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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey and Complaint Investigation KS00171768 and KS00171782. The 2567 was electronically sent to the facility on 07/01/22.	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.	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)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.

§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 had a census of 59 residents. The sample included 18 residents. Based on observation, interview, and record review the facility staff failed to treat Resident (R) 4 and R16 with dignity when staff checked their blood pressure (test measures the pressure in your arteries as your heart pumps) and administered their insulin (a medication used to regulate blood sugar levels) at the dining room table, with nine other residents able to view them during meal service and dining. The staff also failed to close the bedroom curtain to promote dignity and privacy, while R8 sat on a bed pan.

Findings included:

- On 06/22/22 at 08:10 AM, observation revealed Licensed Nurse (LN) G checked R4's and R16's blood pressure and administered their insulin at the dining room table with nine other residents able to view the procedures.

On 06/22/22 at 08:12 AM, LN G stated sometimes she checked R4 and R16's blood pressure and administered their insulin at the dining room table because they wanted her too.

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On 06/27/22 at 09:15 AM, LN H stated she would not administer R4 and R16's insulin or take their blood pressure at the dining room table, she would take them to the spa room or parlor and close the doors.

On 06/22/22 at 08:15 AM, Administrative Nurse D stated staff should not check residents' blood pressure and administer insulin at the dining room table, they should take them to the room or to a private area.

The facility's "Dignity Policy," revised February 2021, documented each resident should be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self -worth and self-esteem.

The facility staff failed to treat R4 and R16 with dignity when staff checked their blood pressure and administered their insulin at the dining room table during meals.

- R8's documented diagnoses included anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), constipation (difficulty passing stool), Diabetes Mellitus type 2 (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), and incontinence (loss off bladder control/urine).

R8's "Quarterly Minimum Data Set" (MDS), dated 03/21/22, recorded R8 had a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. The assessment revealed R8

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required extensive staff assistance of two for bed mobility, personal hygiene, dressing, repositioning, and transfers.

The "Activities of Daily Living Care Area Assessment" (CAA), dated 07/13/21, recorded the resident had actual self-care performance deficits.

The "Activities of Daily Living Care Plan," dated 05/12/22, documented the resident required two staff for toileting, and had a performance deficit due to activity intolerance. The care plan lacked any documentation the resident used a bedpan.

On 06/22/22 at 11:00 AM, observation revealed R8's room door open and Licensed Nurse (LN) J entered the resident's room to administer her medications. Further observation revealed the resident had her dress up, sitting on the bed pan, with the lower part of her body exposed. Continued observation revealed the resident's windows had the blind's half up and visualization to the parking lot.

On 06/23/20 at 11:30 AM, observation revealed R8's sitting on the bed pan with her dress up and the lower part of her body exposed. Continued observation revealed the resident's window had the blinds half up and visualization of the parking lot.

On 06/27/22 at 10:30 AM, Administrative Nurse D verified the resident should have the window blinds closed when she used the bed pan. Administrative Nurse D verified it was not appropriate for the resident to be exposed when in her bed.

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F 550	Continued From page 4 The facility's "Dignity" policy, dated February 2021, documented each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level or satisfaction with life, and feelings of self-worth and self-esteem. Th e policy documented resident would always be treated with dignity and respect and staff would promote, maintain and protect residence privacy, including bodily privacy during assistance with personal cares and during treatment procedures. The facility failed to provide dignity for R8 when using the bedpan.	F 550		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section.	F 625		

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§483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 59 residents. The sample included 18 residents with two reviewed for hospitalization. Based on observation, interview, and record review the facility failed to provide the resident or resident representative with written information regarding the facility bed hold policy, when R18 transferred to the hospital. This placed R18 at risk for not being permitted to return and resume residence in the nursing facility.

Findings included:

- R18's "Electronic Medical Record" (EMR) documented the resident had diagnoses of major depressive disorder (major mood disorder), diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), muscle weakness, and altered mental status (state of awareness that was different from the normal awareness of a person).

R18's "Significant Change Minimum Data Set" (MDS), dated 04/04/22, documented the resident had a Brief Interview of Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS documented the resident required total staff assist with transfers and locomotion off unit, extensive staff assistance with bed mobility,

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dressing, toileting, locomotion on the unit, and limited staff assistance with eating and personal hygiene.

R18's "Activities of Daily Living (ADL) Care Plan," dated 04/11/22, documented the resident required total staff assistance with locomotion, extensive staff assistance with bed mobility, transfers, toileting and personal hygiene, and supervision with eating.

R18's "Progress Notes, dated 03/20/22 at 04:22 PM, documented the resident transferred by ambulance to the hospital.

Review of R18's "Progress Notes" revealed lack of documentation the facility provided the resident or representative with the facility bed hold policy regarding the 03/20/22 hospitalization transfer.

On 06/21/22 at 12:00 PM, observation revealed the resident rested in bed and ate his noon meal independently.

On 06/23/22 at 08:20 AM, Administrative Staff A stated the business office notified the resident or resident representative by telephone regarding the facility bed hold policy.

