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	175525	A. BUILDING _____ B. WING _____	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey.	F 000		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least	F 582		

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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60 days prior to implementation of the change.
(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.
(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.
(v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 37 residents. The sample included 12 residents. Based on record review and interview, the facility failed to provide Resident (R) 3, R14, and R36 or their representative, the completed Centers for Medicare and Medicaid (CMS) Skilled Nursing Facility Advanced Beneficiary Notices (ABN) Form 10055. This placed the resident at risk of uninformed decisions about their skilled services.

Findings included:

- The "Medicare ABN form 10055" informed the beneficiary that Medicare may not pay for future skilled therapy services. The form included an option for the beneficiary to receive specific services listed, and bill Medicare for an official decision on payment. The form stated 1) "I understand if Medicare does not pay, I will be

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responsible for payment but can make an appeal to Medicare," (2) "receive therapy listed, but do not bill Medicare, I am responsible for payment for services," (3) "I do not want the listed services."

Review of the ABN form provided to R3 revealed the form lacked the estimated cost of continued service and R3 received the wrong form. R3 received the CMS-R-131 instead of CMS Form 10055. The resident's skilled services ended on 09/09/24.

Review of the ABN form provided to R14 revealed the form lacked the estimated cost of continued service and R14 received the wrong form. R14 received CMS -R-131 instead of CMS Form 10055. The resident's skilled services ended on 01/24/25.

Review of the ABN form provided to R36 revealed the form lacked the estimated cost of continued service and R36 received the wrong form. R36 received CMS -R-131 instead of CMS Form 10055. The resident's skilled services ended on 01/24/25.

On 03/05/25 at 10:00 AM, Administrative Staff A verified the facility provided the CMS-R-131 form to R3, R14, or R36, and/or their representative, and failed to provide the 10055 with the estimated amount it would cost the resident if they wished to continue services.

The facility's "Advance Beneficiary Notices" policy, dated September 2022, recorded residents were informed in advance when charges would occur to their bills. If the director of admissions or benefits coordinator believed (upon

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admission or during the resident's stay) that Medicare 9Part A of the fee for Service Medicare Program) would not pay for an otherwise covered skilled service(s), the resident (or representative) was notified in writing because the service(s) may not be covered and of the resident's potential liability of the non-covered service(s). If the facility issues the "Skilled Nursing Facility Advanced Beneficiary Notice (CMS form 10055) for the following triggering events:
A) Initiation- In the situation in which the director of admissions or benefits coordinator believes Medicare will not pay for extended care items or services that a physician has ordered, A SNB ABN is issued to the beneficiary before those noncovered extended items or services are furnished to the beneficiary.
B) Reduction- In the situation in which the facility proposes to reduce a beneficiary's extended care items or services because it is expected that Medicare will not pay for a subset of extended care items or services, or any items or services at the current level and/or frequency of care that a physician had ordered the SBF ABN is issued to the beneficiary before items or services to the beneficiary are reduced.
C) Termination- In the situation in which the facility proposes to stop furnishing all extended care items or services to a beneficiary because it is expects Medicare will not continue to pay for the items or services that a physician has ordered and the beneficiary would like to continue receiving the care, the SNF ABN is issued to the beneficiary before each extended care items or services are terminated.
D) The resident (or representative) is informed that they may choose to continue receiving the skilled services that may not be paid for by Medicare and assume financial responsibility.

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F 582	Continued From page 4 The facility failed to provide R3, R14, and R36 or their representatives, the correct 10055 form which included an estimated cost of continued services when discharged from skilled care. This placed the residents at risk of uninformed decisions about their services and the continuation of their skilled services.	F 582		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing	F 607		

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retaliation, as defined at section 1150B(d)(1) and (2) of the Act.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 37 residents. Based on interviews and record review, the facility failed to conduct a criminal background check as required for one facility employee. The employee was allowed access to residents without knowing if they had been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law. This deficient practice placed the affected residents at risk for abuse, neglect, misappropriation, or mistreatment.

Findings included:

- On 03/05/25 at 11:30 AM a review of staffing for background checks was completed for facility Staff. Upon request and review the facility was unable to provide evidence a criminal background check had been completed for Maintenance staff U, who had worked at the facility since 05/21/2020.

On 03/05/25 at 11:35 AM, Administrative Staff A stated the business manager would obtain criminal background/record checks on all employees prior to the employee working at the facility. Administrative Staff A verified she could not find a criminal record check for Maintenance Staff U and the business office manager who was at the facility when he was initially hired no longer worked at the facility. Administrative Staff A verified Maintenance Staff U would be placed on suspension and not work in the building until they obtained a criminal background check.

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The facility's "Background Screening Investigation" dated March 2019 documented the facility conducts employment background screening checks, reference checks, and criminal conviction investigation checks on all applicants for positions with direct access to residents(direct access employees). For purposes of the policy "direct access employee" means any individual who has access to a resident of a long-term care facility or provider through employment or through a contact and has duties that involve (or may involve) one-on-one contact with a resident of the facility or provider, as determined by the state for purposes of the national background check program. The director of personnel, conducts background checks, reference checks, and criminal conviction checks on all potential direct access employees and contractors. Background and criminal checks are initiated within two days of an offer of employment or contract agreement and completed prior to employment. Should the background investigation disclose any misrepresentation on the application form or information indicating that the individual has been convicted of abuse, neglect, mistreatment of individuals, and/or misappropriation of property, the applicant is not employed or contracted.

The facility failed to conduct a criminal background check as required for Maintenance Staff U prior to employment at the facility. The employee was allowed access to residents without knowing if they had been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law. This deficient practice placed the affected residents at risk for abuse, neglect, misappropriation, or mistreatment.

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

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required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

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§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(k).
This REQUIREMENT is not met as evidenced by:
The facility had a census of 37 residents. The sample included 12 residents. Based on observation, interview, and record review, the facility failed to notify the Long Term Care Ombudsman (LTCO) for Resident (R) 8's and R4's facility-initiated discharge to the hospital. This deficient practice placed R8 and R4 at risk for impaired rights.

Findings included:

- R8's Electronic Medical Record (EMR) recorded diagnoses of emphysema (collection of pus in the pleural cavity related to bacterial pneumonia,) dementia (a progressive mental disorder characterized by failing memory and confusion), chronic obstructive pulmonary disease (COPD - a progressive and irreversible condition characterized by diminished lung

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capacity and difficulty or discomfort in breathing), pulmonary fibrosis (a lung disease that causes scarring of the lung tissue, making it stiff and thick), and narcolepsy (excessive uncontrolled daytime sleepiness).

R8's "5 Day Scheduled Minimum Data Set" (MDS), dated 01/30/25, recorded R8 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated intact cognition. The MDS recorded R8 was independent with most activities of daily living (ADL). The MDS recorded the resident received oxygen therapy.

The "Care Area Assessment" (CAA), dated 07/23/24, recorded R8 required substantial assistance with bathing and shower transfers and was independent with bed mobility, transfers, and walking.

