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	17E528	A. BUILDING _____ B. WING _____	04/30/2025

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COUNTRYSIDE HEALTH CENTER	440 SE WOODLAND AVENUE TOPEKA, KS 66607

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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Recertification Survey. The 2567 was sent electronically on 05/13/25. The revised 2567 was sent electronically on 05/21/25.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the	F 656		

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

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

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resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(iii) Be culturally-competent and trauma-informed.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 95 residents. The sample included 19 residents. Based on observation, record review, and interview, the facility failed to develop a plan of care, and implement skin care interventions for Resident (R) 36, who developed at Stage 2 (partial-thickness skin loss into but no deeper than the dermis including intact or ruptured blisters) pressure ulcer (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction). This deficient practice placed R36 at risk for pain, complications, and possible infection associated with pressure ulcers.

Findings included:

- R36's Electronic Medical Record (EMR) documented diagnoses of type 2 diabetes

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mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), seborrheic dermatitis (chronic skin condition characterized by inflammation and scaling), schizoaffective disorder (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought), and chronic obstructive pulmonary disease (COPD - a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing).

R36's "Admission Minimum Data Set (MDS)" dated 09/25/24 documented a Brief Interview for Mental Status (BIMS) of 14, which indicated intact cognition. R36 was independent with most functional abilities and required set-up for eating, showering, oral hygiene, and personal hygiene. R36 was at risk for pressure ulcer development. A formal assessment, the Braden Scale (a risk assessment tool used to predict the risk of developing pressure injuries), was used. R36 had a pressure-reducing device for his bed.

R36's "Pressure Ulcer/Injury Care Area Assessment (CAA)" dated 10/04/24 documented he had the potential to develop altered skin integrity and pressure ulcers/injuries related to his diabetes diagnosis.

R36's "Care Plan" initiated on 09/19/24 directed staff that he was independent with most of his activities of daily living (ADL) care, and was able to ask for assistance as needed. R36's care plan lacked a care area for skin care and pressure ulcer prevention. The care plan was not revised with interventions after the development of his Stage 2 pressure ulcer.

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F 656	Continued From page 3	F 656		

R36's "Orders" tab of the EMR documented a physician's order dated 04/16/25 for Blastx (a wound gel, intended for the management of various wounds) with collagen (protein-derived wound treatment used to promote wound healing) every day shift for the wound on the right upper buttock. Cleanse the right upper buttock wounds with cleanser, apply Blastx with collagen, and cover with a foam dressing. Monitor the dressing each shift.

R36's EMR documented in the "Orders" tab a physician's phone order dated 04/21/25 for active liquid protein two times a day for the wound. Given 30 ml and discontinue when wounds heal.

R36's "Braden Scale for Predicting Pressure Sore Risk" assessment, dated 04/04/24, documented a risk score of 20, which indicated a low risk of pressure ulcer development.

R36's "Weekly Wound Assessment" in the EMR dated 04/15/25 documented the first observation of a pressure wound, Stage 2, to the upper right buttock proximal (nearer to a point of reference or attachment) on the torso. The area was pink and moist with scant drainage. The wound measured 1.2 centimeters (cm) in length by 0.3 cm in width, and 0.1 cm in depth. The physician and the resident's representative were notified. A new order placed to cleanse the wound, apply Blastx with collagen, cover with a foam dressing, and change daily.

R36's "Progress Notes" tab of the EMR documented a "Communication Note" dated 04/14/25 at 08:38 PM, that during the evening treatments, two open areas were located on the

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F 656	Continued From page 4	F 656		

right buttocks near the intergluteal cleft (groove that lies between the two gluteal (pertaining to the buttocks or buttocks muscles) regions). The area was cleansed with wound cleanser, patted dry, and an Opti foam (a soft, absorbent foam dressing) dressing was applied.

On 04/15/25 at 03:28 PM the "Skin/Wound Note" under the "Progress Notes" tab of the EMR documented that it had been noted R36 had two open areas on his upper right buttock. R36's family member was contacted and informed of the areas. A pressure-relieving cushion was placed in his recliner, and he was educated on hygiene and to ask for assistance with peri care after he has a bowel movement.

On 04/16/25at 03:12 PM the "Nutrition/Dietary Note," under the "Progress Notes," in the EMR documented the dietitian had been notified of the two open areas to the right upper buttock. It might be beneficial to offer Pro-stat (a ready-to-drink concentrated liquid protein supplement) 30 milliliters (ml) twice daily until the areas healed.

