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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.	F 550		

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

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

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§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 26 residents with 12 residents sampled, including two residents reviewed for dignity. Based on observation, interview and record review, the facility failed to show respect and dignity to two Residents (R)13 and R 11, regarding wearing dirty clothes to the dining room.

Findings included:

- Review of Resident (R)13's electronic medical record (EMR) revealed a diagnosis of dementia (progressive mental disorder characterized by failing memory, confusion).

Review of the "Annual Minimum Data Set" (MDS), dated 10/24/24, documented the resident had a Brief Interview for Mental Status (BIMS) score of three, indicating severe cognitive impairment. She required substantial to maximal staff assistance with dressing the top half of her body.

The "Functional Abilities Care Area Assessment" (CAA), dated 10/24/24, did not trigger.

The "Quarterly MDS," dated 01/16/25, documented the resident had a BIMS score of four, indicating severe cognitive impairment. She required substantial to maximal staff assistance

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with dressing the top half of her body.

The "Care Plan", revised 01/30/25, instructed staff the resident required assistance with dressing.

Review of the resident's EMR, from 02/11/25 through 03/11/25, revealed she required substantial/maximal to dependence on staff assistance with dressing of her upper body.

On 03/10/25 at 12:07 PM, the resident sat with a peer at the dining room table in the dining room. The resident's shirt had a large area of dried on food and liquid on the front.

On 03/10/25 at 03:05 PM, the resident continued to wear the soiled shirt while in the front commons area with her peers.

On 03/10/25 at 04:17 PM, the resident sat with a peer at the dining room table in the dining room. She continued to wear the same soiled shirt.

On 03/11/25 at 08:11 AM, Certified Nurse Aide (CNA) M stated the resident required staff assistance with dressing.

On 03/11/25 at 08:20 AM, CNA P stated the resident required staff assistance with dressing.

On 03/11/25 at 01:49 PM, Licensed Nurse (LN) H stated staff should change resident's clothing when soiled.

On 03/12/25 at 09:41 AM, Administrative Nurse D stated it was the expectation for staff to change residents clothing when it became soiled.

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The facility policy for "Resident Rights", undated, included: Residents have the right to quality care regardless of diagnosis, severity of condition or payment source.

The facility failed to show respect and dignity to this dependent resident by failing to change her soiled shirt which she had to wear amongst her peers.

- R11's Electronic Health Record (EHR) revealed diagnoses of anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear) and age-related physical debility.

The 07/25/24 Annual "Minimum Data Set" (MDS) documented a Brief Interview for Mental Status (BIMS) score of 11, indicating moderately impaired cognition. The resident required substantial to maximum assistance from staff with dressing.

The 07/25/24 "Cognitive Loss / Dementia Care Area Assessment" (CAA) documented R11 had a moderate cognitive impairment. R11 required staff assistance with some activities of daily living and the CAA noted some days she needed cueing for completion of activities of daily living and other days she did fine on her own.

The 01/09/25 "Quarterly MDS" documented a BIMS score of 9, indicating moderately impaired cognition. The resident required substantial to maximum assistance with dressing.

During an observation on 03/10/25 at 02:25 PM, R11's shirt was dirty and with stains on the front.

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F 550	Continued From page 4 During an observation on 03/11/25 at 01:17 PM, R11 had on a dark colored shirt with a light-colored spot from lunch in the middle of the front of her shirt. Several staff members went by her and talked to her about her leaving to go to an appointment. CNA MM approached R11 to see if she was ready to go and started pulling her back. This nurse pointed out the large spot on the resident's shirt and asked her if she could help her before she went to the appointment. CNA MM took her immediately to get her shirt changed. During an interview on 03/12/25 at 10:21 AM, Administrative Nurse D revealed it was her expectation that all residents be clean and be treated with dignity. The "Prairie Mission Retirement Village Resident Rights" policy, which was undated, revealed residents have the right to quality care regardless of diagnosis, severity of condition. The facility failed to provide R11 care in a dignified manner when R11 was not assisted to change her shirt when it was dirty. This deficient practice placed the resident at risk for decreased psychosocial well-being.	F 550		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: The facility reported a census of 26 residents with 12 residents sampled. Based on observation, interview, and record review the	F 641		

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facility failed to complete an accurate "Minimum Data Set" (MDS) for two Residents (R)16, regarding limited range of motion (ROM) and R9, regarding eating assistance.

Findings included:

- Review of Resident (R)16's electronic medical record (EMR) revealed diagnoses which included: dementia (progressive mental disorder characterized by failing memory, confusion), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear) and weakness.

The "Annual Minimum Data Set" (MDS), dated 12/12/24, documented the resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. She used a wheelchair for mobility and was independent with wheeling the wheelchair 150 feet in the corridor.

The "Functional Abilities Care Area Assessment" (CAA), dated 12/12/24, documented the resident was independent with locomotion.

The "Medicare 5-Day MDS," dated 10/11/24, documented the resident had a BIMS score of 12, indicating moderately impaired cognition. She was dependent on staff to wheel her in her wheelchair, 150 feet in the corridor.

The "Care Plan", revised 12/15/24, instructed staff the resident had an unsteady gait (a person's manner of walking) and had a limited range of motion (ROM) in her lower extremities (LE).

Review of the resident's EMR revealed the

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F 641	Continued From page 6 resident used a wheelchair for mobility in the facility with partial to moderate to dependent on staff for assistance. On 03/12/25 at 09:33 AM, Administrative Nurse E stated the MDS, dated 12/12/24, was inaccurate as the resident did have a limitation in ROM. On 03/12/25 at 09:41 AM, Administrative Nurse D stated it was the expectation for the MDSs to be completed correctly. The facility utilized the Resident Assessment Instrument (RAI) manual for accurate completion of the MDSs. The facility failed to complete an accurate MDS for this resident with a limitation in ROM.	F 641		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: The facility reported a census of 26 residents with 12 residents selected for review. Based on observation, interview, and record review, the facility failed to assess and address proper positioning in accordance with professional standards of practice for Resident (R) 5. This	F 684		

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deficient practice had the potential to place R5 at an increased risk for development of increased pain and additional medical problems.

Findings included:

- Review of the "Electronic Medical Record" (EMR) included diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), restlessness and agitation, chronic pain, neuropathy (weakness, numbness and pain from nerve damage, usually in the hands and feet), arthritis (inflammation of a joint characterized by pain, swelling, redness and limitation of movement), and low back pain.

