.

The "Psychotropic Drug Use Care Plan," dated 10/22/24, directed staff to observe for nonverbal signs of anxiety, restlessness, trembling, or

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pacing. Administer Risperdal as ordered. See the Black Box Warning (BBW - highest safety-related warning that medications can have assigned by the Food and Drug Administration) in the physician orders and follow pharmacy recommendations. Disruptive Behavior Problems related to inappropriate statements or questions towards staff and residents such as "Are you a man or a woman," repetitive questions, yelling at staff, and taunting other residents. The care plan directed staff to remind R27 that this type of talk is inappropriate, reapproach him as needed, or try using different staff members. Assess whether he understands what he is doing, and all staff were to be consistent with the handling of behaviors. Staff were directed to have R27 sit with other men in the dining room. Staff were directed to notify the provider of increased behaviors and document the behaviors. Staff were to escort R27 to and from the dining room to help ensure that he was not making comments to other residents that were upsetting to them.

The "Physician Order," dated 08/28/23, directed staff to administer Risperdal (an antipsychotic drug), 0.5 milligrams (mg) (½ tab) at bedtime for recurrent MDD.

The "Consultant Pharmacist Recommendation," dated 08/28/23, requested clarification of the diagnosis for Risperdal and if using for a non-approved diagnosis requested thorough documentation describing what has been tried and failed and why the severity of the symptoms justified the use of the drug. The provider wrote the patient was admitted on these medications for dementia with behaviors and they were actively working on dose reduction as they did not seem to be necessary at this time. No rationale for the

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continued use of Risperdal was written.

The fax note to the physician, dated 12/02/23, stated R27 had some behaviors in the last month such as repetitively asking if you are a man or woman, looking down staff shirts and said, "I can tell you're a woman." The spouse stated his psychotropic medications were decreased and she would like them changed back or a different medication.

The "Physician Order," dated 12/13/23, increased Risperdal to 0.5 mg twice daily for MDD.

The "Consultant Pharmacist Recommendation," dated 06/29/24, requested an approved diagnosis for Risperdal, or a GDR-gradual dose reduction. The physician did not provide a rationale for the continued use of Risperdal for dementia with behaviors.

The "Physician Order," dated 07/07/24, decreased Risperdal to 0.25 mg, twice daily, for dementia with behaviors.

The facility's fax to the physician, dated 09/06/24 fax to Primary Care Physician (PCP) stated no behaviors of psychosis, hallucinations or harmful behaviors documented. Do you want to re-evaluate if Risperdal should be continued? PCP responded- has been decreased in the past. No rationale written.

Review of progress notes from 06/01/24 to 01/10/25 revealed one note documented personal sexual behavior on 09/02/24 at 01:29 AM, and a behavior note regarding a sexual comment on 12/07/24. The progress notes lacked any more behavior notes.

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The "Consultant Pharmacist Recommendation," dated 12/30/24, requested a GDR for Risperdal. The physician wrote that Risperdal was decreased.

The "Physician Order," dated 01/10/25, directed staff to decrease Risperdal to 0.5 mg (1/2 tab) at bedtime. The order was documented as noted by a facility nurse on 01/10/25.

The January 2025 Medication Administration Record (MAR) did not show any change in the dose of Risperdal starting 01/10/25 to 01/14/25. The MAR had documentation staff administered 0.5 mg (1/2 tab) twice daily on 01/11/25, 01/12/25, 01/13/25, and 01/14/25, which was four doses more than physician ordered.

The fax note to the physician, dated 01/14/25, stated R27's spouse would like to decline the Risperdal change, and stated she did not like the aggressive comments he has made.

The "Physician Order," dated 01/14/25, Risperdal 0.5 mg tablet 1/2 tab (0.25 mg) by mouth daily, twice daily For Dementia with Behaviors

January 2025 Point of Care documentation for verbal behavioral symptoms directed toward others was all 0s. Physical hitting, kicking, pushing, scratching, grabbing, and sexual were all 0s. Other physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming disruptive sounds, and rejection of care. All shifts documented no behaviors in January.