On 04/29/25 at 11:50 AM, R36 sat in the dining room with other residents waiting for lunch.

On 04/30/25 at 11:25 AM, Certified Nurse Aide (CNA) O stated that a resident should have something on the care plan regarding skin care and wound prevention. CNA O stated she would report any new skin concerns to the nurse when noticed during bathing. CNA O stated R36 should have something on his care plan about his wound care, but could not say for certain that it did.

On 04/30/25 at 11:40 AM, Licensed Nurse (LN) G stated that R36's care plan should have had an

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F 656	Continued From page 5	F 656		

intervention in place for generic skin care to prevent wound development. LN G stated R36's care plan should have been updated with interventions after he developed the pressure area.

On 04/30/25 at 12:17 PM, Administrative Nurse E stated that each resident should have a care area that addressed the skin and have interventions in place to decrease the chance of a pressure area developing. Administrative Nurse E stated R36's care plan should have been updated to reflect interventions to prevent further pressure ulcer development.

The facility's "Wound Assessment, Prevention and Treatment" policy, dated 11/28/17, documented a resident who entered the facility without pressure ulcers would not develop them unless the individual's clinical condition demonstrated that they were unavoidable. Residents would be evaluated and monitored to prevent the development of pressure ulcers and promote rapid healing of any pressure ulcers that were present. Pressure ulcer risk prevention would be accomplished by completion of the "Braden Pressure Ulcer Risk Assessment"; identifying and evaluating the risk factors and changes in resident condition; identifying and evaluating factors that can be removed or modified; implementing individualized interventions to attempt to stabilize, reduce or remove underlying risk factors; and monitoring the impact of the interventions for effectiveness and modifying them as appropriate. A comprehensive, individualized care plan would be developed to address the prevention of the development of pressure ulcers, management of risk factors, and treatment strategies for residents

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F 656	Continued From page 6 with pressure ulcers. The strategies would be developed through collaboration between the resident, his/her representative, the physician, the dietitian, and the clinical staff.	F 656		
F 678 SS=E	Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3) §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: The facility reported a census of 95 residents. The facility identified 85 residents who had requested to be full code (term used to indicate the desire to receive resuscitative measures in the event of cardiac arrest). Based on interview and record review, the facility failed to establish and maintain a system to ensure nursing staff maintained current cardiopulmonary resuscitation (CPR - a life-saving medical procedure that consists of chest compressions to allow oxygenated blood to circulate to vital organs, such as the brain and heart and artificial ventilation) certification for healthcare providers. This deficient practice placed these residents who desired CPR if needed at risk for inadequate resuscitative measures. Findings included: - On 04/29/25 at 12:32 PM, CPR verification wass requested for the following dates and shifts: day shift on 04/07/25 and 04/21/25, evening shift on 04/08/25 and 04/22/25, and night shift on	F 678		

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F 678	Continued From page 7 03/31/25 and 04/01/25. The facility was unable to provide verification of CPR certification for staff members on the evening and night shifts as requested. On 04/29/25 at 02:35 PM, Administrative Staff A stated he was unable to locate CPR certification for staff who had worked on the dates of the evening and night shifts that were requested. Administrative Staff A stated the facility did not have a system in place to track staff CPR certification. The facility's "Cardo-Pulmonary Resuscitation (CPR)" policy, last revised 04/27/18, documented that emergency basic life support would be provided when needed, including cardio-pulmonary resuscitation (CPR) in accordance with physician orders and the resident's advance directives. Basic life support and cardio-pulmonary resuscitation would be initiated for any resident whose advance directive indicates them to be a full code. This would be continued until the arrival of emergency medical personnel.	F 678		
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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F 686	Continued From page 8	F 686		

necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 95 residents. The sample included 19 residents. Based on observation, record review, and interview, the facility failed to recognize or address the potential for developing a pressure ulcer. The facility failed to identify the risks, develop a plan of care, and implement interventions when Resident (R) 36 developed at Stage 2 (partial-thickness skin loss into but no deeper than the dermis including intact or ruptured blisters) pressure ulcer (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction). This deficient practice placed R36 at risk for pain, complications, and possible infection associated with pressure ulcers.

Findings included:

- R36's Electronic Medical Record (EMR) documented diagnoses of type 2 diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), seborrheic dermatitis (chronic skin condition characterized by inflammation and scaling), schizoaffective disorder (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought), and 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).