The 07/16/24 "Admission Minimum Data Set" (MDS) documented a "Brief Interview for Mental Status" (BIMS) of 0, indicating severely impaired cognition. R5 had a total mood severity score of 0, indicating no depression. The MDS documented behaviors of rejection of care and wandering on one to three days out of the 7 prior to 07/16/24. R5's wandering affected others. The resident required substantial to maximum assistance from staff to transfer. R5 required supervision or touching assistance to walk 50 feet and make two turns. R5 required supervision or touching assistance for mobility 50 ft in a wheelchair.

The 01/02/25 "Quarterly MDS" documented R5 was unable to complete the BIMS. Staff interview for cognition documented R5 as severely impaired. She rarely or never understands or was understood others. R5 did not know staff, where her room was, the season, or that she was in a nursing home. Her mood score was zero indicating no depression. R5 required substantial

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to maximal assist with wheel walking and was dependent on staff for mobility in her wheelchair.

The resident's "Care Plan" revealed the following:

Staff would know R5 was unsteady on her feet, required assistance, and R5 used a Broda chair (specialized wheelchair with the ability to tilt and recline) to get around. After standing she could walk with staff standing by her. Some of the concerns that affect her mobility were arthritis (inflammation of a joint characterized by pain, swelling, redness and limitation of movement), low back pain, fatigue, chronic pain, and muscle weakness.
On 07/11/24, staff would know they were to push R5 in her wheelchair.
On 01/09/25 staff would know R5 required two staff assistance with walking and transfers.

During an observation on 03/10/25 at 02:20 PM, R5 sat leaning to in an uncomfortable position in her Broda Chair. There was no footrest and her feet were dangling about one to two inches off the floor.

During an observation on 03/11/25 at 10:25 AM, Certified Nurse Aide (CNA) P pushed R 5 in the Broda chair with no foot pedals. R5's feet were dragging on the floor. CNA P turned the chair and her foot touched the wheel but did not go under the wheel. This nurse asked CNA P if there were pedals for R5's Broda chair and CNA P found some.

During an observation on 03/11/25 at 01:48 PM, R5 rested with her eyes closed in her Broda chair. R5 leaned to the left side hanging over her arm rest with her upper body unsupported.

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F 684	Continued From page 9 During an interview on 03/12/25 at 07:35 AM, Licensed Nurse (LN) H revealed the facility had pillows and a wedge they used for positioning R5, which were kept in the supply closet. LN H stated it was not a weakness thing as she had plenty of strength in her torso, she just leaned. When asked why she was in a Broda chair, LN H said she leaned forward if she was not reclined. Positioning equipment should be in the care plan. During an interview on 03/12/25 at 10:21 AM, Administrative Nurse D stated she expected the residents to be positioned comfortably, and the proper positioning devices used. The facility did not provide a policy related to positioning as requested on 03/12/25. The facility failed to assess and address proper positioning in accordance with professional standards of practice for Resident (R) 5. This deficient practice had the potential to place R5 at an increased risk for development of increased pain and additional medical problems.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives	F 686		

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necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 26 residents with 12 residents sampled, including one resident reviewed for pressure ulcers (PU). Based on observation, interview, and record review the facility failed to notify the Registered Dietician (RD) of the development of a facility acquired stage II (partial thickness skin loss) PU for one Resident (R)13.

Findings included:

- Review of Resident (R)13's electronic medical record (EMR) revealed a diagnosis of (progressive mental disorder characterized by failing memory, confusion).

The "Annual Minimum Data Set" (MDS), dated 10/24/24, documented the resident had a Brief Interview for Mental Status (BIMS) score of three, indicating severe cognitive impairment. She required substantial to maximal staff assistance to roll left to right and was dependent on staff for going from sitting to lying, lying to sitting, and chair to bed to chair transfers. She was at risk for the development of pressure ulcers (PU) but had no unhealed PUs at the time of the assessment.

The "Pressure Ulcer Care Area Assessment" (CAA), dated 10/24/24, documented the resident had a pressure reduction mattress for her bed and a cushion for her wheelchair.

The "Quarterly MDS," dated 01/16/25,

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documented the resident had a BIMS score of four, indicating severe cognitive impairment. She required substantial to maximal staff assistance to roll left to right and was dependent on staff for going from sitting to lying, lying to sitting and chair to bed to chair transfers. She was at risk for the development of PU with no unhealed PUs at the time of the assessment.

The "Care Plan", revised 01/30/25, instructed staff the resident had a stage II PU to her right gluteal (muscles which make up the buttocks) proximal (nearer to the center of the body) to her sacrum (tailbone).

Review of the resident's EMR revealed a "Wound Assessment and Treatment Flowsheet", dated 02/27/25, which included: Stage II PU to resident's right gluteal proximal to her sacrum, measuring 1.0 centimeters (cm) in length (L), 1.0 cm in width (W) and 0.1 cm in depth (D). The wound bed was 100% red/pink and had no odor or exudate (drainage).

Review of the resident's EMR revealed a "Wound Assessment and Treatment Flowsheet", dated 02/27/25, which included: 1.0 cm in L, 1.0 cm in W and 0.1 cm in D. The wound bed had no odor or exudate.

Review of the resident's EMR revealed the Registered Dietician (RD) had not been notified of the resident's new stage II PU.

Review of the resident's EMR revealed the following physician's orders:

Multivitamin (MVI), 1 tablet, by mouth (po), every morning (QAM), for a diagnosis of vitamin

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supplement, ordered 07/30/20.

Review of the resident's EMR revealed the medication was administered, as ordered.

Vitamin C, 500 milligrams (mg), po, QAM, for a diagnosis of wound care management, ordered 03/07/25.

Review of the resident's EMR revealed the medication was administered, as ordered.

Cleanse the right gluteal proximal to the sacrum stage II PU wound with wound cleanser, apply skin prep and cover with a foam dressing. Change every three days, for diagnosis of PU, ordered 02/28/25.

Review of the resident's EMR revealed the treatment was done, as ordered.

On 03/11/25 at 08:33 AM, Licensed Nurse (LN) H entered resident's room to perform wound care. LN H cleansed the wound bed to the resident's right glute with wound cleanser on a gauze pad. The peri-wound (area around the wound) was normal in color for the resident with the wound bed having 100% red granulation (a new connective tissue) tissue. LN H covered the wound with a bordered foam dressing. The wound had no exudate (drainage) or odor and measured 1.0 cm in L, 1.0 cm in D and 0.1 cm in D.

