STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175044	A. BUILDING _____ B. WING _____	10/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey and Complaint Investigation #181195. The 2567 was sent electronically on 10/13/23.	F 000		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).	F 655		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 10/13/2023

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§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:
(i) The initial goals of the resident.
(ii) A summary of the resident's medications and dietary instructions.
(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.
(iv) Any updated information based on the details of the comprehensive care plan, as necessary.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 76 residents. The sample included 18 residents. Based on observation, record review, and interview, the facility failed to develop a complete baseline care plan for Resident (R)226 which included instructions to staff regarding R226's fluid restriction (limitation of amount of liquid consumed each day). The facility also failed to include information to staff regarding R226's hospice services. This placed the resident at risk for uncommunicated care needs.

Findings included:

- R226's Electronic Medical Record (EMR) documented the resident admitted 10/02/23.

R226's EMR documented she had diagnoses of hemiplegia (paralysis of one side of the body), hemiparesis (muscular weakness of one half of the body), chronic kidney disease (condition characterized by a gradual loss of kidney (a pair of organs that are found on either side of the spine, just below the rib cage in the back which

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F 655	Continued From page 2	F 655		

filter waste materials out of the blood and pass them out of the body as urine) function), and atrial fibrillation (rapid, irregular heart beat).

R226's "Admission Minimum Data Set" (MDS), dated 10/06/23, documented it was in progress.

R226's "Baseline Care Plan," dated 10/02/23, documented R226's favorite foods. The plan documented R226 had her own teeth and glasses, no skin issues, and she was continent of bladder and bowel. The baseline care plan instructed staff to use a gait belt and two staff assist for transfers. The care plan lacked information regarding hospice services or fluid restriction instructions for staff.

The "Physician Order," dated 10/02/23, instructed staff to admit R226 for respite stay with hospice services.

The "Physician Order," dated 10/03/23, instructed staff to provide R226 with a 2-liter per 24 hour fluid restriction.

On 10/04/23 at 08:30 AM, observation revealed R226 rested in bed with her eyes closed. She had a container of water, three-quarters full, on a bedside table.

On 10/04/23 at 03:06 PM, Certified Nurse Aide (CNA) M stated she was unaware the resident had a fluid restriction. CNA M stated she would look at R226's care plan, or staff would pass on in report, what cares R226 required. CNA M said if R226 was on a fluid restriction, staff would fill out a form on fluid intake for the shift and give it to the charge nurse. CNA M stated she knew the resident was receiving hospice services but was

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F 655	Continued From page 3 not aware of when hospice staff came to the facility and what cares they provided. On 10/04/23 at 03:06 PM, Licensed Nurse (LN) G verified R226's baseline care plan lacked documentation regarding her fluid restriction and hospice information. On 10/09/23 at 10:53 AM, Administrative Nurse D stated R226's physician order for fluid restriction should be on the baseline care plan. Administrative Nurse D stated hospice service information should also be on the baseline care plan. The facility's "Person-Centered, Comprehensive Care Plan," revised 04/20/23,documented the facility would provide an individualized, person-centered, interdisciplinary plan of care for all residents that was appropriate to the resident's needs, strengths, limitations and goals based on initial, recurrent and continual needs of the resident. The facility failed to develop a complete baseline care plan for R226 with instructions to staff regarding R226's fluid restriction and hospice services information. This placed the resident at risk due to uncommunicated care needs.	F 655		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that	F 657		

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includes but is not limited to--
(A) The attending physician.
(B) A registered nurse with responsibility for the resident.
(C) A nurse aide with responsibility for the resident.
(D) A member of food and nutrition services staff.
(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.
(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.
(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 76 residents. The sample included 18 residents. Based on observation, interview, and record review, the facility failed to revise the care plan interventions related to Resident (R)48's diagnoses and medications, and for R52's dental orders. This deficient practice placed the residents at risk for impaired care due to uncommunicated care needs.

Findings included:

- R48's Electronic Medical Record documented R48 was admitted 07/18/23, and had diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and

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memory failure), iron deficiency anemia (inadequate number of healthy red blood cells to carry adequate oxygen to body tissues), heart failure, type 2 diabetes mellitus, (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), diabetic neuropathy (weakness, numbness and pain from nerve damage, usually in the hands and feet), hypertension (elevated blood pressure), pain in right and left knees, major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), history of gastrointestinal hemorrhage (bleeding into the stomach and/or digestive tract) and Covid-19 (highly contagious respiratory virus).

The "Admission Minimum Data Set" (MDS), dated 07/24/23, documented a Brief Interview for Mental Status (BIMS) was not conducted. Per staff interview, R48 had short- and long-term memory problems with severely impaired decision making. The MDS documented R48 required limited staff assistance with eating and extensive staff assistance for all other activities of daily living. The MDS documented R48 received insulin (hormone that lowers the level of glucose in the blood), diuretic (medication to promote the formation and excretion of urine), and antidepressant (class of medications used to treat mood disorders) medications for six days of the observation period and antipsychotic (class of medications used to treat major mental conditions which cause a break from reality) and antibiotic (medication used in the treatment and prevention of infections) medications seven days of the observation period.