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On 01/13/25 at 02:52 PM, R27 sat in a recliner, in his room. He asked the surveyor questions about education and religion but was not upset, angry, or confrontational.

On 01/14/25 at 04:12 PM, Certified Nurse Aide (CNA) P assisted R27 to stand with a gait belt and walker. She provided incontinence care, changed gloves, and placed a clean brief on R27. The resident sat back down in his recliner to wait for his wife. The resident was pleasant and very cooperative.

On 01/14/25 at 12:10 PM, Administrative Nurse D stated when the pharmacist consultant recommended documentation of behaviors the staff sent the request to the physician to reduce or discontinue the Risperdal due to a lack of behaviors.

On 01/14/25 at 01:55 PM, Licensed Nurse (LN) H stated she had not observed the resident display angry or harmful behaviors. LN H stated the spouse reported the resident became verbally aggressive when visiting her at the independent living facility. LN H verified staff had not changed the MAR to reflect the 01/10/24 physician order to decrease the Risperdal. The order to keep the Risperdal dose at twice daily came on 01/14/25. She verified the resident had received Risperdal twice daily from 1/11/25 through 01/14/25 and should not have.

On 01/15/25 at 09:55 AM, Administrative Nurse D verified staff should have followed the physician's order of 01/10/25 to decrease the dose of Risperdal.

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MENNONITE FRIENDSHIP COMMUNITIES INC	600 W BLANCHARD AVENUE SOUTH HUTCHINSON, KS 67505

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The facility's "Psychotropic Medication Use" policy, dated 11/2022, stated residents who use psychotropic drugs would receive a gradual dose reduction and behavioral interventions unless clinically contraindicated. This was to ensure the elder did not receive unnecessary medications and the lowest possible dose would be administered for the shortest amount of time. The elder's need for psychotropic medication would be monitored and when the medication could be lowered or discontinued. The attending physician must certify that a psychotropic medication was necessary to treat a specific condition or behavior. Behaviors for which these drugs are used must present a danger for elders or others, interfere with the staff's ability to provide care, or cause the elder "frightful distress" due to paranoia, hallucinations, or delusions. The consultant pharmacist would review the appropriateness of all medication orders for medications to be administered by staff. The drug dosage must be periodically reduced with the goal of discontinuing it or replacing it with another less potent prescription. All antipsychotics would be tapered as a gradual dose reduction unless clinically contraindicated. After the first year a GDR would be attempted annually unless clinically contraindicated. For any elder receiving an antipsychotic to treat behavioral symptoms related to dementia, the GDR may be clinically contraindicated if the elder's target symptoms returned or worsened after the most recent attempt at a GDR and the physician has documented the clinical rationale for why any additional attempted dose reduction would be likely to impair the resident's function or increase distressed behavior.

The facility failed to obtain the physician's

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F 758	Continued From page 40 rationale for the continued use of the antipsychotic Risperdal for R27 who had a diagnosis of Alzheimer's dementia, placing R27 at risk for adverse effects of the antipsychotic medication.	F 758		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: The facility had a census of 65 residents. The sample included 16 residents with six reviewed for unnecessary drugs. Based on observation, interview, and record review the facility failed to follow physician orders when administering medication to Resident (R) 27, resulting in a medication error continuing for 4 days. This placed R27 at risk for adverse effects from the medication. - R27's "Electronic Medical Record" documented diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure) and recurrent major depressive disorder (MDD - mood disorder that causes a persistent feeling of sadness and loss of interest). The "Quarterly Minimum Data Set" (MDS), dated 10/08/24, documented a Brief Interview for Mental Status (BIMS) score of 10, indicating moderately impaired cognition. The MDS documented R27 had verbal behaviors, was independent with eating, wheelchair mobility, required supervision for walking, and moderate	F 760		

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staff assistance for dressing and transfers. The MDS documented R27 received antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) medication, and the physician documented a dose reduction was clinically contra-indicated.