On 03/11/25 at 08:11 AM, Certified Nurse Aide (CNA) M stated staff helped the resident resituate every two hours when she was in bed or up in her wheelchair. CNA M stated the resident had a gel cushion in her wheelchair.

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F 686	Continued From page 13 On 03/11/25 at 08:20 AM, CNA P stated the resident was able to feed herself and had a good appetite. The staff would help the resident reposition every two hours. On 03/12/25 at 11:30 AM, Dietary Staff BB stated the facility had not notified the RD of the resident's new PU. Dietary Staff BB stated she was unaware of the need to notify the RD when a resident developed a new wound. The RD visited the facility monthly and would be notified at that time. On 03/12/25 at 09:52 AM, Administrative Nurse D stated it was the expectation the RD would be notified by e-mail when a resident developed a new PU so that any nutritional interventions could be initiated to help with wound healing. Administrative Nurse D stated the RD had not been notified of the resident's new PU. The facility policy for "Pressure Ulcer (PU) Prevention Guidelines", revised 12/04/17, included: The facility Registered Dietician (RD) will complete a nutritional screen for residents if they develop a PU at a stage II or above. The facility failed to notify the RD of this dependent resident's new facility acquired stage II PU.	F 686		
F 689 SS=E	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	F 689		

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§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 26 residents with 12 residents sampled, including nine residents reviewed for accidents. Based on observation, interview, and record review, the facility failed to provide appropriate, safe transfers for one Resident (R) 27, failed to ensure safe transport for two residents R16 and R5 while in their wheelchair, R 6, regarding leaving medications in his room and R 11, regarding inappropriate interventions following a fall.

Findings included:

- Review of Resident (R)16's electronic medical record (EMR) revealed a diagnosis of dementia (progressive mental disorder characterized by failing memory, confusion).

The "Annual Minimum Data Set" (MDS) dated 12/12/24, documented the resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. She was independent with her wheelchair for 150 feet in the corridor.

The "Functional Abilities Care Area Assessment" (CAA), dated 12/12/24, documented the resident was independent with locomotion.

The "Medicare 5-Day MDS," dated 10/11/24, documented the resident had a BIMS score of 12, indicating moderately impaired cognition. She used a wheelchair for locomotion and was dependent on staff for mobility.

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The care plan, revised 12/15/24, lacked staff instruction regarding the resident's need for staff assistance with propelling her wheelchair and the need for footrests on her wheelchair while staff propelled her in the facility.

Review of the resident's EMR, from 02/01/25 through 03/10/25, revealed the resident required partial/moderate assistance to dependence on staff for mobility in her wheelchair.

On 03/10/25 at 04:11 PM, Certified Nurse Aide (CNA) N propelled the resident in her wheelchair. The resident's shoed feet were pulled back underneath the wheelchair seat and skimmed the floor during transport.

On 03/11/25 at 07:29 AM, CNA M propelled the resident in her wheelchair to the shower room. The resident's shoed feet were pulled back underneath the wheelchair seat and skimmed the floor during transport.

On 03/11/25 at 07:41, Certified Medication Aide (CMA) R propelled the resident in her wheelchair from the front commons area to the dining room. The resident's shoed feet were pulled back underneath the wheelchair seat and skimmed the floor during transport.

On 03/10/25 at 04:11 PM, CNA N stated the resident did not have footrests on her wheelchair because she was able to propel herself at times.

On 03/11/25 at 07:41, CMA R stated the resident did not have footrests for her wheelchair because she would propel herself at times.

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On 03/11/25 at 01:49 PM, Licensed Nurse (LN) H stated the resident did not have footrests on her wheelchair. Staff did not put footrests on the wheelchair while propelling her.

On 03/12/25 at 07:25 AM, LN G stated staff should use footrests while propelling residents in their wheelchairs.

On 03/12/25 at 09:41 AM, Administrative Nurse D stated it was the expectation for staff to utilize footrests while propelling residents in their wheelchairs.

The facility policy for "Footrest Plan for Wheelchair Mobility Policy", dated 03/11/25, included: Apply footrests prior to pushing the resident in wheelchair to keep their feet from dragging and possibly causing injury or the resident is unable to hold up their feet.

The facility failed to utilize footrests while propelling this resident in her wheelchair.

- Review of Resident (R)27's electronic medical record (EMR) revealed a diagnosis of dementia (progressive mental disorder characterized by failing memory, confusion).

The "Admission Minimum Data Set" (MDS), dated 10/03/24, documented the resident had a Brief Interview for Mental Status (BIMS) score of three, indicating severe cognitive impairment. She had limited range of motion (ROM) to her bilateral (both sides) lower extremities and required substantial to maximal staff assistance with toilet transfers.

The "Functional Abilities Care Area Assessment"

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(CAA), dated 10/03/24, did not trigger.

The "Quarterly MDS," dated 12/26/24, documented the resident had a BIMS score of one, indicating severe cognitive impairment. She had limited ROM to her bilateral lower extremities and required substantial to maximal staff assistance with toilet transfers.

The resident's Care Plan, revised 01/01/25, instructed staff the resident required two staff for transfers.

Review of the resident's EMR, from 02/01/25 through 03/10/25, revealed she required partial/moderate to dependent staff assistance with toilet transfers.

On 03/11/25 at 12:57 PM, Certified Nurse Aides (CNA) M and CAN O transferred the resident from her wheelchair to the toilet and back to the wheelchair following toileting and peri-care (the cleansing of genitals). The resident was unable to bear weight and her feet slid on the tile floor during the transfers.

On 03/11/25 at 12:57 PM, CNA M stated it would depend on the day on whether the resident was able to bear weight during transfers.

On 03/11/25 at 12:57 PM, Licensed Nurse (LN) H stated the resident was not able to fully straighten her legs, so she was not always able to bear weight during her transfers.

On 03/11/25 at 02:41 PM, Administrative Nurse D stated residents should be able to bear weight during transfers. The facility may need to see if staff need to use a mechanical lift to transfer the

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resident.

The facility lacked a policy for safe transfers.

The facility failed to provide appropriate, safe transfers for this dependent resident.