R36's "Admission Minimum Data Set (MDS)" dated 09/25/24 documented a Brief Interview for Mental Status (BIMS) of 14, which indicated intact cognition. R36 was independent with most functional abilities and required set-up for eating, showering, oral hygiene, and personal hygiene. R36 was at risk for pressure ulcer development. A formal assessment, the Braden Scale (a risk assessment tool used to predict the risk of developing pressure injuries), was used. R36 had a pressure-reducing device for his bed.

R36's "Pressure Ulcer/Injury Care Area Assessment (CAA)" dated 10/04/24 documented he had the potential to develop altered skin integrity and pressure ulcers/injuries related to his diabetes diagnosis.

R36's "Care Plan" was initiated on 09/19/24, directed staff that he was independent with most of his activities of daily living (ADL) care, and was able to ask for assistance as needed. R36's care plan lacked a care area for skin care and pressure ulcer prevention.

R36's "Orders" tab of the EMR documented a physician's order dated 04/16/25 for Blastx (a wound gel, intended for the management of various wounds) with collagen (protein-derived wound treatment used to promote wound healing) every day shift for the wound on the right upper buttock. Cleanse the right upper buttock wounds with cleanser, apply Blastx with collagen, and cover with a foam dressing. Monitor the dressing each shift.

R36's EMR documented in the "Orders" tab a

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F 686	Continued From page 10	F 686		

physician's phone order dated 04/21/25 for active liquid protein two times a day for the wound. Given 30 ml and discontinue when wounds heal.

R36's "Braden Scale for Predicting Pressure Sore Risk" assessment, dated 04/04/24, documented a risk score of 20, which indicated a low risk of pressure ulcer development.

R36's "Weekly Wound Assessment" in the EMR dated 04/15/25 documented the first observation of a pressure wound, Stage 2, to the upper right buttock proximal to the torso. The area was pink and moist with scant drainage. The wound measured 1.2 centimeters (cm) in length by 0.3 cm in width, and 0.1 cm in depth. The physician and the resident's representative were notified. A new order placed to cleanse the wound, apply Blastx with collagen, cover with a foam dressing, and change daily.

R36's "Progress Notes" tab of the EMR documented a "Communication Note" dated 04/14/25 at 08:38 PM, that during the evening treatments, two open areas were located on the right buttocks near the intergluteal cleft (groove that lies between the two gluteal regions). The area was cleansed with wound cleanser, patted dry, and an Opti foam (a soft, absorbent foam dressing) dressing was applied.

On 04/15/25 at 03:28 PM the "Skin/Wound Note," under the "Progress Notes," tab of the EMR, documented that it had been noted R36 had two open areas on his upper right buttock. R36's son was contacted and informed of the areas. A pressure-relieving cushion was placed in his recliner, and he was educated on hygiene and to ask for assistance with peri care after he has a

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F 686	Continued From page 11	F 686		

bowel movement.

On 04/16/25at 03:12 PM the "Nutrition/Dietary Note," under the "Progress Notes," in the EMR documented the dietitian had been notified of the two open areas to the right upper buttock. It might be beneficial to offer Pro-stat (a ready-to-drink concentrated liquid protein supplement) 30 milliliters (ml) twice daily until the areas heal.

On 04/29/25 at 11:50 AM, R36 sat in the dining room with other residents waiting for lunch.

On 04/30/25 at 11:25 AM, Certified Nurse Aide (CNA) O stated that a resident should have something on the care plan regarding skin care and wound prevention. CNA O stated she would report any new skin concerns to the nurse when noticed during bathing. CNA O stated R36 should have something on his care plan about his wound care, but could not say for certain that it did.

On 04/30/25 at 11:40 AM, Licensed Nurse (LN) G stated that R36's care plan should have had an intervention in place for generic skin care to prevent wound development. LN G stated R36's care plan should have been updated with interventions after he developed the pressure area.

On 04/30/25 at 12:17 PM, Administrative Nurse E stated that all residents got a weekly skin check. Administrative Nurse E stated that the aides looked over the resident's skin during bathing and should be reporting any new skin issues. Administrative Nurse E stated that each resident should have a care area that addressed the skin and have interventions in place to decrease the chance of a pressure area developing.