On 06/23/22 at 08:40 AM, Administrative Staff A verified the facility did not send the bed hold policy with the resident or resident representative on transfer to the hospital or go over the bed hold policy with them.

The facility's "Bed-Holds and Returns Policy," revised March 2017, documented prior to transfers and therapeutic leaves, residents or resident representative would be informed in

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F 625	Continued From page 7 writing of the bed-hold and return policy. The facility failed to provide R18 or his representative with the bed hold policy when he was transferred to the hospital on 03/20/22. This placed the resident at risk for not being permitted to return and resume residence in the nursing facility.	F 625		
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 had a census of 59. The sample included 18 residents. Based on observation, interview, and record review the facility failed to provide care in a timely manner for Resident (R) 54 when facility staff did not answer her call light (used to request assistance) for 28 minutes. This deficient practice placed R54 at risk to not have care or assistance in a timely manner. Findings included: - R54's "Physician Oder Sheet," dated 06/21/22, included diagnoses of 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	F 684		

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the brain), diabetes mellitus (condition results from insufficient production of insulin, causing high blood sugar), meningitis (infection of meninges, protective tissue of the brain that causes stiff neck, headache and fever), and myopathy (disorders in which the primary symptom is muscle weakness due to dysfunction of muscle fiber).

The "Care Plan," dated 06/12/22, directed staff to anticipate and meet the resident's needs, ensure her call light remained within reach and encourage the resident to use the bell to call for assistance. The resident wanted to have the call light left on until someone provided assistance. The resident usually knew when she needed the bathroom.

On 06/21/22 at 10:09 AM, R54 stated staff come in and turn off the call light and do not come back to help for up to an hour later, sometimes.

On 06/23/22 at 08:52 AM, the surveyor entered R54's room to visit with the resident. At 09:37 AM, the surveyor activated the bedside call light. At 09:55 AM, the surveyor activated the bathroom call light. Observation revealed at 10:05 AM Licensed Nurse (LN) I and Certified Nurse Aide (CNA) P responded to the call light, 28 minutes after activating the bedside call light.

On 06/27/22 at 11:40 AM, Administrative Nurse D verified staff were expected to answer call lights promptly. She stated the facility used pagers connected to the call lights and if staff did not answer within five minutes the call would go to Certified Medication Aides (CMAs), then after no answer for another five minutes the notice would page the nurse on duty. Administrative Nurse D

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F 684	Continued From page 9 stated she expected staff to respond and they should leave the call light on. The facility's policy for "Answering the Call Light," dated 03/2021, documented the purpose of the procedure was to ensure timely responses to the resident's needs and requests. The policy stated staff were to ensure the call light plugged in and functioning at all times, within reach of the resident, and report all defective call lights to the nurse supervisor immediately. The facility failed to ensure timely response to R54's call for assistance, placing R54 at risk to not have care needs met.	F 684		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: The facility had a census of 59 residents. The sample included 18 residents with one reviewed for pressure ulcers. Based on observation, interview, and record review, the facility failed to	F 686		

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initiate effective interventions according to standards of care to prevent the development of a right dorsal (the back, or upper surface of the foot) foot, facility acquired Stage 3 pressure ulcer (full-thickness loss of skin, in which subcutaneous fat may be visible in the ulcer and granulation tissue may be present) for Resident (R)2.

Findings included:

- R2's "Physician Order Sheet" dated 06/21/22, included diagnoses of anxiety (mental or emotional reaction characterized by apprehension), diabetes mellitus Type 2 (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), hyponatremia (greater than normal concentration of sodium in the blood), and right-side hemiplegia (paralysis of one side of the body).

R2's "Quarterly Minimum Data Set" (MDS) assessment, dated 04/21/22, documented R2 had severely impaired cognition and required extensive assistance with two staff for bed mobility, transfers, dressing, toileting, and personal hygiene. The MDS further documented the resident had no skin issues.

The 10/18/21 "Pressure Ulcer Care Area Assessment" (CAA) documented the resident had a 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) that placed him at risk for impaired skin and had impaired mobility, incontinence, and not able to communicate his needs to the staff. The CAA documented the resident had no skin issues or pressure ulcers.

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The "Braden Scale Assessment" for predicting pressure ulcer risk, dated 10/01/21 and 02/01/21 documented a score of 10 which indicated the resident a high risk for pressure ulcer development.

The "Activities of Daily Living (ADL) Care Plan," dated 03/08/22 directed the staff to monitor the resident for skin break down, turn and reposition at least every two hours, more often as needed or if he/she displayed discomfort. The "ADL Care Plan" documented the resident had impaired mobility, was at risk for pressure ulcer development, and directed staff to use off-loading boots to prevent skin breakdown.

The "Physician Order," dated 10/12/21 ordered the staff to obtain weekly skin assessments.

The "Physician Order," dated 02/23/22 directed the staff to apply the Prevalon (a boot designed with an open, floated-heel design which means the heel is completely floated. This provides continuous pressure relief.) boots when the resident was in bed.

The "Skin Alteration Assessment," dated 05/30/22 documented a wound on the resident's lateral 5th toe, that measured 1.2 centimeters (cm) by 1.1 cm, with no drainage.