R8's "Care Plan," dated 01/24/25 recorded R8 had an ADL self-care performance deficit due to dementia and poor safety awareness. The care plan documented the resident was on continuous oxygen due to COPD with hypoxia (a medical condition where there is an inadequate supply of oxygen to the body tissue), but often removes the oxygen. The care plan documented staff would notify the physician of changes in behavior, altered mental status, disorientation, lethargy, dehydration, or infections.

The "Physician's Order," dated 03/25/24, directed the staff to provide the resident oxygen at five liters per nasal cannula due to hypoxia.

The "Physician Order, "dated 02/25/24, directed the staff to administer Albuterol Sulfate (bronchodilator medication that relaxes and

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opens the air passages in your lungs) Nebulization solution (two and a half milligrams (mg)/ three milliliters (mL), one inhalation per nebulizer every two hours as needed for shortness of breath.

The "Physician Order," dated 02/22/25, directed staff to administer Budesonide (steroid medication that reduces inflammation in the lungs) suspension 0.25 mg/ two mL, two mL inhale orally per nebulizer every 12 hours as needed for shortness of breath.

On 01/19/25 at 08:00 AM the "Nurse's Notes" documented R8 was observed in the bathroom with her oxygen above her nose, had a nonproductive cough, and increased shortness of breath. Staff reapplied the resident's oxygen and she was assisted back to bed.

On 01/19/24 at 11:34 AM the "Nurse's Notes" documented R8 received an as-needed Albuterol breathing treatment at 11:04 AM and her lungs were clear with no further shortness of breath. The resident complained of "pain in her back", with weakness and lethargy (a state of extreme tiredness, drowsiness, and lack of energy). R8's oxygen saturation was 94 (normal range is 95 percent -100 percent) percent on five liters of oxygen per nasal cannula. The resident was moaning/groaning with back pain and the resident had pain and discomfort with urination. The nurse notes documented staff administered Norco (Opioid pain medication) at 11:41 AM.

On 01/19/25 at 12:34 PM the "Nurse's Notes" documented that staff notified the on-call provider and stated her "change in condition" and the physician ordered lab work and a Covid test.

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On 01/19/25 at 12:50 PM the "Nurses Notes" documented lab work was obtained and sent to the hospital and staff tested the resident for Covid and it was negative.

On 01/1/9/25 at 02:06 PM the "Nurses Notes" documented a nurse received a call from the provider and stated the resident's White blood Count (measures the number of white blood cells in your blood, white blood cells are a part of the immune system that help fight off infections and other diseases) was 14 which was elevated and indicated the resident had an infection somewhere and showed signs of dehydration. The nurse's notes documented the provider had the facility send the resident to the hospital for further workup.

On 01/19/25 at 03:04 PM, the resident was transported to the hospital via facility van.

On 01/19/25 at 04:49 PM, the hospital called the facility to report the resident was being admitted for pneumonia (type of bacterial infection).

R8's clinical record lacked documentation that staff notified the LTCO of the resident's discharge from the facility.

On 03/04/25 at 02:30 PM, Administrative Staff A stated they did not have any notification to the Ombudsman regarding the resident's discharge to the hospital. Administrative Staff A stated she was unaware of the last time they sent a discharge from the facility to the Ombudsman and was not aware she needed to send that information to the LTCO. Administrative Staff A stated it was her understanding they were to

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(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
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notify the Ombudsman only if it was a facility-initiated discharge against the resident's wishes.

The facility's "Transfer or Discharge, Facility Initiated" policy, dated October 2022, documented that once admitted to the facility, residents had the right to remain in the facility. Facility-initiated transfers and discharges, when necessary, must meet specific criteria and require resident/representative notification, orientation, and documentation as specified by this policy. "Transfer and discharge" include movement of a resident from a certified bed in the facility to a non-certified bed in another part of the facility, or to a non-certified bed outside of the facility. Transfer and discharge did not refer to the movement of a resident to a bed within the same facility. When residents are sent emergently to an acute setting, such as a hospital, were permitted to return to the facility. Residents who were sent to the acute care settings for routine treatment/planned procedures are also allowed to return to the facility. The "Notice of Transfer" is provided to the resident and representative as soon as practicable before the transfer and to the long-term (LTC) Ombudsman when practicable (e.g., in a monthly list of residents that includes all notices content requirements). The notice of discharge will be provided.

The facility failed to notify the LTCO of R8's facility-initiated discharge to the hospital. This deficient practice placed the resident at risk for impaired rights.
- R4's Electronic Medical Record (EMR) documented diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), basal cell

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carcinoma (a type of skin cancer that originates in the basal cells, which are the deepest layer of the outer layer of the skin), congestive heart failure (CHF - a condition with low heart output and the body becomes congested with fluid), chronic obstructive pulmonary disease (COPD - a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), and retention of urine (a condition where a person is unable to completely empty their bladder).

R4's "Discharge Minimum Data Set (MDS)" dated 12/12/24 documented he had an unplanned discharge to a short-term acute hospital with a return anticipated.

R4's "Entry MDS" dated 12/16/24 documented a re-entry to the facility from a critical access hospital.

R4's "Discharge MDS" dated 01/12/25 documented he had an unplanned discharge to a short-term acute hospital with a return anticipated.

R4's "Entry MDS" dated 01/29/25 documented a re-entry to the facility from a critical access hospital.

R4's "Significant Change MDS" dated 02/04/25 documented he had a Brief Interview for Mental Status (BIMS) score of five which indicated severely impaired cognition. R4 displayed verbal behaviors on one to three days during the look-back period. R4 required substantial to totally dependent on staff for his functional abilities and activities of daily living (ADL). R4 utilized a walker and a wheelchair to assist with

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his mobility. R4 had an indwelling catheter (tube placed in the bladder to drain urine into a collection bag).

R4's "Cognition Care Area Assessment (CAA)" dated 02/06/25 documented he had a potential for further mobility decline, falls, skin break-down, and pain related to muscle weakness, impaired mobility, difficulty walking, malaise, CHF, and Alzheimer's dementia.

R4's "Care Plan" revised 02/18/25 directed staff that R4 wished to return home, however, he is here long-term due to progressive dementia and did not have 24-hour care at home. Staff were directed to establish a pre-discharge plan with R4's family, evaluate the progress, and revise the plan as needed.

The facility failed to provide the required written notification of transfer to R28 and his representative for his facility-initiated discharges on 12/12/24 and 01/12/25 that included: the reason for the transfer; the effective date of transfer; the specific location of the transfer; an explanation of the right to appeal the transfer to the state; the name, address, and telephone number of the state entity which receives appeal requests; the name, address, and phone number of the representative of the office of the stated long-term care ombudsman; and the notice must be provided to the resident and resident's representative as soon as practicable.

The facility failed to provide evidence that the long-term care ombudsman (LTCO) was notified of R4's facility-initiated transfers to the hospital on 12/12/24 and 01/12/25.