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F 686	Continued From page 12 Administrative Nurse E stated R36's care plan should have been updated to reflect interventions for further pressure ulcer development. The facility's "Wound Assessment, Prevention and Treatment" policy, dated 11/28/17, documented a resident who entered the facility without pressure ulcers would not develop them unless the individual's clinical condition demonstrated that they were unavoidable. Residents would be evaluated and monitored to prevent the development of pressure ulcers and promote rapid healing of any pressure ulcers that were present. Pressure ulcer risk prevention would be accomplished by completion of the "Braden Pressure Ulcer Risk Assessment"; identifying and evaluating the risk factors and changes in resident condition; identifying and evaluating factors that can be removed or modified; implementing individualized interventions to attempt to stabilize, reduce or remove underlying risk factors; and monitoring the impact of the interventions for effectiveness and modifying them as appropriate. A comprehensive, individualized care plan would be developed to address the prevention of the development of pressure ulcers, management of risk factors, and treatment strategies for residents with pressure ulcers. The strategies would be developed through collaboration between the resident, his/her representative, the physician, the dietitian, and the clinical staff.	F 686		
F 699 SS=D	Trauma Informed Care CFR(s): 483.25(m) §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent,	F 699		

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trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 96 residents. The sample included 19 residents, with four residents reviewed for trauma-informed care (treatment or care directed to prevent re-experiencing or reducing the effects of traumatic events). Based on observation, record review, and interviews, the facility failed to identify trauma-based triggers related to Residents (R) 45's and R10 post-traumatic stress disorder (PTSD - a mental disorder characterized by an acute emotional response to a traumatic event or situation involving severe environmental stress) and failed to implement individualized interventions to prevent re-traumatization. These deficient practices placed R45 and R10 at risk for decreased psychosocial well-being and ineffective treatment.

Findings included:

- R45's Electronic Medical Record (EMR) from the "Diagnosis" tab documented diagnoses hypertension (high blood pressure), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), nicotine dependence on cigarettes, posttraumatic stress disorder (PTSD- a mental disorder characterized by an acute emotional response to a traumatic event or situation involving severe environmental stress), schizoaffective (a mental disorder characterized by gross distortion of reality, disturbances of language and

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communication, and fragmentation of thought), bipolar disorder (a major mental illness that causes people to have episodes of severe high and low moods), and insomnia (inability to sleep).

The "Quarterly Minimum Data Set" (MDS) dated 02/19/25 documented a Brief Interview of Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS documented R45 had an active diagnosis of PTSD. The MDS documented R45 had delusions (misconceptions or beliefs that are firmly held, contrary to reality). The MDS documented R2 had received antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality), antianxiety (a class of drugs that calm and relax people), antidepressant (a class of medications used to treat mood disorders), and a hypnotic (a class of medications used to induce sleep).

R45's "Psychosocial Wellbeing Care Area Assessment (CAA)" dated 05/27/24 documented R45 was a new admit to the facility. The CAA documented R45 would be encouraged to put up personal belongings and items in her room. The CAA documented R45 would be encouraged to participate in activities and meals to meet and begin to form friendships.

R45's "Care Plan" dated 05/23/2024 documented R45 would manage her symptoms of anxiety to be able to function in day-to-day situations. The plan of care documented R45 would no longer have control over all aspects of my life. Staff were to include R45 and her guardian in all care planning and decision-making. The plan of care documented R45 would keep her routine the same to help me manage her anxiety. R45's plan of care documented she took medication for my

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anxiety, staff were to monitor my medication for effectiveness, side effects, and adverse reactions. The plan of care for R45 documented if she began to show signs of anxiety, such as having trouble going to sleep, decreased appetite, weight loss, crying, increased agitation, and disruptive behavior, staff were directed to notify the physician. The plan of care lacked what trauma had caused her PTSD or what might have caused her to be retraumatized. The plan of care lacked personalized interventions to assist her with coping with her PTSD.

R45's EMR under the "Assessment" tab revealed the following: "Primary Care PTSD Screen" dated 05/20/24 documented no PTSD issues reported.

On 04/28/25 at 08:22 AM, R45 sat in her chair in her room, looking at her hats.

On 04/28/25 at 08:25 AM, R45 stated she did have some things in her past she worried about, but her sisters have had more to worry about.

On 04/30/25 at 11:25 AM, Certified Nurse Aide (CNA) O stated that if a resident had PTSD, she would know what the triggers are, either by asking her nurse or looking in the resident's care plan. CNA O stated she had access to the Kardex (a nursing tool that gives a brief overview of the care needs of each resident).