The "Wound Care Plus Skin Assessment," dated 06/02/22, documented R2 had one open area on his right dorsal foot, measuring 2.0 cm by 1.2 cm by 0.1 cm depth with a moderate amount of yellow drainage. The nurse practitioner ordered the staff to cleanse the wound with wound cleanser and use to irrigate or scrub the wound

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bed (mechanical debride). Protect the peri wound with Skin Prep Protectant (forms protective film), cover with a border gauze, and change the dressing every other day and as needed for soiling, saturation, or unscheduled removal.

The "Wound Care Plus Skin Assessment," dated 06/09/22, documented R2 had one open area on his right dorsal foot, and the Nurse Practitioner debrided the area measuring 1.5 cm by 1.5 cm by 0.1 cm with moderate amount of yellow drainage. The nurse practitioner ordered the staff to apply a skin protectant around the wound, apply a cut to fit Calcium Alginate (a dressings are highly absorptive, non-occulsive dressings made of soft, non-woven calcium alginate fibers derived from brown seaweed or kelp) dressing to the wound base and cover with a silicone border foam gauze and change every Tuesday, Thursday, and Saturday and as needed.

The "Skin Alteration Assessment," dated 06/09/22, documented a wound on the resident's lateral 5th toe, that measured 1.5 cm by 1.5 cm by 0.1 cm, with moderate drainage.

The "Skin Alteration Assessment," dated 06/16/22, documented a wound on the resident's right toes, measuring 1.5 cm by 1.5 cm by 0.1 with moderate drainage.

The "Physician Order," dated 06/18/22, documented to apply Calcium Alginate to the wound area, cover with Opti foam (a foam dressing that has silicone adhesive border, waterproof backing that can stay in place for 7 days) border, and change every Tuesday, Thursday and Saturday.

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The "Skin Alteration Assessment," dated 06/23/22, documented a wound on the resident's right toes, that measured 1.2 cm by 1.2 cm by 0.1 with moderate drainage.

The "Wound Care Plus Skin Assessment," dated 06/23/22, documented R2 had one open area noted on his right dorsal foot, measuring 1.2 cm centimeters by 1.2 cm, with 0.1 cm depth with maceration. The nurse practitioner ordered the staff to cleanse the wound with wound cleanser, use to irrigate or scrub the wound bed (mechanical debride), apply Skin Prep Protectant (a liquid film-forming dressing that, upon application to intact skin, forms a protective film to help reduce friction during removal of tapes and films) around the wound, apply a cut to fit dressing to the wound base, cover with a silicone border foam gauze, and change every Tuesday, Thursday, and Saturday and as needed.

On 06/22/22 at 03:30 PM, observation revealed R2 lying on their back in bed with the lights off and eyes closed. R2 laid on a low air loss mattress with protective boots on both feet.

On 06/23/22 at 10:20 AM, observation revealed R2 lying on their back in bed when Licensed Nurse (LN) H removed the protective boot and gauze dressing from R2's right dorsal foot. Continued observation revealed the dressing was embedded into the wound and LN H pulled the dressing off and the resident winced and shook his head as he was having pain. LN H cleansed the wound with wound cleanser, applied a cut-to-fit calcium alginate dressing to the open area, and covered with an Opti foam dressing on top of the dressing.

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F 686	Continued From page 14 On 06/23/22 at 10:40 AM interview with LN H, facility wound nurse, verified R2 developed a pressure ulcer on his right dorsal foot on 05/30/22. LN H said R2 wore a Prevalon boot when in bed and the boot caused a sore on his toes. LN H verified the resident refused to get out of bed. On 06/27/22 at 01:45 PM, Administrative Nurse D verified the resident developed the facility acquired Stage 3 pressure ulcer on his right dorsal foot on 05/30/22. Administrative Nurse E verified the resident had pressure relieving boots since 02/2022 and would cross his legs at the ankle area and developed the area on the foot from positioning. The facility "Skin and Wound Management" policy, dated January 2021, documented the policy was to prevent the development of pressure injury unless clinically unavoidable. The policy documented all residents are screened to determine their risk of development of pressure injury using the Braden Scale. A licensed nurse would perform a visual "head to toe" skin review upon admission or readmission to determine general skin condition and identify any pre-existing skin concerns and/or wounds. All wounds are monitored at least weekly by a licensed nurse. The facility failed to initiate timely interventions to prevent the development of a Stage 3 facility acquired pressure ulcer for R2, placing the resident at risk for further skin breakdown.	F 686		
F 697 SS=D	Pain Management CFR(s): 483.25(k)	F 697		

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§483.25(k) Pain Management.
The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 59 residents. The sample included 18 residents with two reviewed for pain. Based on observation, interview, and record review the facility failed to provide interventions during wound care to manage Resident (R) 2's distress and pain. This placed the resident at risk for prolonged and unnecessary pain or distress.

Findings included:

- R2's "Physician Order Sheet" dated 06/21/22, included diagnoses of anxiety (mental or emotional reaction characterized by apprehension), diabetes mellitus type 2 (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), hyponatremia (greater than normal concentration of sodium in the blood), and right-side hemiplegia (paralysis of one side of the body).