The "Psychotropic Drug Use Care Plan," dated 10/22/24, directed staff to observe for nonverbal signs of anxiety, restlessness, trembling, or pacing. Administer Risperdal as ordered. See the Black Box Warning (BBW - highest safety-related warning that medications can have assigned by the Food and Drug Administration) in the physician orders and follow pharmacy recommendations. Disruptive Behavior Problems related to inappropriate statements or questions towards staff and residents such as "Are you a man or a woman," repetitive questions, yelling at staff, and taunting other residents. The care plan directed staff to remind R27 that this type of talk is inappropriate, reapproach him as needed, or try using different staff members. Assess whether he understands what he is doing, and all staff were to be consistent with the handling of behaviors. Staff were directed to have R27 sit with other men in the dining room. Staff were directed to notify the provider of increased behaviors and document the behaviors. Staff were to escort R27 to and from the dining room to help ensure that he was not making comments to other residents that were upsetting to them.

The "Physician Order," dated 01/10/25, directed staff to decrease Risperdal to 0.5mg 1/2-tab at bedtime. The order was documented as noted by a facility nurse on 01/10/25.

The January 2025 Medication Administration

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Record (MAR) did not show any change in the dose of Risperdal starting 01/10/25 to 01/14/25. The MAR had documentation staff administered 0.5 mg (1/2 tab) twice daily on 01/11/25, 01/12/25, 01/13/25, and 01/14/25; which was four doses more than the physician ordered.

The fax note to the physician, dated 01/14/25, stated R27's spouse would like to decline the Risperdal change, and stated she did not like the aggressive comments he has made.

The "Physician Order," dated 1/14/25, Risperdal 0.5 mg tablet 1/2 tab (0.25 mg) by mouth daily, twice daily For Dementia with Behaviors

On 01/14/25 at 04:12 PM, Certified Nurse Aide (CNA) P assisted R27 to stand with a gait belt and walker. She provided incontinence care, changed gloves, and placed a clean brief on R27. The resident sat back down in his recliner to wait for his wife. The resident was pleasant and very cooperative.

On 01/14/25 at 01:55 PM, Licensed Nurse (LN) H verified staff had not changed the MAR to reflect the 01/10/24 physician order to decrease the Risperdal. The order to administer the Risperdal dose twice daily came on 01/14/25. She verified the resident had received Risperdal twice daily from 1/11/25 through 01/14/25 and should not have.

On 01/15/25 at 09:55 AM, Administrative Nurse D verified staff should have followed the physician's order of 1/10/25 to decrease the dose of Risperdal.

The facility's "Medication Administration" policy,

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F 760	Continued From page 43 dated 05/2023, stated staff were to review all new medication orders and fax them to the pharmacy in a timely manner. Staff were directed to start all initial doses of medications within 24 hours or as instructed by the provider. The facility failed to follow physician orders when administering medication to R27, resulting in a medication error that continued for four days. This placed R27 at risk for adverse effects from the medication.	F 760		
F 849 SS=D	Hospice Services CFR(s): 483.70(n)(1)-(4) §483.70(n) Hospice services. §483.70(n)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(n)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of	F 849		

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the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following:
(A) The services the hospice will provide.
(B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter.
(C) The services the LTC facility will continue to provide based on each resident's plan of care.
(D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day.
(E) A provision that the LTC facility immediately notifies the hospice about the following:
(1) A significant change in the resident's physical, mental, social, or emotional status.
(2) Clinical complications that suggest a need to alter the plan of care.
(3) A need to transfer the resident from the facility for any condition.
(4) The resident's death.
(F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided.
(G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs.
(H) A delineation of the hospice's responsibilities, including but not limited to, providing medical

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direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions.
(I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility.
(J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation.
(K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.