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F 623	Continued From page 16 On 03/04/25 at 07:58 AM, R4 sat at the dining table eating breakfast. R4 had his supplemental oxygen on. On 03/04/25 at 02:45 PM, Administrative Staff A stated she could not provide notification to the ombudsman it was their understanding the ombudsman was only notified if it was a facility-initiated discharge against a resident's wish. Administrative Staff A stated that the facility did not do any written notification of transfer as the family was notified by a phone call when a resident was sent out to the hospital. The "Transfer or Discharge, Facility-Initiated" policy revised October 2022 documented the notice of transfer or discharge (emergent or therapeutic leave) was given as soon as practicable. The notice of transfer was provided to the resident and representative as soon as practicable before the transfer and to the LTCO when practicable (in a monthly list of residents that included all notice content requirements). The facility failed to provide written notification of transfer to R4 or their representatives for their facility-initiated transfers. The facility failed to provide notification to the LTCO for R4. These deficient practices had the risk of miscommunication between the facility and resident/family and possible missed opportunities for healthcare service for R4.	F 623		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a	F 625		

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nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies-
(i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility;
(ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;
(iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and
(iv) The information specified in paragraph (e)(1) of this section.

§483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 37 residents. The sample included 12 residents, with two residents reviewed for discharge. Based on observation, record review, and interview, the facility failed to provide Resident (R) 8 and R4 with written information regarding the facility bed hold policy when she was transferred to the hospital. This placed the resident at risk of not being permitted to return and resume residence in the nursing facility.

Findings included:

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- R8's Electronic Medical Record (EMR) recorded diagnoses of emphysema (collection of pus in the pleural cavity related to bacterial pneumonia), dementia (a progressive mental disorder characterized by failing memory and confusion), chronic obstructive pulmonary disease (COPD - a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), pulmonary fibrosis (a lung disease that causes scarring of the lung tissue, making it stiff and thick), and narcolepsy (excessive uncontrolled daytime sleepiness).

R8's "5 Day Scheduled Minimum Data Set" (MDS), dated 01/30/25, recorded R8 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated intact cognition. The MDS recorded R8 was independent with most activities of daily living (ADL). The MDS recorded the resident received oxygen therapy.

The "Care Area Assessment" (CAA), dated 07/23/24, recorded R8 required substantial assistance with bathing and shower transfers and was independent with bed mobility, transfers, and walking.

R8's "Care Plan," dated 01/24/25 recorded R8 had an ADL self-care performance deficit due to dementia and poor safety awareness. The care plan documented the resident was on continuous oxygen due to COPD with hypoxia (a medical condition where there is an inadequate supply of oxygen to the body tissue), but often removed the oxygen. The care plan documented staff would notify the physician of changes in behavior, altered mental status, disorientation, lethargy,

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dehydration, or infections.

The "Physician's Order," dated 03/25/24, directed the staff to provide the resident oxygen at five liters per nasal cannula due to hypoxia.

The "Physician Order," dated 02/25/24, directed the staff to administer Albuterol Sulfate (bronchodilator medication that relaxes and opens the air passages in your lungs) Nebulization solution (two and a half milligrams (mg)/ three milliliters (ml), one inhalation per nebulizer every two hours as needed for shortness of breath.

The "Physician Order," dated 02/22/25, directed staff to administer Budesonide (steroid medication that reduces inflammation in the lungs) suspension 0.25 mg/ two milliliters, two ml inhale orally per nebulizer every 12 hours as needed for shortness of breath.

On 01/19/25 at 08:00 AM the "Nurses Notes" documented R8 was observed in the bathroom with her oxygen above her nose and had a nonproductive cough and increased shortness of breath. Staff reapplied the resident's oxygen and she was assisted back to bed.

On 01/19/24 at 11:34 AM the "Nurse's Notes" documented R8 received an as-needed Albuterol breathing treatment at 11:04 AM and her lungs were clear with no further shortness of breath. The resident complained of "pain in her back", with weakness and lethargy (a state of extreme tiredness, drowsiness, and lack of energy), oxygen saturation was 94 (normal range is 95 percent -100 percent) percent on five liters of oxygen per nasal cannula. The resident was

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moaning/groaning with back pain and the resident had pain and discomfort with urination. The nurse notes documented staff administered Norco (pain medication) at 11:41 AM.

On 01/19/25 at 12:50 PM, "Nurses Notes" documented staff notified the on-call provider and stated her "change in condition" and the physician ordered lab work and a Covid test.

On 01/19/25 at 12:50 PM, the "Nurses Notes" documented lab work was obtained and sent to the hospital and staff tested the resident for Covid and it was negative.

On 01/19/25 at 02:06 PM, "Nurses Notes" documented the nurse received a call from the provider and stated the resident's White blood Count (measures the number of white blood cells in your blood, white blood cells are a part of the immune system that help fight off infections and other diseases) was 14 which was elevated and indicated the resident had an infection somewhere and showed signs of dehydration. The nurse's notes documented the provider had the facility send the resident to the hospital for further workup.

On 01/19/25 at 03:04 PM, "Nurses Notes" documented the resident was transported to the hospital via facility van.

On 01/19/25 at 04:49 PM, "Nurses Notes" documented the hospital called the facility to report the resident was being admitted to the hospital for pneumonia (type of bacterial infection).

R 8's clinical record revealed a copy of the bed

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hold policy dated 10/20/21 (date of admission) that had her resident representative signature. Administrative Staff A verified the resident's representative did sign the paper on admission however the facility was unable to provide written evidence upon request they had spoken with the representative to acknowledge her understanding of the facility bed hold policy at the time of the hospital admission 01/19 thru 01/24/25.

On 03/04/25 at 02:03 PM, Administrative Nurse E verified the facility lacked evidence of a signed bed hold policy notice that had been verbally acknowledged, provided, or signed by the resident's representative when R8 was transferred and admitted to the hospital on 01/19/25.

The facility's "Bed Hold" policy dated 10/20/21 documented that privately paying residents would be charged the hospital reserve rate for their rooms during hospitalization or any other leave of absence from the facility until the day they are officially discharged from the facility. The reserve daily rate equals 67 percent of the daily rate of the room. Medicaid reimburses the facility for the first 10 days per hospitalization, during which time the resident's bed would be held for them. On the 11th day of hospitalization, the resident risked losing their bed at the facility. If the facility is not able to hold their bed after the 1oth day, and assuming the facility can still care for the resident successfully after the hospital event, the resident would have priority in returning to the facility as soon as an appropriate bed becomes available. Medicaid would allow 18 days of therapeutic leave a year, during which a resident's bed is held for them. This would include any stay outside the facility that is not medically necessary, such as a

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family visit or vacation. Residents and responsible parties would be reminded of the bed hold policy at the time of the resident's admission to the hospital or prior to a leave of absence.

The facility failed to provide R8's representative with a copy of the facility bed hold policy when she was transferred to the hospital. This placed the resident at risk of not being permitted to return and resume residence in the nursing facility.
- R4's Electronic Medical Record (EMR) documented diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), basal cell carcinoma (a type of skin cancer that originates in the basal cells, which are the deepest layer of the outer layer of the skin), congestive heart failure (CHF - a condition with low heart output and the body becomes congested with fluid), chronic obstructive pulmonary disease (COPD - a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), and retention of urine (a condition where a person is unable to completely empty their bladder).

R4's "Discharge Minimum Data Set (MDS)" dated 12/12/24 documented he had an unplanned discharge to a short-term acute hospital with a return anticipated.