R2's "Quarterly Minimum Data Set" (MDS) assessment, dated 04/21/22, documented R2 had severely impaired cognition and required extensive assistance with two staff for bed mobility, transfers, dressing, toileting, and personal hygiene. The MDS further documented the resident had no skin issues, and received scheduled pain medication

The 10/18/21 "Pain Care Area Assessment"

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(CAA) documented the resident had a 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) and documented the resident was not able to be interviewed, due to aphasia (condition with disordered or absent language function) however, staff noted some facial grimacing when the resident moved. R2 did not express any vocal expression of pain but had the potential for pain due to his impaired mobility. The CAA documented staff would observe for pain during routine care.

The "Pain Care Plan," dated 03/08/22, documented the resident had signs of pain due to a recent stroke and directed the staff to monitor the resident for pain, provide pain relief, and respond immediately to any signs of pain. The "Care Plan" directed the staff to evaluate the effectiveness of pain interventions within 45 minutes of administering, review for compliance, alleviated the symptoms, dosing schedules, and resident satisfaction with results, impact on functional ability and impact on cognition. Continued "Care Plan" directed the staff to monitor the resident for non-verbal signs of pain including changes in breathing, moaning, yelling out, mood and behavior changes, face grimacing, rocking, and thrashing.

On 06/22/22 at 03:30 PM, observation revealed R2 lying on their back in bed with the lights off and eyes closed. R2 rested on a low air loss mattress with protective boots on both feet.

On 06/23/22 at 10:20 AM, observation revealed R2 lying on their back in bed when Licensed Nurse (LN) H removed the protective boot and

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gauze dressing from R2's right dorsal foot. Continued observation revealed the dressing was embedded into the wound and when LN H pulled the dressing off, the resident winced and shook his head as he was having pain. LN H cleansed the wound with wound cleanser and applied the physician ordered dressing.

On 06/23/22 at 08:50 AM, LN G verified the resident had discomfort during the wound dressing change and cares. LN G said she normally does not give the resident pain medication during dressing changes.

On 06/27/22 at 01:45 PM, Administrative Nurse D verified she expected nursing staff to administer pain medication 30 minutes prior to wound care and to notify her if the resident's complaints of pain during the wound care continued.

The facility's "Pain Assessment and Recognition" policy, dated March 2018, documented the nursing staff would assess each individual's pain upon admission to the facility, at the quarterly review. Whenever there is a significant change in condition, and when there is onset of a new pain or worsening of existing pain. The nursing staff would identify any situations or interventions where an increase in the resident's pain may be anticipated; for example, wound care, ambulation, or repositioning. The physician would order appropriate non-pharmacological and medications interventions to address the individual's pain. Pain medication should be selected based upon pertinent treatment guidelines.

The facility failed to provide interventions during wound care to manage R2's distress and pain.

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F 697	Continued From page 18 This placed the resident at risk for prolonged and unnecessary pain and discomfort.	F 697		
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. This REQUIREMENT is not met as evidenced by: The facility had a census of 59 residents. The sample included 18 residents with one reviewed for dialysis (blood purifying treatment given when kidney function is not optimum). Based on observation, interview, and record review the facility failed to obtain communication from the dialysis center regarding Resident (R) 33's health status with each procedure. This deficient practice placed R33 at risk for unmet needs due to lack of information regarding the resident's health status during the dialysis procedures. Findings included: - R33's "Physician Order Sheet" (POS), dated 06/21/22, documented diagnoses of end stage renal disease (condition where the kidney reaches advanced state of loss of function), and type 2 diabetes mellitus (condition from insufficient production of insulin, causing high blood sugar). The "Admission Minimum Data Set" (MDS), dated 04/18/22, documented a Brief Interview for Mental Status (BIMS) score of 14, indicating	F 698		

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intact cognition. The MDS documented the resident was independent with eating, required two staff assistance for all other activities of daily living, and received dialysis.

The "Dialysis Care Plan," dated 04/12/22, documented R33 had end stage renal disease, received dialysis Monday, Wednesday, and Friday at a local dialysis center, had a dialysis catheter to his right upper chest, and a fistula (dialysis access) to his right wrist. The care plan directed staff to obtain thrill and bruit (rumbling or swooshing sound and feel of a dialysis fistula every shift, notify the physician of any abnormalities, and observe for bleeding, or signs of infection. The care plan directed staff to monitor, document every shift, and report to the physician any signs of infection to the access site, such as redness, swelling, warmth, coolness, or drainage. The care plan documented the facility would assist, as needed, to coordinate services and care with the dialysis clinic and communication with the dialysis center will be done pre/post each visit using a communication sheet or via phone and documented. The care plan documented R33 may require more assistance on dialysis days.

The "Dialysis Book" contained forms completed by facility staff relating information to the dialysis center, but no resident information returned by the dialysis staff.

The "Dialysis Agreement," dated 06/22/22, signed by a dialysis representative and the facility lacked responsibilities of each entity.