§483.70(n)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State

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scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident.
The designated interdisciplinary team member is responsible for the following:
(i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services.
(ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family.
(iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians.
(iv) Obtaining the following information from the hospice:
(A) The most recent hospice plan of care specific to each patient.
(B) Hospice election form.
(C) Physician certification and recertification of the terminal illness specific to each patient.
(D) Names and contact information for hospice personnel involved in hospice care of each patient.
(E) Instructions on how to access the hospice's 24-hour on-call system.
(F) Hospice medication information specific to each patient.
(G) Hospice physician and attending physician (if any) orders specific to each patient.
(v) Ensuring that the LTC facility staff provides

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orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents.

§483.70(n)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 65 residents. The sample included 16 residents with one reviewed for hospice (a type of health care that focuses on the terminally ill patient's pain and symptoms and attending to their emotional and spiritual needs at the end of life) services. Based on observation, record review, and interview, the facility failed to ensure coordinated care and services provided by the facility with the care and services provided by hospice for Resident (R) 41. This placed the residents at risk for inadequate end-of-life care.

Findings included:

- R41's Electronic Health Record (EHR) revealed diagnoses of Chronic Obstructive Pulmonary Disease chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), and dysphagia (swallowing difficulty).

R41's "Quarterly Minimum Data Set" (MDS), dated 11/01/24, recorded R41 had a Brief

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Interview for Mental Status score of six which indicated severe cognitive impairment. The MDS recorded he required extensive staff assistance with transfers and activities of daily living (ADLs). The MDS documented the resident received hospice services.

R41's facility "Care Plan," dated 11/08/24, recorded R41 required extensive staff assistance with most ADL care. R41's "Care Plan" documented the resident had a terminal prognosis and required hospice services. The care plan directed the staff to provide comfort and encourage family and friends support system. The care plan directed staff to observe closely for signs of pain and administer medications as ordered. The facility care plan lacked instruction on the services provided by hospice including the frequency and type of support visits, supplies and medical equipment provided by hospice, medications covered by hospice, and the hospice contact information.

Review of R41's clinical record revealed the resident was admitted to hospice care on 07/27/23. The facility had a plan of care provided by hospice in the electronic health record.

On 01/13/25 at 03:45 AM, R41 was dressed in street clothes and sat in a recliner in her room.

On 01/15/25 at 09:00 AM, Administrative Nurse D verified the facility lacked specific information on the facility care plan that coordinated with the hospice care plan.

The facility's "Hospice Service" policy, dated 6/2020, documented what each resident would receive, and the facility would provide the

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necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care.
The facility would provide continuity of care to provide residents who are terminally ill with the opportunity to receive comprehensive, interdisciplinary care that recognizes their spiritual needs and to assist the residents, family members, and friends to live as fully and completely as possible with meaning and dignity. Residents and family members may be offered hospice care upon request of the residents and families and/or guardians to meet the care and service needed. The physician would provide a written certification and request hospice care when the resident is determined to require hospice care. An individualized plan of care would be developed before hospice care begins, including an assessment of the resident's and family's needs for services. The interdisciplinary team would review and plan to implement the hospice care services, with advanced care planning, and would address the resident's wishes regarding treatment of acute illness, hospitalization treating acute illness, and hospitalization. The staff would provide and periodically review the resident plan of care, addressing services, and support that accommodate and honor the resident's choices and rights, manage pain and other physical, mental, and psychosocial symptoms, and strive to meet the resident's physical, mental, psychosocial, and spiritual needs. The interdisciplinary care plan would integrate the care and services provided by the facility and the hospice provider including resident, staff, and physician comfort with dealing with death. The care plan would communicate and/or provide the

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F 849	Continued From page 50 coordination of participants and agencies providing aspects of palliative care including the hospice providers and the facility would exchange information from respective care plan reviews, assessment updates, and resident and family conferences to ensure continued provision of changing necessary care and services. The care plan documented the facility would notify hospice when the resident experiences a significant change in physical, mental, social, emotional, cultural, and spiritual needs related to the terminal illness and related conditions related to the resident's well-being, comfort, and dignity throughout the dying process. The facility failed to coordinate care between the facility and the hospice provider for R41, who received hospice services. This deficient practice placed herm at risk for inadequate end-of-life care.	F 849		