- Review of the "Electronic Medical Record" (EMR) included diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), fatigue, restlessness and agitation, chronic pain, neuropathy (weakness, numbness and pain from nerve damage, usually in the hands and feet), arthritis (inflammation of a joint characterized by pain, swelling, redness and limitation of movement), and low back pain.

The 07/16/24 "Admission Minimum Data Set" (MDS) documented a "Brief Interview for Mental Status" (BIMS) of 0, indicating severely impaired cognition. R5 had a total mood severity score of 0, indicating no depression. The MDS documented behaviors of rejection of care and wandering on one to three days out of the seven prior to 07/16/24.

R5's wandering affected others. The resident required substantial to maximum assistance from staff to transfer. R5 required supervision or touching assistance to walk 50 feet and make two turns. R5 required supervision or touching assistance for mobility 50 ft in a wheelchair.

The 01/02/25 "Quarterly MDS" documented R5 was unable to complete the BIMS. Staff interview

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for cognition documented R5 was severely impaired. She rarely or never understands or was understood, R5 did not know staff, where her room was, the season, or that she was in a nursing home. Her mood score was zero indicating no depression. R5 required substantial to maximal assist with wheel walking and was dependent on staff for mobility in her wheelchair.

The 03/11/25 "Care Plan" documented a focus for mobility initiated on 10/15/24. R5 was unsteady on her feet and required assistance. R5 used a Broda chair (specialized wheelchair with the ability to tilt and recline) to get around. After standing she could walk with staff standing by her. Some of the concerns that affect her mobility were arthritis (inflammation of a joint characterized by pain, swelling, redness and limitation of movement), low back pain, fatigue, chronic pain, muscle weakness.

Initiated on 06/27/24, Assist R5 to reposition for comfort. Offer to elevate her legs for comfort. Offer hot pack to painful areas. Offer Whirlpool if R5 is hurting.
Initiated on 07/11/24, Assist R5 to reposition every 2 hours while awake.
Initiated on 07/11/24, push R5 in her wheelchair.
initiated on 01/09/25, R5 required two staff assistance with walking and transfers.

During an observation on 03/10/25 at 02:20 PM, R5 sat leaning to in an uncomfortable position in her Broda Chair. There was no footrest, and her feet were danglingly about one to two inches off the floor.

During an observation on 03/11/25 at 10:25 AM, Certified Nurse Aide (CNA) P pushed R 5 in the

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Broda chair with no foot pedals. R5's feet were dragging on the floor. CNA P turned the chair, and her foot touched the wheel but did not go under the wheel. This nurse asked CNA P if there were pedals for R5's Broda chair and CNA P found some.

During an observation on 03/11/25 at 02:10 PM, CNA P assisted R5 in her Broda chair with her feet off the pedals. CNA P said she probably needed a foot board for better positioning, but she hadn't seen one in a long time at the facility. CNA P assisted R5 to the bathroom. CNA M entered the bathroom and assisted CNA P with toileting R5. When they were done, R5 wanted to walk so they walked with her out to the commons area to the recliner to rest.

During an Interview on 03/11/25 at 02:10 PM, CNA M reported that they do not have one restorative aided. All CNAs are responsible for providing restorative care to the residents.

During an interview on 03/11/25 at 11:48 AM, Licensed Nurse (LN) H stated that all residents should have foot pedals unless they self-propelled. This should be in their care plan. R5 did not self-propel and did not have foot pedals until requested. Staff provide all her cares for her.

During an interview on 03/12/25 at 10:21 AM, administrative nurse D stated she expected the residents to have wheelchair pedals on their wheelchairs unless they self-propelled. It should be care planned if they did not have them.

The facility policy for "Fall Prevention Protocol", dated 04/15/19, included: Each resident residing

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at the facility will be provided services and care that ensures the resident's environment remains as free from accident hazards as possible and each resident received adequate supervision and assistive devices to prevent accidents.

The facility failed to ensure R5's environment was free from accident hazards to prevent accidents when facility staff pushed R5 in a wheelchair without proper foot pedals. This deficient practice had the potential to place R5 at an increased risk for injury.

- The Electronic Health Record (EHR)revealed the following diagnoses for R9 cerebrovascular accident (CVA-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), chronic fatigue, pain, unhappiness, and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest).

The 09/26/24 Annual "Minimum Data Set" (MDS) documented a brief interview for mental status (BIMS) of 12, indicating moderately impaired cognition. Total severity score of 2, indicating no depression. R9 refused care.

The 09/26/24 "Cognitive Loss / Dementia" (CAA) documented R9 had moderate cognitive impairment. R9 had chronic pain due to Poly osteoarthritis and pain in his back from being burned years ago. He took a lot of narcotics to control his pain. He refuses care at times. He has refused baths and toileting. R9 required help with ADLs due to chronic pain, unsteadiness on feet, muscle weakness, and limited range of motion to

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his legs.

The 09/26/24 "Psychosocial Well-Being" (CAA) documented R9 had stated in the past that he is ready to die. He said he is tired of living in pain but says his pain is controlled. He said he wanted to go home but his wife cannot physically take care of him anymore. He refused to see a mental health specialist. Staff as well as his wife think he would benefit from a mental health specialist. He does not want his wife to waste any more money on him. He was a CNA in the past and worked in mental health. He is aware that there is help available but refuses all of it. He preferred to stay to himself in his room. He refused all activities offered.

The 09/26/24 "Behavioral Symptoms" (CAA) documented R9 refused facility meals most of the time, refused care at times, refused to shower and to be toileted at times. Hx of depression and chronic pain.

The 12/19/24 "Quarterly MDS" documented a BIMS of 14, indicating intact cognition. R9 had a total severity score of 18 indicating moderately severe depression and had thoughts that he would be better off dead, or of hurting himself in some way 12 to 14 days out of the last 14 days. R9 had no behaviors documented. R9 required set up assistance for meals and had no concerns with eating or swallowing.

The 12/03/24 focus on the "Care Plan" documented that R9 had stated that he was ready to die, and his wife was aware and had heard this. He did not want to cause his wife any trouble and didn't want her to waste any more money on him. He has issues with being

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depressed. R9 refused to take more depression meds and refused to see a mental health provider. He stated he could deal with this on his own. He stays in his room and lays in his recliner and alone. R9's wife said this is normal. R9 was burned several years ago and lives in pain and that caused depression. It was not unusual for R9to be up a lot during the night or to sleep a lot.