On 06/22/22 at 09:35 AM, observation revealed R33 self-propelled his wheelchair to the nurse's

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desk and requested to be weighed, which staff did. R33 requested a pain pill and Licensed nurse (LN) I administered the pain pill and completed a pre-dialysis evaluation of the resident.

On 06/22/22 at 03:32 PM, LN I stated the resident just got back from dialysis and was eating. She stated he ate breakfast and staff saved lunch for when he returned between 3 and 4 PM. LN I stated R33 received dialysis with an access port and the physician created a dialysis fistula on his right wrist last week. LN I stated the facility sent the pre dialysis information with him, but dialysis staff had not sent any information back unless it was a new physician's order.

On 06/23/22 at 01:35 PM, Administrative Nurse D stated the dialysis center only sent changes in medications, and stated she encouraged facility nurses to request labs from them. Administrative Nurse D verified she expected dialysis staff to send information regarding the resident's status during the procedure.

The facility's "End-Stage Renal Disease Care of a Resident" policy, dated 09/2010, documented agreements between this facility and the contracted dialysis facility would include all aspects of how the resident's care would be managed, including how information would be exchanged between the facilities.

The facility failed to obtain communication from the dialysis center regarding R33's health status with each procedure, placing R33 at risk for unmet needs due to lack of information regarding the resident's health status during the dialysis procedures.

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F 732	Continued From page 21	F 732		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever	F 732		

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is greater.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 59 residents. The sample included 18 residents. Based on observation, interview, and record review, the facility failed to post the actual scheduled working hours for nursing staff directly responsible for resident care per shift.

Findings included:

- On 06/21/22 at 08:00 AM, upon entrance into the facility, observation revealed the facility lacked a "Daily Nurse Staffing Report" posted in the facility.

On 06/22/22 at 07:30 AM, observation revealed the facility lacked a "Daily Nurse Staffing Report" posted in the facility.

On 06/23/22 at 07:30 AM, observation revealed the facility lacked a "Daily Nurse Staffing Report" posted in the facility.

On 06/23/22 at 09:30 AM, Administrative Staff A verified the facility had not posted the "Daily Nurse Staffing Report" since her employment at the facility. Administrative Staff A verified she was told the facility no longer needed to post the staffing and it was not a requirement.

The facility's "Posting Direct Care Daily Staff Numbers" policy, dated 07/2016, documented the facility would post, daily for each shift, the number of nursing personnel responsible for providing direct care to residents. Within two hours of the beginning of each shift, the number of licensed nurses, Registered Nurse (RN), Licensed

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F 732	Continued From page 23 Registered Nurse (LPN), and the number of unlicensed personnel Certified Nurse Aides (CNAs) directly responsible for resident care would be posted in a prominent location)accessible to residents and visitors) and in a clear and readable format. The completed "Daily Staffing Records" would be maintained for a minimum of 18 months or as required by state law. The facility failed to post the daily staffing schedule with the nursing personnel directly responsible for resident care per shift.	F 732		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.	F 756		

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(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.

§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by:

The facility had a census of 59 residents. The sample included 18 residents with five reviewed for unnecessary medications. Based on observation, interview, and record review the facility failed to follow up on the Consultant Pharmacist request for an appropriate diagnosis for the use of Seroquel, an antipsychotic (a drug used to treat psychotic disorders) medication for Resident (R) 13. This deficient practice placed R13 at risk for adverse effects related to the use of antipsychotic medication.

Findings included:

- R13's "Physician Order Sheet" (POS), dated 06/16/22, documented diagnoses of cerebral infarction (stroke), atherosclerosis (condition where the arteries become narrowed and hardened due to buildup of plaque (fats), dementia (group of symptoms that affects memory, thinking and interferes with daily life), vertigo (sense of spinning experienced even

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when someone is perfectly still), myoclonus (spasmodic jerky contraction of groups of muscles), hallucinations (experience in which you see, hear, feel, or smell something that does not exist), metabolic encephalopathy (abnormalities of the water, electrolytes, vitamins, and other chemicals that adversely affect brain function), and cerebral infarction (stroke).

The "Admission Minimum Data Set" (MDS), dated 04/07/22, documented a Brief Interview for Mental status (BIMS) score of 12, indicating moderately impaired cognition. The MDS documented R13 did not have mood or behavior issues, was independent with bed mobility, and required supervision for most other activities of daily living. The MDS documented R13 had one non-injury fall and received antipsychotic medication four days of the lookback period.

The "Psychotropic Care Area Assessment" (CAA), dated 04/07/22, documented the resident was at risk for side effects related to the use of Seroquel (antipsychotic) and Cymbalta (antidepressant), and had a history of hallucinations and dementia.

The "Cognitive/Dementia CAA" was blank.

The "Medication Care Plan," dated 04/5/22, documented R13 used Seroquel related to a diagnosis of dementia with behavior disturbance and directed staff to administer medications as ordered, monitor for side effects and effectiveness. The care plan directed staff to consult with pharmacy and the physician to consider dosage reduction when clinically appropriate, discuss with the physician and family any ongoing need for use of medication and risks,

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benefits and the side effects or toxic symptoms of Seroquel. The care plan directed staff to monitor and record occurrences of for target behavior symptoms (not specified) and document per facility protocol, monitor and report to the physician side effects and adverse reactions of psychoactive medications. Arrange for psych consult and follow up as indicated. Monitor, document, and report to the nurse signs of depression and provide a pharmacy review monthly.