On 04/30/25 at 11:40 AM, Licensed Nurse (LN) G stated residents with a diagnosis of PTSD have a care plan, which states what their triggers were and what the staff should do to deescalate those triggers. LN G stated that all nursing staff have access to the plan of care.

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On 04/30/25 at 12:17 PM, Administrative Nurse E stated that with most of the residents who had PTSD, the staff communicated by word of mouth. Administrative Nurse E stated she expected the care plan to address triggers for residents with PTSD.

The facility's "Trauma Informed Care" policy, undated, documented the facility would ensure residents who were trauma survivors receive culturally competent, trauma-informed care, accounting for the resident's experiences and preferences. Trauma-informed care recognizes the effects of physical, psychological, and emotional trauma on the overall well-being of residents. Trauma can result from a variety of experiences that may occur at any time throughout the resident's lifetime.

- R10's Electronic Medical Record (EMR) recorded diagnoses of schizoaffective (a mental disorder characterized by gross distortion of reality, disturbances of language, and communication, and fragmentation of thought) disorder, bipolar disorder (a major mental illness that causes people to have episodes of severe high and low moods), and posttraumatic stress disorder (PTSD - a mental disorder characterized by an acute emotional response to a traumatic event or situation involving severe environmental stress).

R10's "Annual Minimum Data Set (MDS)" dated 06/27/24 documented a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. R10 was independent with his functional abilities and activities of daily living (ADL). R10 had a diagnosis of PTSD.

R10's "Psychotropic Drug Use Care Area

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Assessment (CAA)" dated 06/28/25 documented he took psychotropic (alters mood or thought) medications to manage his moods and behaviors related to his mental health disorders. R10 would be care planned for the management of psychotropic medications as per order and standards of practice.

R10's "Psychosocial Care Plan" was revised on 11/16/22, directed staff that he had a history of PTSD but had not suffered from many side effects lately. Staff were directed that he could be easily startled or feel detached from others. Staff were directed that if he displayed any of those symptoms or did not seem himself, to talk to him to see if he needed help coping. R10's care plan lacked staff direction that addressed his triggers or interventions to prevent further re-traumatization.

R10's EMR "Assessments" tab documented "Primary Care PTSD Screen- V2" completed on 10/27/21, 10/27/22, 10/23/23, and 11/12/24. These assessments lacked the specific trauma or possible triggers for R10.

On 04/29/25 at 10:26 PM, R10 and a couple other male residents met to talk about resident council. R10 had no behaviors noted.

On 04/30/25 at 11:40 AM, Licensed Nurse (LN) G stated that R10's care plan should reflect the cause of his PTSD and what might trigger it, so staff would be aware and monitor him for possible re-traumatization.

On 04/30/25 at 12:19 PM, Administrative Nurse E stated that staff should be made aware of what R10's trauma was and possible triggers that

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F 699	Continued From page 18 could cause re-traumatization. Administrative Nurse E stated R10's care plan would be updated to reflect that information. The facility policy "Trauma Informed Care" was updated 11/09/21 and documented that the facility would ensure residents who were trauma survivors received culturally competent, trauma-informed care, accounting for the resident's experiences and preferences. Trauma-informed care recognized the effects of physical, psychological, and emotional trauma on the overall well-being of residents. Trauma could result from a variety of experiences that may occur at any time throughout the resident's lifetime. A screening would be completed on residents to identify any potential experiences that may impact care needs. The Post-Traumatic Stress Disorder (PTSD) Screening would be completed during the lookback period for the admission, significant change, and annual MDS.	F 699		
F 730 SS=F	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: The facility identified a census of 95 residents. The sample included 19 residents, two Certified Nurse Aides (CNA), and three Certified Medication Aides (CMA) were reviewed for yearly performance evaluations and the associated	F 730		

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in-service training. Based on record review and interview, the facility failed to ensure five of the two CNAs and three CMA staff reviewed had yearly performance evaluations completed. This placed the residents at risk for inadequate care.

Findings included:

- A review of the facility's staffing list revealed the following CNAs and CMAs were employed with the facility for more than 12 months:

CMA T, hired on 04/18/18, had no yearly performance evaluation upon request.

CMA S, hired on 11/27/20, had no yearly performance evaluation upon request.

CNA M, hired on 01/21/23, had no yearly performance evaluation upon request.