The Electronic Health Records (EHR) "Physician Orders" lacked documentation of any medications to be kept at bedside.

The "Care Services" note on 12/19/24 at 03:08 PM documented sometimes he feels lonely or isolated from those around him. Depression score of 18. He and his wife know that he has issues with depression. He has told his wife and staff that he is ready to die. He has refused to talk to a mental health specialist on many occasions. He is on an antidepressant currently. The physician is aware of his depression.

During an observation on 3/10/25 at 02:06 PM, Vicks VapoRub was on the bedside table which was beside his chair. A bucket of items on the bed including a pair of scissors sticking up out of the box.

During an observation on 03/11/25 at 07:46 AM, R9 sat in his room with a strong smell of urine.

During an interview on 03/11/25 at 07:33 AM, Certified Nurse Aide (CNA) P revealed that R9 refused meals and to get up and toilet or anything, Said depressive statements like he doesn't want to live. Staff can redirect him.

During an interview on 03/11/25 08:46 AM,

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Certified Medication Aide (CMA) R revealed that R9 was on the light asking for a pain pill. Refused to go to the bathroom R9 has depression and wants to go home. Denies suicidal statements.

During an interview on 03/11/25 11:48 AM, Licensed Nurse (LN) H revealed R9 was not social, he self-isolated, refused activities, and was depressed. Denied suicidal ideations.

During an interview on 03/12/25 at10:21 AM, Administrative Nurse D sated she was not concerned about the scissors because he has never tried to harm himself. Was not aware that R9 had the Vicks in his room. She was aware that he was very depressed but was not aware of any suicidal ideations. It was the policy to get an order for any medications at bedside and to do a Self - administer assessment for any medications at bedside, Administrative Nurse was not sure if she would do an assessment for the Vicks because it was an over-the-counter medication.

"Quarterly Assessment" Policy dated 05/12/25 documented the "Self - administer assessment" be completed quarterly and PRN for residents with medications in their room.

The facility failed to ensure R9's environment was free from hazards, placing R9 at risk for injury.

- The Electronic Health Record (EHR)revealed the following diagnoses for R11 repeated falls, muscle weakness, overactive bladder, bradycardia (low heart rate, less than 60 beats per minute), hypertension (HTN-elevated blood pressure) anxiety (mental or emotional reaction characterized by apprehension, uncertainty and

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irrational fear) and age-related physical debility.

The 07/25/24 Annual "Minimum Data Set" (MDS) documented a brief interview for mental status (BIMS) of 11, indicating moderately impaired cognition. Total mood severity score of 1, indicating no depression. No behaviors noted. The resident required substantial to maximum assistance with dressing , supervision to touching assistance with transfers, and independent with wheelchair mobility, R11 had two or more non injury falls since 05/02/24.

The 07/25/24 "Cognitive Loss / Dementia Care Area Assessment" (CAA) documented R11 had a moderate cognitive impairment. She took Lorazepam to manage anxiety. R11 required staff assistance with some ADLs. Some days she needs cueing for completion of ADLs and other days she does fine on her own.

The 07/25/24 "Functional Abilities (Self-Care and Mobility" CAA documented R11 required assistance with ADLs. She had a diagnosis of anxiety. R11 had several falls. She had a motion sensor in her room, and she tried to get up without setting off the sensor. She has crawled over the foot of the bed to avoid setting off the motion sensor. Lorazepam to manage anxiety. She was frequently incontinent. She had limited range of motion to both legs due to poor balance, weakness, and unsteadiness on feet. Resident required substantial to maximal assistance with dressing tasks and cueing due to moderate cognitive impairment. Resident required partial to moderate assistance with bathing tasks and cueing due to moderate cognitive impairment. Resident requires Supervision or touching assistance with toilet transfers and was

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dependent on staff for toilet hygiene. R11 required supervision or touching assistance all the way up to partial to moderate assistance with transfers.

The 07/25/24 "Falls" CAA documented R11 had several falls and was at risk for falls. She tried to avoid her motion sensor when she gets out of bed. She has had several falls getting out of bed during the night to go to bathroom. Lorazepam to manage anxiety. Resident had anemia, anxiety and frequent incontinence. BIMS 11. All of these things can increase the risk for falls.

The 01/09/25 "Quarterly MDS" documented a BIMS of 9, indicating moderately impaired cognition. Total severity score of 1, indicating no depression. No behaviors noted. The resident required substantial to maximum assistance with dressing, dependent on staff for hygiene after toileting, and partial to moderate assistance with transfers. R11 had one noninjury fall and two or more injury falls that were not major injury since 10/14/24.

The 03/11/25 "Care Plan" documented a focus on 01/08/25 that R11 was fall risk because of a history of falls. She did not remember to use my call light for assistance. She forget to put on my shoes or gripper socks and preferred to go barefoot. R11 attempted transferring without asking for assistance. She needed assistive devices. She had a motion sensor. She was on psychotropics and B/P Medications that place R11 at more risk for falls. The interventions included:
Monitor blood pressure and vitals
Initiated on 05/22/24 Be aware: at times R11 turn may off or move over my motion sensor.

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Initiated on 06/04/24- Soft tough call light facilitated for resident's convenience. Clip it to my right side of the bed by my pillow so R11 can see it when trying to get.
Initiated on 07/17/24, change motion sensor battery weekly.
Initiated on 08/13/24, the sensor is screwed into window seal.
Initiated on 10/06/24, Fall Intervention: Staff counseling on routine check of motion sensors at end and beginning of shifts to make sure they are turned on.
Initiated on 10/25/24, Lower bed to floor when R11 was in bed.
Initiated on 11/08/24, PCP to re-eval psychotropic regimen. On 11/11/24, stop Trazodone and increase Ativan to 0.5mg at noon and 1mg at HS.
Initiated on 11/23/24, Charge nurse discussion with staff that motion sensor must face doorway, not toward bed to catch resident swinging out legs and sitting up in bed prior to self-transfers.
Initiated on 01/15/25, All primary staff interviewed and educated not to move placement of motion sensor.
Initiated on 02/08/25, note post at door to remind all staff to turn motion sensor back on.
Initiated on 02/08/25: Scoop Mattress to bed
Initiated on 03/28/24 Fall Intervention: Encourage resident to sit in the lobby after supper unless ready for bed.