The "Physician's Order," dated 04/20/22, directed staff to administer Seroquel, 25 milligrams (mg), at bedtime for a diagnosis of dementia.

Review of "Nursing Notes" and the May and June 2022 "Medication Administration Record (MAR)" revealed no abnormal behaviors of yelling, agitation, or hallucinations noted by staff.

The "Consultant Pharmacist Review," dated 04/15/22, documented an inappropriate diagnosis for the use of Seroquel and requested a risk versus benefit statement. The physician response stated "done."

The "Healthcare Provider Note," dated 04/19/22, documented the patient doing well on current dosing, but given her history, would recommend continue Seroquel at this time as benefit outweighs risk.

The "Consultant Pharmacist Review," dated 06/16/22, noted an inappropriate diagnosis for the use of Seroquel and requested a risk versus benefit statement. The physician response stated, "risk outweighs benefit" and did not address the inappropriate diagnosis.

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On 06/23/22 at 08:08 AM, observation revealed R13 independently ambulated to the dining room with a walker where Licensed Nurse (LN) K obtained her blood pressure and administered R13's medications.

On 06/27/22 at 01:17 PM, LN K sated R13 obsessed about her eye drops, but had no hallucinations or abnormal thoughts. LN K verified the diagnosis of dementia for Seroquel was not appropriate and stated the medication was started when the resident was in the hospital.

On 06/27/22 at 01:30 PM, LN I verified dementia was an inappropriate diagnosis for the use of Seroquel.

On 06/27/22 at 02:00 PM, Administrative Nurse D verified the diagnosis of dementia for the use of Seroquel was inappropriate and she did not realize the consultant pharmacist requested an appropriate diagnosis.

The "Pharmacy Services Role of the Consultant pharmacist" policy, dated 04/2019, documented the consultant pharmacist would review the medication regimen of each resident monthly, provide communication to prescribers and community leadership about potential or actual problems related to any aspect of medications or pharmacy services including medication irregularities.

The facility failed to follow up on the Consultant Pharmacist request for an appropriate diagnosis for the use of Seroquel, an antipsychotic (a drug used to treat psychotic disorders) medication for R13. This deficient practice placed R13 at risk for

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F 756	Continued From page 28 adverse effects related to the use of antipsychotic medication.	F 756		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs	F 758		

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are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.

§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 59 residents. The sample included 18 residents with five reviewed for unnecessary medications. Based on observation, interview, and record review the facility failed to ensure Resident (R) 13 did not receive antipsychotic (a drug used to treat psychotic disorders) medication without an appropriate diagnosis. This deficient practice placed R13 at risk for adverse effects related to the use of antipsychotic medication.

Findings included:

- R13's "Physician Order Sheet" (POS), dated 06/16/22, documented diagnoses of cerebral infarction (stroke), atherosclerosis (condition where the arteries become narrowed and hardened due to buildup of plaque (fats), dementia (group of symptoms that affects memory, thinking and interferes with daily life), vertigo (sense of spinning experienced even when someone is perfectly still), myoclonus (spasmodic jerky contraction of groups of muscles), hallucinations (experience in which you

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see, hear, feel, or smell something that does not exist), metabolic encephalopathy (abnormalities of the water, electrolytes, vitamins, and other chemicals that adversely affect brain function), and cerebral infarction (stroke).

The "Admission Minimum Data Set" (MDS), dated 04/07/22, documented a Brief Interview for Mental status (BIMS) score of 12, indicating moderately impaired cognition. The MDS documented R13 did not have mood or behavior issues, was independent with bed mobility, and required supervision for most other activities of daily living. The MDS documented R13 had one non-injury fall and received antipsychotic medication four days of the lookback period.

The "Psychotropic Care Area Assessment" (CAA), dated 04/07/22, documented the resident was at risk for side effects related to the use of Seroquel (antipsychotic) and Cymbalta (antidepressant), and had a history of hallucinations and dementia.

The "Cognitive/Dementia CAA" was blank.

The "Medication Care Plan," dated 04/05/22, documented R13 used Seroquel related to a diagnosis of dementia with behavior disturbance and directed staff to administer medications as ordered, monitor for side effects and effectiveness. The care plan directed staff to consult with pharmacy and the physician to consider dosage reduction when clinically appropriate, discuss with the physician and family any ongoing need for use of medication and risks, benefits and the side effects or toxic symptoms of Seroquel. The care plan directed staff to monitor and record occurrences of for target behavior

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symptoms (not specified) and document per facility protocol, monitor and report to the physician side effects and adverse reactions of psychoactive medications. Arrange for psych consult and follow up as indicated. Monitor, document, and report to the nurse signs of depression and provide a pharmacy review monthly.

The "Physician's Order," dated 04/20/22, directed staff to administer Seroquel, 25 milligrams (mg), at bedtime for a diagnosis of dementia.