CMA R, hired on 01/08/24, had no yearly performance evaluation upon request.

CNA N, hired on 03/25/24, had no yearly performance evaluation upon request.

On 04/29/25 at 10:12 AM, Administrative Staff A stated the employee's supervisor was responsible for completing the yearly performance review. Administrative Staff A stated that the facility completed the employees' yearly performance reviews in November. Administrative Staff A stated that the five nursing staff had not received a yearly performance review in the past 12 months.

The facility was unable to provide a policy related required yearly performance reviews.

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F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: The facility identified a census of 95 residents. The sample included 19 residents, with two medication rooms. Based on observation, record review, and interviews, the facility failed to properly label and store medications in the medication room, and further failed to secure medication carts containing residents' insulin (a hormone that lowers the level of glucose in the blood) pens and needles. This placed the residents at risk for adverse outcomes or	F 761		

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ineffective medication regimens.

Findings included:

- On 04/28/25 at 07:05 AM, a medication cart sitting in the dining room was unlocked, and the medication cart had an insulin pen laid on top of the cart. The medication cart had a box that included an insulin pen, needles, and a glucose monitor in a plastic box. The medication cart revealed several residents' insulin pens and needles.

On 04/30/25 at 8:15 AM, the medication refrigerator contained an opened, undated vial of tuberculin test serum(method of determining whether a person is infected).

On 04/30/25 at 10:55 AM, the medication cart in the commons area was unsecured. Administrative Nurse E secured the medication cart.

On 04/28/25 at 07:07 AM, Licensed Nurse (LN) H stated medication carts should never be left unattended. She stated insulin pens and needles should be locked in the cart when staff are not within eyesight of the medication cart.

On 04/30/25 at 12:17 PM, Administrative Nurse E stated medication carts should be locked and never left unattended. She stated it is the policy of the facility to keep keys on person at all times, and keep carts locked.

The facility's "Storage of Medication and Biologicals" dated 03/11 documented medications and biologicals were stored safely, securely, and properly, following manufacturer's

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F 761	Continued From page 22 recommendations or those of the supplier. The medication supply was accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications.	F 761		
F 838 SS=F	Facility Assessment CFR(s): 483.71(a)(1)(3)(b)(1)(c)(1)-(5) §483.71 Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations (including nights and weekends) and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. §483.71(a) The facility assessment must address or include the following: §483.71(a)(1) The facility's resident population, including, but not limited to: (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population, using evidence-based, data-driven "methods" that considering the types of diseases, conditions, physical and behavioral health needs, cognitive disabilities, overall acuity, and other pertinent facts that are present within that population, consistent with and informed by individual resident assessments as required under § 483.20; (iii) The staff competencies and skill sets that are	F 838		

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necessary to provide the level and types of care needed for the resident population;
(iv)The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and
(v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services.

§483.71(a)(2) The facility's resources, including but not limited to the following:
(i) All buildings and/or other physical structures and vehicles;
(ii) Equipment (medical and non- medical);
(iii) Services provided, such as physical therapy, pharmacy, behavioral health, and specific rehabilitation therapies;
(iv) All personnel, including managers, nursing and other direct care staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care;
(v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and
(vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations.

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

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

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

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

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

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

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F 838	Continued From page 25 §483.71(c)(5) Inform contingency planning for events that do not require activation of the facility's emergency plan, but do have the potential to affect resident care, such as, but not limited to, the availability of direct care nurse staffing or other resources needed for resident care. This REQUIREMENT is not met as evidenced by: The facility identified a census of 95 residents. The sample included 19 residents. Based on observations, interviews, and record reviews, the facility failed to conduct a thorough facility-wide assessment to determine the resources necessary to care for residents competently during day-to-day operations and emergencies. This failure affected all 95 residents residing in the facility. Findings included: - On 04/28/25, Administrative Nurse D provided a "Facility Assessment" updated 01/30/25. A review of the assessment revealed the following: The assessment identified the required staffing needs per day but failed to identify the specific staffing needs by shifts for the weekends. On 04/29/25, a review of the facility's Payroll Based Journaling (PBJ - Staffing Data Report) from 04/01/24 to 03/31/25 revealed excessively low weekend staffing triggered on all four quarters. On 04/30/25 at 08:41 AM, Administrator A stated the nursing hours were set by the corporate office, and the assessment was recently updated to reflect the hours needed for days and nights.	F 838		