Review of the "Fall Risk Assessment 2" documented R11 had a high risk for falls on all assessments from 06/04/24 to 02/08/25.

During an observation on 03/10/25 at 02:28 PM, Administrative Nurse E assisted R11 to her room to toilet. R11 had a motion sensor that activated when we walked in the room. Administrative

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Nurse E assisted R11 to toilet and assisted her back to her wheelchair. The motion sensor was activated the whole time, and no other staff came to check it out.

During an observation on 03/12/25 at 08:40 AM, this nurse walked by R11's room and noticed the light was on for the call light. Knocked and went in to see if R11 was in there. She was in the bathroom attempting to transfer. This nurse asked her if she could wait for assistance, which she stated she could not. This nurse steadied her while R11 transferred to the toilet. This nurse went to the hall to get a staff member, but did not see anyone. Went back in R11's bathroom. She attempted to pull up her pants while steadying herself by leaning with her head against the wall. At 08:46 AM, CNA MM came to assist her. She saw her alert on the screen by the nurse's station. CNA MM did not carry a pager.

During an interview 03/12/25 at 08:52 AM, CNA O stated that R11 had a motion sensor because she was a fall risk. When the light comes, she answered it as soon as she could. She did have a pager and pulled it out of her pocket. It was on vibrate. She was not aware that R11's call light was on as she was in a room with another resident. She reported that when a motion alarm sounded, the alert goes to the pager the same as a call light. There was noting to indicate it was an alarm except they know who has a motion sensor.

During an interview on 03/12/25 at 10:21 AM, Administrative Nurse D stated that R11 had a motion sensor. Staff try to make it there in time. This allows her to me independent as possible, but staff are alerted and get there as quickly as

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F 689	Continued From page 29 they can. R11's family agreed for this intervention. If the CNAs were unavailable, it triggered to show up for the CMAs and nurse at the Nurse's station. Administrative staff D stated her expectation was for staff to answer the light as soon as possible. There was no way to put a time frame for the expectation on it. During an interview on 03/12/25 at 01:06 PM, surveyor asked Administrative Nurse D how the alarms were an effective intervention to prevent falls. Administrative Nurse D stated the motion sensor does not prevent falls. It was just to alert staff she is in her room and staff can assist when they are able. The facility policy for "Fall Prevention Protocol", dated 04/15/19, included: Each resident residing at the facility will be provided services and care that ensures the resident's environment remains as free from accident hazards as possible and each resident received adequate supervision and assistive devices to prevent accidents. The facility failed to identify, implement, and reevaluate fall prevention interventions to prevent falls for R11 when they failed to implement new effective interventions to prevent falls, placing the residents at risk for falls with injury.	F 689		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.	F 698		

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This REQUIREMENT is not met as evidenced by:
The facility identified a census of 26 residents with 12 sampled. Based on observation, interview, and record review, the facility failed to provide dialysis post care and services to Resident (R) 6. This deficient practice had the potential to negatively affect the resident's physical well-being.

Findings included:

- The Electronic Health Record (EHR) revealed the following diagnoses for R6 end-stage renal disease (ESRD-a terminal disease of the kidneys), dependence on dialysis (procedure where impurities or wastes were removed from the blood), Down's syndrome (chromosomal abnormality characterized by varying degrees of mental retardation and multiple defects), and dementia (progressive mental disorder characterized by failing memory, confusion).

The 04/25/24 "Annual Minimum Data Set" (MDS) documented a Brief Interview for Mental Status (BIMS) of two, indicating severely impaired cognition.

The 04/25/24 "Cognitive Loss / Dementia Care Area Assessment" (CAA) documented R6 had a BIMS score of two and is aware of his dialysis days. He has as ESRD managed by going to dialysis three times a week.

The 01/02/25 "Quarterly MDS" documented a BIMS score of 5, indicating severely impaired cognition. R6 required set up assistance with eating, he was independent with walking, and required supervision with dressing.

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The Electronic Health Records (EHR) "Physician Orders" instructed staff to:
Measure the resident's blood pressure on dialysis days, prior to leaving in the morning, and write it on the dialysis flow sheet, which started on 01/17/22.
Feel for the thrill (palpable vibration on the skin over the area of turbulent blood flow) of the resident's vein on left arm two times a day, which started on 05/04/19.
Provide the residnet a regular diet, regular texture, regular consistency, and fortify foods to help increase calories related to ESRD, which started on 11/15/16.

Review of the "Dialysis Forms" revealed staff documented medication given prior to dialysis, blood pressures, and weights, noted they felt the thrill prior to dialysis, medications sent, and diet order of reg diet with extra protein snack were noted. The dialysis center documented wet weight (weight before dialysis), dry weight (weight after dialysis), labs if drawn, medications given, any complications, registered dietician recommendations, and upcoming appointments. The facility failed to document anything on the form when the resident returned from dialysis.

Review of the "Progress Notes" revealed the facility documented R6 was out to dialysis and returned from dialysis with no blood pressure or assessment.

During an observation on 03/10/24, R6 returned from dialysis and went to the dining area to play Bingo.

During an observation on 03/12/25 at 08:26 AM,

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R6 sat at the table. Certified Medication Aide (CMA) R got him from the table walked with him to the scale and weighed him. The resident weighed 121.2 lbs. Staff took his blood pressure, which measured 113/71 millimeters of mercury (mm Hg). Licensed Nurse (LN) H got the dialysis book out and wrote down the information she obtained, CMA R gave the medications to go with him to the nurse, who placed them in the book. LN H assessed the resident for thrill and listen to for the bruit. At 08:35 AM, R6's family member came to pick him up for dialysis.

During an interview on 03/11/25 at 07:33 AM, Certified Nurse Aide (CNA) P stated sometimes when the resident returned from dialysis R6 had weakness and the CNA's assisted him. CNA P stated they did not watch for anything for R6, except they were aware he was on a fluid restriction. The CNA's did not monitor the resident's fluid intake.

During an interview on 03/11/25 at 08:46 AM, CMA R stated prior to dialysis they gave R6 medications, they took his blood pressure, and obtained his weight. After dialysis they gave him a snack and he got a nutritional supplement at night with strawberry syrup. CMA R noted the resident was on a fluid restriction, but no other restrictions. CMA R stated the facility did not monitor for anything after the returned from dialysis or any other time.