Review of nursing notes and the May and June 2022 "Medication Administration Record (MAR)" revealed no abnormal behaviors of yelling, agitation or hallucinations noted by staff.

The "Consultant Pharmacist Review," dated 04/15/22, documented an inappropriate diagnosis for the use of Seroquel and requested a risk versus benefit statement. The physician response stated "done."

The "Healthcare Provider Note," dated 04/19/22, documented the patient doing well on current dosing, but given her history, would recommend continue Seroquel at this time as benefit outweighs risk.

On 06/23/22 at 08:08 AM, observation revealed R13 independently ambulated to the dining room with a walker where Licensed Nurse (LN) K obtained her blood pressure and administered R13's medications.

On 06/27/22 at 01:17 PM, LN K sated R13 obsessed about her eye drops, but had no hallucinations or abnormal thoughts. LN K verified

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F 758	Continued From page 32 the diagnosis of dementia for Seroquel was not appropriate and stated the medication was started when the resident was in the hospital. On 06/27/22 at 01:30 PM LN I verified dementia was an inappropriate diagnosis for the use of Seroquel. On 06/27/22 at 02:00 PM, Administrative Nurse D verified the diagnosis of dementia for the use of Seroquel was inappropriate. The facility's "Antipsychotic Medication Use" policy, dated 12/2016, documented residents will only receive antipsychotic medications when necessary to treat specific conditions for which they are indicated and effective. Residents who are admitted form the community or hospital already receiving antipsychotics will be evaluated for the appropriateness and indication for use and diagnosis alone does not warrant the use of antipsychotic mediation. All antipsychotic medications should be used within the dosage guidelines and the regulations, or clinical justification would be documented. The physician shall respond appropriately by changing or stopping problematic medications or clearly documenting why the benefits of the medication of outweigh the risks. The facility failed to ensure R13 did not receive antipsychotic medication without an appropriate diagnosis or clinical justification for its use, placing R13 at risk for adverse side effects related to the use of Seroquel.	F 758		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812		

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F 812	Continued From page 33 §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: The facility had a census of 59 residents. The sample included 18 residents. Based on observation, record review, and interview the facility failed to store, distribute and serve food in accordance with professional standards for food service safety for the 59 residents who resided in the facility and received their food from the facility kitchen and two kitchenettes, when staff failed to use safe food handling, failed to dispose of expired food items, failed to disinfect a thermometer between food items when checking the temperatures of the food, and failed to wear a hair net in the kitchen during the preparation a meal. Findings included: - On 06/21/22 at 08:18 AM, observation revealed	F 812		

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the kitchen freezer had the following undated or expired food items:
1/2 bag of French fries
1/4 bag of French fries
1/4 bag of chicken strips
1/4 bag of tater tots

On 06/22/22 at 11:10 AM, observation revealed in the kitchen, during the preparation of the noon meal, Dietary Staff (DS) CC without a hair net.

On 06/21/22 at 08:10 AM, DS BB verified the items in the kitchen freezer and discarded the items in the trash. DS BB stated staff should label and date food items when they open them.

On 06/22/22 at 11:37 AM, observation revealed DS DD applied gloves, touched the oven door, the prep table, and pans, with the same contaminated gloves on, picked up slices of garlic bread and some in another pan, then placed two slices into a bowl for the pureed diet .

On 06/27/22 at 11:48 AM, observation in the west hall kitchenette, DS EE reheated the mechanical soft pork chops in the microwave, placed a thermometer in them, placed the thermometer on the counter underneath the microwave, then placed it (without disinfecting it) into a bowl of gravy. At 12:00 PM DS EE wiped the thermometer off with her apron, placed it back on the counter, then, without disinfecting it, placed it in a ham and cheese sandwich. Further observation revealed at 12:14 PM DS EE picked up a pork chop with tongs, placed it on a resident's plate, then used the same tongs to pick up a sweet potato and placed it on the plate.

On 06/22/22 at 11:59 AM, DS CC verified he was

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not wearing a hair net and stated it must have fallen off when he went to break. He reached outside the front entrance door and grabbed a hair net and placed it on.

On 06/27/22 at 12:34 PM, DS EE verified she wiped the thermometer with her apron and did not disinfect the thermometer in-between each item she reheated in microwave. DS EE verified she used the same tongs to place a pork chop and sweet potato on a resident's plate.

On 06/22/22 at 11:59 AM, DS BB verified DS CC did not have a hair net on and stated should staff wear one when in the kitchen. DS BB stated staff should use tongs to pick up food items.

On 06/27/22 12:36 PM, DS BB stated when staff checked the temperatures of food items they should disinfect the thermometer between them.

The facility's "Food Receiving and Storage Policy," revised October 2017, documented all foods stored in the refrigerator or freezer would be covered, labeled, and dated ("use by" date).

The facility staff failed to use safe food handling, failed to dispose of expired food items, failed to disinfect a thermometer between food items when checking the temperatures of the food, and failed to wear a hair net in the kitchen during the preparation a meal.