R4's "Entry MDS" dated 12/16/24 documented a re-entry to the facility from a critical access hospital.

R4's "Discharge MDS" dated 01/12/25 documented he had an unplanned discharge to a short-term acute hospital with a return

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anticipated.

R4's "Entry MDS" dated 01/12/25 documented a re-entry to the facility from a critical access hospital.

R4's "Significant Change MDS" dated 02/04/25 documented he had a Brief Interview for Mental Status (BIMS) score of five which indicated severely impaired cognition. R4 displayed verbal behaviors on one to three days during the look-back period. R4 required substantial to totally dependent on staff for his functional abilities and activities of daily living (ADL). R4 utilized a walker and a wheelchair to assist with his mobility. R4 had an indwelling catheter (tube placed in the bladder to drain urine into a collection bag).

R4's "Cognition Care Area Assessment (CAA)" dated 02/06/25 documented he had a potential for further mobility decline, falls, skin breakdown, and pain related to muscle weakness, impaired mobility, difficulty walking, malaise, CHF, and Alzheimer's dementia.

R4's "Care Plan" revised 02/18/25 directed staff that R4 wished to return home, however, he is here long-term due to progressive dementia and did not have 24-hour care at home. Staff were directed to establish a pre-discharge plan with R4's family, evaluate the progress, and revise the plan as needed.

The facility failed to provide evidence a bed-hold was completed and signed by R4 or his representative upon R4's hospitalizations on 12/12/24 and 01/12/25.

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The facility failed to provide evidence that the long-term care ombudsman (LTCO) was notified of R4's facility-initiated transfers to the hospital on 12/12/24 and 01/12/25.

On 03/04/25 at 07:58 AM, R4 sat at the dining table eating breakfast. R4 had his supplemental oxygen on.

On 03/04/25 at 02:45 PM, Administrative Staff A stated the facility would send a copy of the bed-hold that was signed at admission. Administrative Staff A was not aware that a new bed-hold had to be provided and signed by the resident or representative upon a hospital stay.

The facility's "Bed-Holds and Returns" policy revised October 2022 documented that residents and or the representatives were informed (in writing) of the facility and state (if applicable) bed-hold policies. All residents and representatives were provided written information regarding the facility and state bed-hold policies, which address holding or reserving a resident's bed during periods of absence (hospital or therapeutic leave). Residents, regardless of the payer source, were provided notice about these policies at least twice: notice 1- well in advance of any transfer (in the admission packet); notice 2- at the time of transfer (or, if the transfer was an emergency, within 24 hours). The written bed-hold notices provided to the residents/representatives explain in detail: the duration of the state bed-hold policy, if any, during which the resident was permitted to return and resume residence in the facility; the reserve bed payment policy as indicated by the state plan (for Medicaid resident); the facility policy regarding bed-hold periods; the facility per-diem rate

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F 625	Continued From page 25 required to hold a bed (for non-Medicaid residents), or to hold a bed beyond the stated bed-hold period (for Medicaid residents); and the facility return policy. The requirement that residents be permitted to return to the facility following hospitalization or therapeutic leave is applied to all residents regardless of payer source. Residents who sought to return to the facility within the bed-hold period defined in the state plan were allowed to return to their previous room, if available. The facility failed to provide a bed hold policy to R4 or their representatives when they transferred to the hospital. This deficient practice had the risk of impaired ability for R4 to return to the facility and to his previous room.	F 625		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility had a census of 37 residents. The sample included 12 residents with two reviewed for accidents. Based on observation, interview, and record review the facility failed to thoroughly investigate the causative factor to prevent further falls for Resident (R)1 after she slid out of her wheelchair. This deficient practice placed R1 at risk for injuries related to falls. The facility failed to	F 689		

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promote an environment free of hazards for Resident (R) 6 who smoked cigarettes but lacked a smoking assessment since admission to the facility. This placed the resident at risk for avoidable injuries and fire-related hazards

Findings included:

- R1's Electronic Medical Record (EMR) documented diagnoses of intellectual disabilities (IDD - a significantly below-average score on a test of mental ability or intelligence and limitations in the ability to function in areas of daily life), epilepsy (brain disorder characterized by repeated seizures), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and restless leg syndrome (is a condition that causes a very strong urge to move legs).

The "Quarterly Minimum Data Set" (MDS), dated 02/27/25, documented a Brief Interview for Mental Status (BIMS) score of nine which indicated moderately impaired cognition. The MDS documented R1 required supervision for eating and extensive staff assistance for bed mobility, transfers, toileting, and dressing; R1 did not walk. The MDS documented R1 used a wheelchair and received opioid (class of drug used to reduce moderate to severe pain) medications seven days of the look-back period.

The "Fall Care Area Assessment" (CAA), dated 02/27/25, documented R1 was at risk for falls due to diagnoses, behaviors, and weakness.

The "Fall Care Plan," dated 02/27/25, documented R1 had safety needs due to weakness, was at risk for falls, and stated staff

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would perform hourly checks in order to ensure the resident's safety. The care plan documented the resident would be laid down as soon as possible following long periods of time being up due to weakness. The care plan documented the resident had a self-care deficit, required assistance with activities of daily living, and had limited range of motion in her shoulders and knees that placed her at risk for injury. The care plan documented R1 was nonambulatory, transferred with a sling lift with two staff, and utilized a Panacea tilt chair (a mobile, pressure redistributing chair that can tilt and recline) for positioning and safety.

The "Fall Progress Note" dated 11/14/24 at 11:11 PM, documented the resident was in a wheelchair and a Certified Nurse Aide and a Certified Medication Aide found the resident face down on the floor with the wheelchair beside her. The notes documented the resident denied hitting her head and denied pain. The facility implemented neurological checks every 15 minutes for the first hour per physician assistant order. The nurse completed a head-to-toe assessment and the resident had full range of motion to all four extremities.

The "Nurse's Note," dated 11/15/24 at 01:01 PM, documented R1 had an unwitnessed fall on 11/14/24 at 09:55 PM in her room. The nurse's notes documented the resident fell out of her wheelchair, with no injuries noted, vital signs were obtained, and the resident denied pain with no injuries noted.

The "Risk Investigation," dated 11/14/24, documented the nurse was called to R1's room after staff reported the resident was on the floor.

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Upon entering the resident's room, the nurse noted the resident was being assisted by staff to her bed, and a registered nurse was present with the transfer. The nurse documented the resident had been in the emergency room earlier and upon return ate a late supper staff then pushed the resident to her room in a transport manual wheelchair. The investigation report documented when staff returned to R1's room she had slid from the wheelchair to the floor. The staff documented new interventions for the staff to return the resident to her Panacea wheelchair after transport in a regular wheelchair. The investigation documented no injuries noted at the time of the accident.

On 03/05/25 at 07:15 AM, R1 sat in her Panacea wheelchair in her room with a call light on the left side of the wheelchair.

On 03/03/25 at 04:20 PM, Administrative Nurse E stated R1 went to the emergency room and upon return, at approximately 09:00 PM, ate a late supper. Staff then pushed R1 into her room and she was still in the manual transport wheelchair. Administrative Nurse E was unable to provide a timeline of how long the resident was in her room until staff summonsed the nurse the resident had slid out of her wheelchair. Administrative Nurse E stated the facility had done an investigation and remembers interviewing staff but was unable to provide written documentation of the witness interviews and documentation of the investigation and verify no abuse was suspected.