During an interview on 03/11/25 at 11:48 AM, LN H stated that his family takes him to dialysis on Monday, Wednesday, and Friday. Every day they check the thrill and bruit. R6 had a fluid restriction but no other dietary restriction. Prior to dialysis the staff checked his blood pressure and weight.

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F 698	Continued From page 33 After dialysis the nurse does not assess anything. That night she removed his dressing over his fistula and placed a Band-Aid on it. Review of the facilities policy "Hemo-dialysis" dated 06/21/19 revealed post dialysis care would include the dialysis nurse providing either a written or verbal report to the nurse at this facility including pertinent information for interdisciplinary care, food and fluid intake, assessment of the shunt, and vital signs. Post dialysis assessment instructed facility staff to assess the access site for bleeding and ensure blood pressue is stable before allowing resumption of normal activities, monitor vital signs upon arrival from dialysis center and monitor the dressing. During an interview on 03/12/25 at 10:21 AM, Administrative Nurse D stated she was not aware that post dialysis assessment was required, and they have not been doing that. After looking at the policy, she revised the process for post dialysis charting to include assessment. Administrative Nurse D also stated R6 did not want to follow a renal diet and they were going by his preference. The facility failed to provide dialysis post care and services to Resident (R) 6. This deficient practice had the potential to negatively affect the resident's physical well-being.	F 698		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed	F 755		

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personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.

§483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-

§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.

§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and

§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 26 residents with 12 residents sampled, including six residents reviewed for unnecessary medications. Based on interview, record review, and observation, the facility failed to follow physician's orders for one of the six sampled residents, Resident (R)13, regarding administration of Ativan (an anti-anxiety medication that calms and relaxes people).

Findings included:

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- Review of Resident (R)13's electronic medical record (EMR) revealed a diagnosis of anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear).

The "Annual Minimum Data Set" (MDS), dated 10/24/24, documented the resident had a Brief Interview for Mental Status (BIMS) score of three, indicating severe cognitive impairment. She received antianxiety medication (medication that calms and relaxes people) during the assessment period.

The "Psychotropic Drug Care Area Assessment" (CAA), dated 10/24/24, documented the resident received antianxiety medication and was followed by a mental health specialist.

The "Quarterly MDS," dated 01/16/25, documented the resident had a BIMS score of four, indicating severe cognitive impairment. She received antianxiety medication during the assessment period.

The "Care Plan", revised 01/30/25, instructed staff the resident would become anxious in the evenings and received an antianxiety medication.

Review of the resident's EMR revealed the following physician's orders:

Ativan (an anti-anxiety medication that calms and relaxes people), 0.25 milligrams (mg), by mouth (po), twice daily (BID), for a diagnosis of anxiety, ordered 01/11/24.

Ativan, 0.5 mg, po, in the evening, for a diagnosis of anxiety, ordered 01/11/24.

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F 755	Continued From page 36 Review of the resident's EMR revealed Licensed Nurse (LN) I administered Ativan 0.5 mg po on 03/07/25 at 08:00 PM, on 03/08/25 at 04:00 AM and on 03/08/25 at 08:00 PM, instead of the ordered dose of 0.25 mg. Documentation revealed the resident had no adverse effects from the incorrect dose of medication being administered. The resident's family and physician were notified, with no new orders received. On 03/12/25 at 12:17 PM, LN I stated she did not notice the medication error until 03/09/25. She then notified Administrative Nurse D, the resident's family, and her physician. On 03/12/25 at 12:30 PM, Administrative Nurse D stated LN I notified her of the medication error immediately upon discovering the error. Administrative Nurse D stated she did re-education with LN I on medication administration and LN I voiced understanding. The facility policy or "Medication Errors", revised 10/04/19, included: The facility shall ensure medications are administered to residents according to the physician's orders. The facility failed to follow physician's orders in the administration of antianxiety medication to this dependent resident.	F 755		
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-	F 757		

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F 757	Continued From page 37 §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 reported a census of 26 residents with 12 residents sampled, including six residents reviewed for unnecessary medications. Based on interview and record review, the facility failed to ensure one Resident (R) 27 remained free from unnecessary medications related to failure to discontinue (DC) an as needed (PRN) hypertensive medication (medications used to lower blood pressure). Findings included: - Review of Resident (R)27's electronic medical record (EMR) revealed a diagnosis of hypertension (HTN-elevated blood pressure). The "Admission Minimum Data Set" (MDS), dated 10/03/24, documented the resident had a Brief Interview for Mental Status (BIMS) score was three, indicating severe cognitive impairment	F 757		

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and had a diagnosis of HTN.

The "Psychotropic Drug Care Area Assessment" (CAA), dated 10/03/24, documented the resident took antihypertensive medications (medications used to lower blood pressure (BP)) for a diagnosis of HTN.

The "Quarterly MDS," dated 12/26/24, documented the resident had a BIMS score of one, indicating severe cognitive impairment and had a diagnosis of HTN.

The "Care Plan", revised 01/01/25, instructed staff to obtain the resident's BP weekly.

Review of the resident's EMR revealed the following physician's order:

Clonidine (a hypertensive medication used to lower BP), 0.1 milligrams (mg), by mouth (po), every (Q) four hours, as needed (PRN) for systolic blood pressure (SBP) greater than 170, ordered 10/24/24.

Review of the resident's EMR revealed the PRN medication had not been used from 10/24/24 through 03/11/25.

Review of the resident's EMR revealed the resident's BP was taken weekly. The resident's SBP was not greater than 170 on the documented weekly BPs.

On 03/11/25 at 02:41 PM, Administrative Nurse D stated the facility had not administered the PRN medication to the resident since the medication was ordered. Administrative Nurse D stated the PRN medication should have been DC'd after 30

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F 757	Continued From page 39 days due to non-use but had not been. The facility policy for "PRN Blood Pressure Medication Administration", revised 05/03/17, included: Blood pressure medications not used after 30 days or more shall be discontinued unless otherwise instructed by the resident's physician. The facility failed to DC an unnecessary PRN medication for this dependent resident.	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 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	F 758		

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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 reported a census of 26 residents with 12 residents sampled including six residents reviewed for unnecessary medications. Based on observation, record review and interview, the facility failed to ensure the six Residents (R)1, R 27, R 14, R 16, R5, and R10 remained free from unnecessary psychotropic medications (any drug that affects behavior, mood, thoughts, or perception), regarding the facility's failure to obtain psychotropic medication consents.