- On 06/21/22 at 11:54 AM, observation revealed Certified Nurse Aide (CNA) N picked up Resident (R) 21's used glass and refilled it with lemonade. Continued observation revealed she did not use hand gel or wash her hands before she touched

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F 812	Continued From page 36 the wheelchair handles of R111, filled a clean glass with ice and water for R 116, handled clean glasses for another resident, wiped her hands on her uniform, and obtained a glass of juice for another resident. On 06/21/22 at 12:03 PM, observation revealed CNA N picked up three soiled glasses from R54, refilled them and served them, picked up R54's soiled plate, wiped hands on her uniform, picked up R21's soiled dishes, and touched the handles of R116's wheelchair when she assisted him out of the dining room without washing or disinfecting her hands. On 06/27/22 at 02:20 PM, Administrative Nurse D verified staff should disinfect or wash their hands after touching contaminated items and prior to handling residents' clean glasses. The facility's "Preventing Foodborne Illness-Employee Hygiene and Sanitary Practices" policy, dated 10/2017, documented employees must wash their hands after engaging in activities that contaminate the hands. The facility failed to perform sanitary practices during the meal services, placing residents at risk for communicable illnesses.	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable	F 880		

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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 §483.70(e) and following accepted national standards;

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

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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 had a census of 59 residents. The sample included 18 residents. Based on observation, interview, and record review the facility failed to provide thorough infection control during a wound dressing change for Resident (R) 21 and failed to update their Infection Control policies annually. This deficient practice placed R21 at increased risk for infection.

Findings included:

- On 06/22/22 at 10:55 AM, observation revealed R21 laid in bed, on his right side. Licensed Nurse (LN) GG placed a clean bed pad under R21's left leg and unwrapped the wound dressing. The gauze wound dressing had a large amount red/yellow drainage, with slough (dead tissue). After LN GG removed the soiled wound dressings

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and her gloves, she washed her hands and applied new gloves. LN GG set the wound care supplies on the bedside table without first cleaning or disinfecting the table and she did not place a clean towel on the contaminated surface. Observation revealed the same bedside table held a urinal with dark yellow fluid and an empty, used urinal.

On 06/22/22 at 11:05 AM, LN GG verified she should have placed a clean barrier on the bedside table for the wound care items.

On 06/27/22 at 11:50 AM, Administrative Nurse D verified staff should place a clean barrier to set wound care supplies on during wound care.

The "Wound Care" policy, dated 10/2010, documented during the provision of wound care staff were to use disposable cloth or paper towel to establish a clean field on the resident's overbed table and place all items to be used during the procedure on the clean field.

The facility failed to provide a clean field for wound care supplies during a wound dressing change for Resident (R) 21. This deficient practice placed R21 at increased risk for infection.

- Review of the facility's "Infection Control" policies revealed the following areas included and dated of revision:
Infection Control Policy, revised 04/2020
Antibiotic Stewardship policy, revised 04/2020
Pneumococcal Vaccine, revised 08/2016
Influenza August, revised 2014

On 06/27/22 at 11:50 AM, Administrative Nurse D

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F 880	Continued From page 40 verified the facility's infection control policies were not updated or reviewed at least annually. The facility's "Infection Control Policy and Practices" statement, dated 07/2014, did not address the Center for Medicaid/Medicare Services (CMS) required annual review of infection control policies. The facility failed to update their Infection Control policies annually.	F 880		
F 920 SS=D	Requirements for Dining and Activity Rooms CFR(s): 483.90(h)(1)-(4) §483.90(h) Dining and Resident Activities The facility must provide one or more rooms designated for resident dining and activities. These rooms must-- §483.90(h)(1) Be well lighted; §483.90(h)(2) Be well ventilated; §483.90(h)(3) Be adequately furnished; and §483.90(h)(4) Have sufficient space to accommodate all activities. This REQUIREMENT is not met as evidenced by: The facility had a census of 59 residents. The sample included 18 residents. Based on observation and interview the facility failed to provide sufficient space in one of two dining areas to accommodate residents' needs. Findings included: - On 06/21/22 at 11:57 AM, observation in the	F 920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175563	A. BUILDING _____ B. WING _____	06/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZRIA HEALTH WICHITA	7057 WEST VILLAGE CIRCLE WICHITA, KS 67205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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east dining room revealed residents seated at dining room tables, other residents entered the dining room, some with wheelchairs, others with walkers, and staff moved residents away from their tables so other residents entering could get to the tables for the noon meal.

On 06/22/22 at 11:30 AM, observation revealed residents seated at the dining room tables. The staff had to move residents currently seated at the dining room tables, away from their tables, so other residents could get to the tables for the noon meal.

On 06/27/22 at 02:04 PM, Administrative Nurse D stated she could see how the east dining room was crowded and they needed to try to rearrange the tables to make more room, because not all of the residents on that end come out for dining at this time.

On 6/27/22 at 03:31 PM, Administrative Staff A stated when the facility was first built, (three years ago) the facility dining areas were approved for having space for 35 residents. Administrative Staff A verified the facility now had more residents with wheelchairs and foot extensions who used the east hall dining room.

The facility failed to provide sufficient space in the east dining area to accommodate the residents needs who ate their meals in the east dining room.