On 03/05/25 at 09:20 AM, Administrative Staff A stated she had located a "Risk Evaluation" on the resident's 11/14/24 fall, but lacked a witness

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statement. Administrative Staff A stated she remembered interviewing staff, but failed to get written witness statements documentation and failed to view the camera footage to see if anyone walked in the room when the resident had the fall.

The facility's "Falls-Clinical Protocol" policy, dated March 2018, documented the facility would help identify individuals with a history of falls and risk factors for falling. The staff and the practitioner would review each resident's risk factor for falling and document it in the medical record. The physician would identify medical conditions affecting fall risk and the risk for significant complications after a fall. The staff would evaluate, and document falls that occur while the individual is in the facility, for example, when and where they happen, and observations of the event. Falls should be identified as witnessed or unwitnessed events. After a resident has fallen the staff and practitioner would begin to try and identify possible causes within the first 24 hours. If the cause of the fall is unclear, or if any fall may have a significant medical cause such as a stroke or an adverse drug reaction, or if the individual continues to fall despite attempted interventions, a physician would review the situation and help further identify the cause and contributing factors. The staff and the physician would continue to collect and evaluate information until either the cause of the fall is identified, or it is determined that the cause is not found. As needed, and after an appropriate through review, the physician would document any uncorrectable risk factors and underlying causes.

The facility failed to provide information and investigations that addressed the causative factor to prevent further falls for R1 after she slid out of

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a manual transport wheelchair. This deficient practice placed R1 at risk for injuries related to falls.

- R6's Electronic Medical Record (EMR) recorded diagnoses include 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), hemiplegia (paralysis of one side of the body), hemiparesis (muscular weakness of one half of the body), nicotine dependence (a chronic characterized by a compulsive craving for nicotine), and generalized muscle weakness.

R6's "Quarterly Minimum Data Set" (MDS), dated 12/20/24, documented the resident had a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. The MDS documented R6 required staff assistance with activities of daily living (ADL), lower extremities had impairment on both sides, and used a wheelchair for mobility.

R6's "Activities of Daily Living Care Area Assessment" (CAA), dated 04/21/24, documented the resident had a stroke affecting his right side, had difficulty walking, unsteadiness on feet, and was nicotine-dependent on cigarettes. The CAA documented R6 had functional limitations to the right upper and lower extremity (right dominant side) with contracture to his right hand. The CAA documented R6 required staff assistance with dressing, hygiene, and transfers.

R6's "Care Plan," dated 12/31/24, documented the resident had contractures of the right hand, staff would provide skin care to keep the skin clean, and prevent skin breakdown. The care

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plan documented R6 was nonambulatory and utilized a wheelchair for mobility and was independent with an electric scooter.

R6's" Care Plan" for smoking, dated 03/03/24 recorded R6 was independent with tobacco products and would sign himself out of the building, off the property through the back door, and smoke five times a day. The care plan documented the resident's cigarettes we kept at the nurse's station.

R6's "Smoking Safety Evaluation," dated 03/03/25, documented the resident did not have any cognitive loss, no loss or limitation with a range of motion in arms or hands. The assessment documented the resident was able to light a cigarette, hold a cigarette, extinguish a cigarette, and able to use an ashtray safely.

On 03/03/25 at 12:30 PM, R6 exited the dining room dressed in street clothes, a jacket, and a ball cap on an electric scooter. At 12:45 PM staff stated R6 exited the building through the North patio doors to the driveway to go smoke.

On 03/03/25 at 02:20 PM, Administrative Nurse E verified that R6 was admitted to the facility in April 2024 and the last Director of Nursing allowed the resident to go outside and smoke. Administrative Nurse E verified the facility was a smoke-free facility and the resident had to go off the premises to smoke. Administrative Nurse E stated R6 would go smoke behind the facility where a shed was located or next door at the city park. Administrative Nurse E verified the resident did not have a smoking assessment completed until the first day of the survey 03/03/25.

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F 689	Continued From page 32 The "Employee and Tenant Smoking" policy dated October 2022, documented that smoking by residents is prohibited throughout the Park Lane Nursing Home and on Park Lane Nursing Home grounds for all current and future residents. All vehicles used in connection with Park Lane Nursing Home are also smoke-free. Smoking materials, cigarettes, matches, lighters, or any other incendiary devices may not be kept in the resident's room or nursing home commons area. Employees and tenants of the facility who choose to smoke or use tobacco must smoke only in the areas outside where smoking or tobacco is permitted. The permitted area for the employees is located on the North end of the building underneath the carport. Failure to comply with the Smoking Policy will result in revocation of smoking privileges. The facility failed to assess and promote a safe environment for R6 and all the residents residing in the facility. The deficient practice placed the residents at risk for smoke or fire.	F 689		
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 33 (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 37 residents. The sample included 12 residents, with five reviewed for unnecessary medication. Based on observation, interview, and record review, the facility's consultant Pharmacist failed to obtain an approved indication for use for Seroquel (antipsychotic -class of medications used to treat psychosis and other mental-emotional conditions) for Residents (R) 23, R24, and Zyprexa (antipsychotic) for R15 This deficient practice placed the three residents at risk to receive unnecessary antipsychotic drugs.	F 756		

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Findings included:

- R24's "Electronic Medical Record" included diagnoses of insomnia (inability to sleep), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), restlessness, agitation (feeling of aggravation or restlessness brought on by a provocation or a medical condition), generalized anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear) disorder, dementia (a progressive mental disorder characterized by failing memory, confusion), fibromyalgia (condition of musculoskeletal pain, spasms, stiffness, fatigue, and severe sleep disturbance), and paranoid personality disorder (a mental health condition characterized by a pervasive and unjustified pattern of distrust and suspicion of others).

The "Quarterly Minimum Data Set" (MDS), dated 02/14/25, documented a Brief Interview for Mental Status (BIMS) score of 10 indicating moderate cognitive impairment. The MDS documented R24 was independent with activities of daily living, R24 received antipsychotic and antianxiety (class of medications that calm and relax people) medications.

R24's "Care Plan," dated 02/19/25, stated R24 had a history of mental health and mood disorders and exhibited signs of frustration, such as being short-tempered with staff and easily agitated with staff questioning which impacts the ability to ascertain accurate assessment details. R24 had a history of impulsive behavior and poor decision-making related to her health needs as she was failing to take her prescribed

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medications to help stabilize her moods and improve her mental health state. The care plan directed staff to distract R24 from wandering by offering pleasant diversions, structured activities, food, conversation, television, and books. The care plan stated R24 preferred to walk around or do word search puzzles. The care plan directed staff to cue, reorient, and supervise R24 as needed, initiated 07/03/2023. The care plan stated R24 understood consistent, simple, and directive sentences and staff were to provide her with necessary cues, stop and return if agitated, initiated 06/12/2024. The care plan directed staff to administer psychotropic medications as ordered by the physician and to monitor for side effects and effectiveness every shift, initiated 07/03/2023. The care plan stated R24 used antipsychotic medications related to depression and anxiety and directed staff to consult with the pharmacy and her physician to consider dosage reduction when clinically appropriate at least quarterly, initiated 06/12/2024.