Findings included:

- Review of Resident (R)1's electronic medical record (EMR) revealed a diagnosis of major

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depressive disorder (MDD-major mood disorder which causes persistent feelings pf sadness), bipolar disorder (major mental illness that caused people to have episodes of severe high and low moods) and delusional disorder (untrue persistent belief or perception held by a person although evidence shows it was untrue).

The "Annual Minimum Data Set" (MDS), dated 11/21/24, documented the resident had a Brief Interview for Mental Status (BIMS) score of seven, indiccating severe cognitive impairment. He received antipsychotic (drugs primarily used to manage psychosis, including symptoms like delusions, hallucinations, and disorganized thinking) and antidepressant (prescription medicines to treat depression) medication during the assessment period.

The "Psychotropic (any drug that affects behavior, mood, thoughts, or perception) Drug Care Area Assessment" (CAA), dated 11/21/24, documented the resident took antidepressant and antipschotic medications.

The "Quarterly MDS," dated 02/13/25, documented the resident had a BIMS score of nine, indicating moderately impaired cognition. He received antipsychotic and antidepressant medication during the assessment period.

The "Care Plan", revised 02/20/25, instructed staff the resident received antidepressant and antipsychotic medications.

Review of the resident's EMR revealed the following physician's orders:

Cymbalta (an antidepressant medication), 30

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milligrams (mg), by mouth (po), in the morning (QAM), for a diagnosis of MDD, ordered 12/03/24.

Loxapine (an antipsychotic medication), 5 mg, po, in the evening, for a diagnosis of delusional state, ordered 01/16/25.

Review of the resident's "Medication Administration Record" (MAR) from 02/01/25 through 03/11/25, revealed the resident received the medications, as ordered.

Review of the resident's EMR lacked documentation of a psychotropic consent form for the use of the resident's psychotropic medications.

On 03/11/25 at 08:37 AM, the residen sat in the front commons area with his peers. The resident had no behaviors at that time.

On 03/11/25 at 08:53 AM, Licensed Nurse (LN) H administered insulin to the resident. The resident visited and joked with the staff member. No behaviors were noted at that time.

On 03/12/25 at 09:06 AM, Administrative Nurse D stated she was unaware of the need to have psychotropice consent forms filled out for resident's who took psychoactive medications.

The facility lacked a policy for psychotropic medications consents.

The facility failed to obtain a psychotropic medication consent for this resident who received psychotropic medications.

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- Review of Resident (R)16's electronic medical record (EMR) revealed the following diagnoses: anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), major depressive disorder (major mood disorder which causes persistent feelings pf sadness) and dementia (progressive mental disorder characterized by failing memory, confusion).

The "Annual Minimum Data Set" (MDS), dated 12/12/24, documented the resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. She received antidepressant (prescription medicines to treat depression) medication during the assessment period.

The "Psychotropic (any drug that affects behavior, mood, thoughts, or perception) Drug Use Care Area Assessment" (CAA), dated 12/12/24, documented the resident used psychotropic medications daily.

The "Medicare 5-Day MDS," dated 10/11/24, documented the resident had a BIMS score of 12, indicating moderately impaired cognition. She received antidepressant medication during the assessment period.

The "Care Plan", revised 12/15/24, instructed staff the resident took psychotropic medications for a diagnosis of MDD.

Review of the resident's EMR revealed the following physician's orders:

Fluoxetine (an antidepressant medication), 20 milligrams (mg), by mouth (po), in the morning

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(AM), for a diagnosis of MDD, ordered 02/13/23.

Remeron (an antidepressant medication), 7.5 mg, po, in the evening, for a diagnosis of weight loss, ordered 05/23/24.

Review of the resident's "Medication Administration Record" (MAR) from 02/01/25 through 03/11/25, revealed the resident received the medications, as ordered.

Review of the resident's EMR lacked documentation of a psychotropic consent form for the use of the resident's psychotropic medications.

On 03/12/25 at 09:06 AM, Administrative Nurse D stated she was unaware of the need to have psychotropice consent forms filled out for resident's who took psychoactive medications.

The facility lacked a policy for psychotropic medications consents.

The facility failed to obtain a psychotropic medication consent for this resident who received psychotropic medications.

- Review of Resident (R)27's electronic medical record (EMR) revealed the following diagnoses: dementia (progressive mental disorder characterized by failing memory, confusion) and anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear).

The "Admission Minimum Data Set" (MDS), dated 10/03/24, documented the resident had a Brief Interview for Mental Status (BIMS) score of

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three, indicating severe cognitive impairment. She received antipsychotic (drugs primarily used to manage psychosis, including symptoms like delusions, hallucinations, and disorganized thinking) and antidepressant (prescription medicines to treat depression) medications during the assessment period.

The "Psychotropic (any drug that affects behavior, mood, thoughts, or perception) Drug Care Area Assessment" (CAA), dated 10/03/24, documented the resident received psychotropic drugs daily.

The "Quarterly MDS," dated 12/26/24, documented the resident had a BIMS score of one, indicating severre cognitive impairment. She received antipsychotic, antianxiety and antidepressant medication during the assessment period.

The "Care Plan", revised 01/01/25, instructed stafff the resident took psychotropic (any drug that affects behavior, mood, thoughts, or perception) medications daily for diagnoses of dementia and anxiety.

Review of the resident's EMR revealed the following physician's orders:

Olanzapine (an antipsychotic medication), 5 milligrams (mg), by mouth (po), twice daily (BID), for a diagnosis of dementia, ordered 09/27/24.

Sertraline (an antidepressant medication), 100 mg, po, in the evening, for a diagnosis of dementia, ordered 01/17/25.

Trazodone (an antidepressant medication), 50

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mg, po, in the evening, for a diagnosis of insomnia (the inability to sleep), ordered 12/22/24.

Review of the resident's "Medication Administration Record" (MAR) from 02/01/25 through 03/11/25, revealed the resident received the medications, as ordered.

Review of the resident's EMR lacked documentation of a psychotropic consent form for the use of the resident's psychotropic medications.

On 03/12/25 at 09:06 AM, Administrative Nurse D stated she was unaware of the need to have psychotropice consent forms filled out for resident's who took psychoactive medications.

The facility lacked a policy for psychotropic medications consents.

The facility failed to obtain a psychotropic medication consent for this resident who received psychotropic medications.