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F 838	Continued From page 26 He stated the assessment did not differentiate between the weekdays and the weekends. He stated weekends were staffed differently from the normal nursing hours due to the increased staff presence during the weekdays. He stated the facility put a program in place to ensure consistent staff hours on the weekends to prevent staffing shortages. The facility's "Facility Assessment" policy, revised 06/2018, indicated the facility would conduct and document a facility-wide assessment to determine what resources were necessary to care for the residents during day-to-day operations and emergencies.	F 838		
F 851 SS=F	Payroll Based Journal CFR(s): 483.70(p)(1)-(5) §483.70(p) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(p)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long	F 851		

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	17E528	A. BUILDING _____ B. WING _____	04/30/2025

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F 851	Continued From page 27 term care facility (for example, housekeeping). §483.70(p)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(p)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(p)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(p)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is not met as evidenced by:	F 851		

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F 851	Continued From page 28 The facility had a census of 95 residents. Based on interview and record review, the facility failed to submit complete and accurate staffing information to the federal regulatory agency through Payroll Based Journaling (PBJ - Staffing Data Report). This placed the residents at risk for impaired care due to unidentified staffing issues. Findings included: - The PBJ report provided by the Centers for Medicare & Medicaid Services (CMS) for Fiscal Year 2024, all four quarters indicated the facility triggered for excessively low weekend staffing. On 04/29/25 at 09:10 PM, Administrative Nurse D stated that the weekend staffing was not low. Administrative Nurse D stated that the level of weekend staffing was the same as during the week for direct care staff. Administrative Nurse D stated there must be an error in the reporting of the hours. The facility's "Competent and Sufficient Staffing" policy, dated 09/2024, documented direct care staffing information was submitted to the payroll-based journal (PBJ) system on the schedule specified by the Centers for Medicare & Medicaid Services (CMS), but no less than once a quarter.	F 851		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the	F 880		

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development and transmission of communicable diseases and infections.

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

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

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.

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(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

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

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

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 95 residents. The facility identified three residents on Enhanced Barrier Precautions (EBP - infection control interventions designed to reduce transmission of resistant organisms that employ targeted gown and glove use during high contact care). Based on record reviews, observations, and interviews, the facility failed to implement signage or indicators within the physical environment to alert staff and visitors of the required EBP and personal protective equipment (PPE) for Resident (R) 36 and R52. The facility additionally failed to cover linens in the hallways and further failed to ensure the dirty laundry sorting area was equipped with a gown and mask. This defiant practice placed the residents at risk of infectious diseases.

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Findings included:

- On 04/28/25 at 07:15 AM, an inspection of R36's room revealed no EBP indicator signage to inform visitors or staff.

On 04/28/25 at 07:15 AM, an inspection of R52's room revealed no EBP indicator signage to inform visitors or staff.

On 04/28/25 at 7:42 AM, Laundry Staff U pushed a cart of blankets down Hall B; the cart was not covered.

On 04/30/25 at 08:10 AM, a tour of the laundry room revealed no PPE to sort dirty laundry.

On 04/30/25 at 08:15 AM, Laundry Staff U stated he had not been at the facility very long. He stated he was unaware he would need PPE to sort dirty laundry. Laundry Staff U stated he did know he needed to have the linen covered in the hallways. He stated the smaller carts did not have covers, and he uses a sheet to cover the linens when in the hallway.

On 04/30/25 at 11:25 AM, Certified Nurse's Aide (CNA) O stated she would ask the charge nurse who was on EHB (enhanced barrier) and what PPE should be worn.

On 04/30/25 at 11:40 AM, Licensed Nurse (LN) G stated that any resident with an open wound should have EHB precautions. She stated that there would usually be an orange dot by the resident's name card on the door if the resident was on EHB precautions.

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F 880	Continued From page 32 On 04/30/25 at 12:17 PM, Administrative Nurse E stated the resident's room would have an orange dot on the resident's name plate outside the room. She stated it was through the training of staff that the staff would know what PPE staff were required to wear during resident tasks. Administrative Nurse E stated there was no signage inside the resident's room. The facility's "Infection Tracking and Trending" policy, dated 11/17, documented an infection control program would be utilized to investigate, control, and prevent infections in the facility. The facility's infection prevention and control program prevents, identifies, investigates, and controls infections and communicable diseases for all residents and staff, providing services under a contractual agreement and following accepted national standards.	F 880		