The "Physician Order," dated 06/20/23, directed staff to administer Seroquel 300 milligrams (mg) at bedtime, for depression.

The monthly Pharmacist Consultant reviews from 2024 and 2025 did not request an approved diagnosis or indication for the use of the antipsychotic Seroquel for R24.

On 03/03/25 at 09:45 AM, R24 laid in bed, call light in reach. R24 stated she did not want to be bothered and did not want to talk later either.

On 03/04/25 at 08:41 AM, Certified Medication Aide (CMA) R administered medication to R24 who was in bed. R24 took the pills whole without

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problems and requested an as needed Tylenol for pain rated at 7-8 in her left shoulder area. CMA R administered a Tylenol 500 mg and R24 was polite to the CMA.

On 03/04/25 at 08:41 AM, CMA R stated the resident had never become upset or yelled at her. She was usually polite.

On 03/05/25 at 08:50 AM, Administrative Nurse E verified depression was not an approved diagnosis for Seroquel and the consultant pharmacist had not requested an approved diagnosis for the use of Seroquel either.

The facility's "Pharmacy Services-Role of the Consultant Pharmacist" policy, dated April 2019, stated the consultant pharmacist would provide consultation on all aspects of pharmacy services in the facility and collaborate with the facility and medical director with written or electronic reports and recommendations related to all aspects of medication and pharmaceutical services review. The consultant pharmacist may help to develop procedures or guidance regarding when to contact a prescriber about a medication issue.

The facility's pharmacist consultant failed to obtain an approved indication or thorough rationale from the physician of why the antipsychotic Seroquel was necessary to treat R24, placing her at risk of receiving an unnecessary antipsychotic drug.

- R23's "Electronic Medical Record" included diagnoses of viral encephalitis (inflammatory condition of the brain), major depressive disorder (major mood disorder which causes persistent feelings pf sadness), insomnia (inability to sleep),

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and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear) disorder.

The "Significant Change Minimum Data Set" (MDS), dated 01/24/25, documented a Brief Interview for Mental Status (BIMS) score of 11 indicating moderate cognitive impairment. The MDS documented R23 was independent or required supervision for all activities of daily living. The MDS documented R23 received antipsychotic (a class of medications used to treat major mental conditions which cause a break from reality) and antidepressant (a class of medications used to treat mood disorders) medication.

The "Behavior Care Area Assessment" (CAA), dated 01/24/25, stated R23 had an episode of scratching staff and cursing them. The CAA stated R23 had ineffective coping as evidenced by verbal outbursts with anger or frustration and attention-seeking behaviors. He received Seroquel (an antipsychotic - a class of medications used to treat major mental conditions which cause a break from reality) for nicotine dependence (a compulsive need for nicotine), and the antidepressant Trazodone for restlessness and agitation.

The "Care Plan," dated 01/29/25, documented R23 exhibited behavioral problems secondary to a history of encephalopathy and ineffective coping as evidenced by verbal outbursts with anger or frustration and attention-seeking behaviors. R23 was known to make inappropriate comments and jokes aimed at provoking reactions from others such as staff, friends, and family. These behaviors have been observed

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consistently during interactions. The care plan directed staff to assist R23 to develop more appropriate methods of coping and interacting such as exercising and walking when he is frustrated. The care plan directed staff to remind R23 to talk in a normal voice range and remind him that there are others in the facility who become scared when they hear people yelling. When he became upset direct him to a private room and shut the door to converse with him about the reason he was upset, initiated 09/09/2024.

The "Physician Order," dated 11/07/24, directed staff to administer Seroquel, 25 milligrams (mg), twice daily, for restlessness and agitation.

The "Consultant Pharmacist Review" on 02/05/25 (three months after the order) requested an approved diagnosis for the use of the antipsychotic Seroquel.

On 03/03/25 at 11:24 AM, R23 was sitting in his recliner in his room. When the surveyor knocked on his door and spoke to him, R23 got up and walked to the doorway without his walker. R23 seemed confused and did not answer any questions. He looked out in the hall, mumbled something about staff, then got his walker and walked to the dining room.

On 03/05/25 at 08:50 AM, Administrative Nurse E verified restlessness and agitation was not an approved diagnosis for the use of antipsychotic medications. She verified the consultant pharmacist had not obtained an approved diagnosis for the use of the Seroquel.

The facility's "Pharmacy Services-Role of the

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Consultant Pharmacist" policy, dated April 2019, stated the consultant pharmacist would provide consultation on all aspects of pharmacy services in the facility and collaborate with the facility and medical director with written or electronic reports and recommendations related to all aspects of medication and pharmaceutical services review. The consultant pharmacist may help to develop procedures or guidance regarding when to contact a prescriber about a medication issue.

The facility's pharmacist consultant failed to obtain an approved indication or thorough rationale from the physician of why the antipsychotic Seroquel was necessary to treat R23, placing him at risk of receiving an unnecessary antipsychotic drug.
- R15's Electronic Medical Record (EMR) recorded diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion) with mood and behavioral disturbance, Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), major depressive disorder (major mood disorder that causes persistent feelings of sadness), and cellulitis (skin infection caused by bacteria).

R15's "Annual Minimum Data Set (MDS)" date 07/12/24 documented she was unable to recall the current season, the location of her room, any staff names, or faces, or that she was in a nursing facility. R15 displayed physical behavioral symptoms directed toward others on one to three days during the look-back period. R15 was dependent on staff for all functional abilities and activities of daily living (ADL). R15 took an antipsychotic (a class of medications used to treat major mental conditions that cause a break from

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reality) and an antidepressant (a class of medications used to treat mood disorders) on a regular basis.

R15's "Psychotropic Drug Use Care Area Assessment (CAA)" dated 07/21/24 documented she was at risk for adverse effects from Zyprexa (an antipsychotic medication) and citalopram (a medication used to treat depression).

R15's Care Plan revised on 7/21/24 documented that she used the psychotic medication Zyprexa related to major depressive disorder. R15's care plan directed staff to administer medications as ordered by the physician. Staff were directed to consult with the pharmacy and physician to consider dosage reduction when clinically appropriate at least quarterly.

R15's "Order Summary Report" documented a physician's order for Zyprexa 2.5 milligram (mg) tablet by mouth at bedtime for psychosis related to major depressive disorder.

Review of the consultant pharmacist (CP) monthly regimen review (MRR) form "Note to Attending Physician/Prescriber" from January 2024 to the present for R15 lacked a recommendation to the physician for a CMS-appropriate indication for use of the antipsychotic medication Zyprexa.

The 12/02/24 physician response to the "Note to attending Physician/Prescriber" dated 11/11/24 recommending a gradual dose reduction (GDR) of R15's Zyprexa. The physician declined the recommendation due to a good response to the medication.

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F 756	Continued From page 41 On 03/04/25 at 07:30 AM, R15 sat in her wheelchair in the common area of the 200 hall. R15 had a stuffed cat on her lap that she was petting. On 03/05/25 at 10:05 AM, Administrative Nurse E stated the pharmacist had not identified and recommended a CMS-appropriate diagnosis for R15's Zyprexa. Administrative Nurse E stated that the facility had done education with both the pharmacy and the physician about the use of the antipsychotic medication and the importance of an appropriate indication for use or the risk versus benefit of the medication. The "Pharmacy Services - Role of the Consultant Pharmacist" policy revised on April 2019, documented the CP would provide specific activities related to medication regimen review including a documented review of the medication regimen of each resident at least monthly, or more frequently under certain conditions, based on applicable federal and state guidelines. The CP would provide appropriate communication of information to prescribers and the facility leadership about potential or actual problems related to any aspect of medications and pharmacy services, including medication irregularities, and pertinent resident-specific documentation in the medical record, as indicated. The facility failed to ensure the CP identified and reported R15's Zyprexa failed to have an adequate CMS	F 756		
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.	F 758		

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F 758	Continued From page 42 §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order 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	F 758		

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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 37 residents. The sample included 12 residents, with five reviewed for unnecessary medication. Based on observation, interview, and record review, the facility failed to obtain an approved indication for use for Seroquel (antipsychotic -class of medications used to treat psychosis and other mental-emotional conditions) for Residents (R) 23, R24, and Zyprexa (antipsychotic) for R15 This deficient practice placed the three residents at risk to receive unnecessary antipsychotic drugs.

Findings included:

- R24's "Electronic Medical Record" included diagnoses of insomnia (inability to sleep), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), restlessness, agitation (feeling of aggravation or restlessness brought on by a provocation or a medical condition), generalized anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear) disorder, dementia (a progressive mental disorder characterized by failing memory, confusion), fibromyalgia (condition of musculoskeletal pain, spasms, stiffness, fatigue, and severe sleep disturbance), and paranoid personality disorder (a mental health condition characterized by a pervasive and unjustified

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pattern of distrust and suspicion of others).

The "Quarterly Minimum Data Set" (MDS), dated 02/14/25, documented a Brief Interview for Mental Status (BIMS) score of 10 indicating moderate cognitive impairment. The MDS documented R24 was independent with activities of daily living, R24 received antipsychotic, antianxiety, antidepressant, and anticoagulant medications.

R24's "Care Plan," dated 02/19/25, stated R24 had a history of mental health and mood disorders and exhibited signs of frustration, such as being short-tempered with staff and easily agitated with staff questioning which impacts the ability to ascertain accurate assessment details. R24 had a history of impulsive behavior and poor decision-making related to her health needs as she was failing to take her prescribed medications to help stabilize her moods and improve her mental health state. The care plan directed staff to distract R24 from wandering by offering pleasant diversions, structured activities, food, conversation, television, and book. The care plan stated R24 preferred to walk around or do word search puzzles. The care plan directed staff to cue, reorient, and supervise R24 as needed, initiated 07/03/2023. The care plan stated R24 understood consistent, simple, and directive sentences and staff were to provide her with necessary cues, stop and return if agitated, initiated 06/12/2024. The care plan directed staff to administer psychotropic medications as ordered by the physician and to monitor for side effects and effectiveness every shift, initiated 07/03/2023. The care plan stated R24 used antipsychotic medications related to depression and anxiety and directed staff to consult with the

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pharmacy and her physician to consider dosage reduction when clinically appropriate at least quarterly, initiated 06/12/2024.

The "Physician Order," dated 06/20/23, directed staff to administer Seroquel 300 milligrams (mg) at bedtime, for depression.

The monthly Pharmacist Consultant reviews from 2024 and 2025 did not request an approved diagnosis or indication for the use of the antipsychotic Seroquel for R24.

On 03/03/25 at 09:45 AM, R24 laid in bed, call light in reach. R24 stated she did not want to be bothered and did not want to talk later either.

On 03/04/25 at 08:41 AM, Certified Medication Aide (CMA) R administered medication to R24 who was in bed. R24 took the pills whole without problems and requested an as-needed Tylenol for pain rated at 7-8 in her left shoulder area. CMA R administered a Tylenol 500 mg and R24 was polite to the CMA.

On 03/04/25 at 08:41 AM, CMA R stated the resident had never become upset or yelled at her. She was usually polite.

On 03/05/25 at 08:50 AM, Administrative Nurse E verified depression was not an approved diagnosis for Seroquel and the consultant pharmacist had not requested an approved diagnosis for the use of Seroquel either.

The facility's "Antipsychotic Medication Use" policy, dated July 2022, stated residents would only receive antipsychotic medications when necessary to treat specific conditions for which

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they are indicated and effective. The attending physician would identify, evaluate, and document symptoms that may warrant the use of antipsychotic medications. The policy stated diagnoses alone did not warrant the use of antipsychotic medication. In addition to an approved diagnosis, antipsychotic medication would generally only be considered if the behavioral symptoms presented a danger to the resident or others, or behavioral interventions had been attempted and included in the plan of care (except in an emergency). The policy stated antipsychotic medications would not be used if the only symptoms were one or more of the following: wandering, poor self-care, restlessness, impaired memory, mild anxiety, insomnia sadness or crying not related to depression or other psychiatric disorders, fidgeting, or uncooperativeness.

The facility failed to obtain an approved indication or thorough rationale from the physician of why the antipsychotic Seroquel was necessary to treat R24, placing her at risk of receiving an unnecessary antipsychotic drug.

- R23's "Electronic Medical Record" included diagnoses of viral encephalitis (inflammatory condition of the brain), major depressive disorder (major mood disorder which causes persistent feelings of sadness), insomnia (inability to sleep), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear) disorder.

The "Significant Change Minimum Data Set" (MDS), dated 01/24/25, documented a Brief Interview for Mental Status (BIMS) score of 11, indicating moderate cognitive impairment. The

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MDS documented R23 was independent or required supervision for all activities of daily living. The MDS documented R23 received antipsychotic (a class of medications used to treat major mental conditions which cause a break from reality) and antidepressant (a class of medications used to treat mood disorders) medication.

The "Behavior Care Area Assessment" (CAA), dated 01/24/25, stated R23 had an episode of scratching staff and cursing them. The CAA stated R23 had ineffective coping as evidenced by verbal outbursts with anger or frustration and attention-seeking behaviors. He received the antipsychotic Seroquel for nicotine dependence (a compulsive need for nicotine), and the antidepressant Trazodone for restlessness and agitation.

The "Care Plan," dated 01/29/25, documented R23 exhibited behavioral problems secondary to a history of encephalopathy and ineffective coping as evidenced by verbal outbursts with anger or frustration and attention-seeking behaviors. R23 was known to make inappropriate comments and jokes aimed at provoking reactions from others such as staff, friends, and family. These behaviors have been observed consistently during interactions. The care plan directed staff to assist R23 to develop more appropriate methods of coping and interacting such as exercising and walking when he is frustrated. Remind R23 to talk in a normal voice range and remind him that there are others in the facility who become scared when they hear people yelling. When he became upset direct him to a private room and shut the door to converse with him about the reasons he was upset,

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initiated 09/09/2024.

The "Physician Order," dated 11/07/24, directed staff to administer Seroquel, 25 milligrams (mg), twice daily, for restlessness and agitation.

The "Consultant Pharmacist Review" on 02/05/25 (three months after the order) requested an approved diagnosis for the use of the antipsychotic Seroquel.

On 03/03/25 at 11:24 AM, R23 was sitting in his recliner in his room. When the surveyor knocked on his door and spoke to him, R23 got up and walked to the doorway without his walker. R23 seemed confused and did not answer any questions. He looked out in the hall, mumbled something about staff, then got his walker and walked to the dining room.

On 03/05/25 at 08:50 AM, Administrative Nurse E verified restlessness and agitation were not an approved diagnosis for the use of antipsychotic medications. She verified the consultant pharmacist had not obtained an approved diagnosis for the use of the Seroquel.

The facility's "Antipsychotic Medication Use" policy, dated July 2022, stated residents would only receive antipsychotic medications when necessary to treat specific conditions for which they are indicated and effective. The attending physician would identify, evaluate, and document symptoms that may warrant the use of antipsychotic medications. The policy stated diagnosis alone does not warrant the use of antipsychotic medication. In addition to an approved diagnosis, antipsychotic medication would generally only be considered if the

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behavioral symptoms present a danger to the resident or others or behavioral interventions had been attempted and included in the plan of care (except in an emergency). The policy stated antipsychotic medications would not be used if the only symptoms were one or more of the following: wandering, poor self-care, restlessness, impaired memory, mild anxiety, insomnia sadness or crying not related to depression or other psychiatric disorders, fidgeting, or uncooperativeness.

The facility failed to obtain an approved indication or thorough rationale from the physician of why the antipsychotic Seroquel was necessary to treat R23, placing him at risk of receiving an unnecessary antipsychotic drug.
- R15's Electronic Medical Record (EMR) recorded diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion) with mood and behavioral disturbance, Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), major depressive disorder (major mood disorder that causes persistent feelings of sadness), and cellulitis (skin infection caused by bacteria).

R15's "Annual Minimum Data Set (MDS)" date 07/12/24 documented she was unable to recall the current season, the location of her room, any staff names, or faces, or that she was in a nursing facility. R15 displayed physical behavioral symptoms directed toward others on one to three days during the look-back period. R15 was dependent on staff for all functional abilities and activities of daily living (ADL). R15 took an antipsychotic (a class of medications used to treat major mental conditions that cause a break from

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F 758	Continued From page 50 reality) and an antidepressant (a class of medications used to treat mood disorders) on a regular basis. R15's "Psychotropic Drug Use Care Area Assessment (CAA)" dated 07/21/24 documented she was at risk for adverse effects from Zyprexa (an antipsychotic medication) and citalopram (a medication used to treat depression). R15's "Care Plan" revised on 7/21/24 documented that she used the antipsychotic medication Zyprexa related to major depressive disorder. R15's care plan directed staff to administer medications as ordered by the physician. Staff were directed to consult with the pharmacy and physician to consider dosage reduction when clinically appropriate at least quarterly. R15's "Order Summary Report" documented a physician's order dated 08/02/23 for Zyprexa 2.5 milligram (mg) tablet by mouth at bedtime for psychosis related to major depressive disorder. This order lacked an appropriate CMS diagnosis for use.	F 758		
F 883 SS=E	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	F 883		

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immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;
(iii) The resident or the resident's representative has the opportunity to refuse immunization; and
(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and
(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.

§483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-
(i) Before offering the pneumococcal immunization, each resident or the resident's 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

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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 37 residents. The sample included 12 residents, with five residents reviewed for immunizations. Based on record review and interview the facility failed to ensure that Resident (R) 8, R5, R19, R23, and R24 were offered and educated regarding the Prevnar 20 (PCV20) pneumococcal (type of bacterial infection) vaccination (a pneumococcal conjugate vaccine that protects against 20 different strains of pneumonia) or assessed and deemed contraindicated as recommended by the Centers for Disease Control and Prevention (CDC). This deficient practice placed these residents at risk of acquiring, transmitting, or experiencing complications from pneumococcal disease.

Finding included:

- Review of R8's "Long-Term Care Resident and Staff Annual Vaccination Acknowledgement Consent / Declination Form" dated 09/19/24 was signed by R8's power of attorney (POA) declining to be vaccinated for pneumonia a (two-dose series). The form lacked distinction of all the pneumococcal vaccinations offered.

Review of R15's "Immunizations" tab of the EMR indicated the PCV 20 had been offered to R15 but was refused. The facility was unable to provide documentation that R15 had been offered and declined specifically the PCV 20 vaccination.

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R15 had received the pneumococcal polysaccharide (PPSV23) on 10/11/08.

Review of R19's "Immunizations" tab of the EMR indicated that he had received the PPSV23 vaccination on 12/06/18 and had received the Prevnar 13 (PCV13) vaccination on 09/14/17. R19's "Immunizations" tab or "Misc." tab lacked documentation that he had been offered nor had he declined the PCV20 vaccination.

Review of R23's "Immunizations" tab of the EMR indicated he had received the PCV 13 vaccination on 09/22/20. R23's "Immunizations" tab or "Misc." tab lacked documentation that he had been offered nor had he declined the PCV20 vaccination.

Review of R24's "Immunizations" tab of the EMR indicated she had received the PCV 13 on 01/31/23. R24's "Immunizations" tab or "Misc." tab lacked documentation that he had been offered nor had declined the PCV20 vaccination.

On 03/05/24 at 09:06 AM, Administrative Nurse E stated the PCV 20 she assumed was being offered to the residents. Administrative Nurse E stated the resident immunization information was sent to the pharmacy on admission and yearly and had just assumed that the PCV20 was being offered and provided per the CDC guidelines. Administrative Nurse E stated the facility would update the acceptance and declination form to include the different types of pneumococcal vaccinations. Administrative Nurse E stated the facility would talk to the pharmacy to ensure that the PCV 20 was being recommended and received by the residents as required.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175525	A. BUILDING _____ B. WING _____	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK LANE NURSING HOME	210 E PARK LANE SCOTT CITY, KS 67871

(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 883	Continued From page 54 The "Pneumococcal Vaccine" policy revised on October 2023 documented all residents were offered pneumococcal vaccines to aid in preventing pneumonia or pneumococcal infections. Prior to or upon admission, the resident was assessed for eligibility to receive the pneumococcal vaccine series, and when indicated, was offered the vaccine series within 30 days of admission to the facility unless medically contraindicated or the resident had completed the current recommended vaccine series. Before receiving a pneumococcal vaccine, the resident or legal representative received information and education regarding the benefits and potential side effects of the vaccine. The pneumococcal vaccines were administered to residents per the facility's physician-approved pneumococcal vaccination protocol. Administration of the pneumococcal vaccines was made in accordance with current CDC recommendations at the time of the vaccination. The facility failed to offer PCV20 vaccination as recommended by the CDC to R8, R15, R19, R23, and R24. This placed the facility residents at risk of acquiring, transmitting, or experiencing complications from pneumococcal disease.	F 883		