R48's "Care Plan," dated 08/11/23, directed staff

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to monitor and document indicators of discomfort or distress and follow up as needed. The care plan lacked direction or intervention for problems related to diabetes, high blood pressure, anemia, neuropathy, and the history of gastro-intestinal bleed.

On 10/04/23 at 11:50 AM, observation revealed R48 sat in his wheelchair at a dining table, smiling and pleasant but confused and replied with non-sensible words.

On 10/05/23 at 11:27 AM, Licensed Nurse (LN) J stated the care plan was updated on 10/05/23 to include pain interventions but lacked direction or information regarding R48's other medication issues.

On 10/09/23 at 01:28 PM, Administrative Nurse D verified R48's care plan should reflect concerns related to his diagnoses and medications.

The facility's "Care Plan Revision" policy, dated 04/20/23, stated the care plan would be revised whenever the physician added, removed, or amended any medication in the resident's regimen to included diagnosis or medication, warnings or alerts, instruction to staff on potential adverse effects and specific administration instructions. Revisions to the care plan would be communicated with all staff, all shifts.

The facility failed to revise care plan interventions related to R48's diagnoses and medications, placing R48 at risk for impaired quality of care related to uncommunicated care needs.

- R52's "Electronic Medical Record" documented

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a diagnosis of early onset Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure).

The "Annual Minimum Data Set" (MDS), dated 07/10/23, documented a Brief Interview for Mental Status (BIMS) score of 10, indicating moderately impaired cognition. The MDS documented R52 required limited staff assistance with eating and extensive staff assistance for hygiene.

The "ADL Care Area Assessment" (CAA), dated 07/10/23, stated R52 had a self-care deficit related to her diagnosis of Alzheimer's Disease and she needed assistance from staff to fully complete activities of daily living (ADLs).

R52's "Dental Care Plan," dated 10/03/23, stated R52 had her own teeth, denied pain in her mouth. could tolerate her current diet texture and did not demonstrate trouble chewing or swallowing. The care plan stated R52 could complete her oral cares with reminders or set up from staff, initiated 02/10/2022. The care plan stated R52 would have oral hygiene completed at a minimum of once daily and directed staff to encourage and assist R52 to complete oral hygiene twice daily. The care plan revision on 05/24/2023 directed staff to monitor for non-verbal signs of dental issues such as decreased appetite or fluid intake, grimacing during meals or while drinking and bleeding gums during hygiene. Nursing would complete oral and dental assessments quarterly and as needed. Staff were to report prn any oral or dental problems needing attention and make referrals for dental exams as indicated. The care plan revision on 08/01/2023 stated R52 was able to complete her own dental hygiene at that time,

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however she does require assistance with setting up supplies and cueing. The care plan directed staff to assist to complete the task as needed.

The "Physician's Note," dated 05/22/23, lacked oral or dental concerns.

The "Quarterly Nursing Assessment," dated 07/26/23, documented no oral or dental problems.

The "Personal Hygiene" task lacked documentation staff completed oral care twice daily 18 of 30 days (09/05/23 to 10/03/23).

The "Progress Note," dated 09/06/23 at 12:25 PM, documented R52 left the facility, accompanied by her representative for a dental appointment. The note documented R52 returned with the following progress notes: "Very heavy plaque on teeth- hard to even see upper teeth because of all the plaque. Please help with daily home care. Use Clinpro toothpaste to help prevent tooth decay." The note stated R52 brushed her own teeth with staff cueing, but staff would now be encouraged to offer extensive assistance with brushing.

On 10/04/23 at 09:15 AM, observation revealed Certified Nurse Aide (CNA) P greeted R52 and told her she would help her get ready for the day. CNA P assisted R52 to ambulate with a walker to her bathroom. Continued observation revealed after toileting and peri-care, CNA P assisted R52 to ambulate to the dining room without providing dental care or haircare. Observation revealed staff did not assist R52 to brush her teeth at any time during the morning.

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On 10/05/23 at 08:30 AM, CNA Q assisted R52 to sit up in bed, and R52 followed her directions as much as she could. CNA Q assisted R52 to toilet, provided incontinent cares, washed her hands, combed R52's hair, and dressed R52. CNA Q washed R52's eyeglasses and put them on her, then offered to assist R52 with toothbrushing. CNA Q applied Colgate toothpaste to the brush and brushed R52's teeth for her.

On 10/05/23 at 08:57 AM, CNA Q stated if a resident was standing with their hands on their walker, she would help brush their teeth. CNA Q stated she was not aware of the need to use Clinpro toothpaste. Upon request she found the tube of Clinpro in a basket on the sink, not the basket she had identified as the resident's personal items.

On 10/05/23 at 11:57 AM, Licensed Nurse (LN) J stated R52 was mentally unable to know to brush her teeth, but she could brush them after staff set up the toothbrush. LN J stated she expected staff to provide oral care at least in the morning, at bedtime and as needed. LN J verified no new direction regarding toothbrushing had been added to care plan after the 09/06/23 dental appointment with the new order for special toothpaste and more assistance.

On 10/05/23 at 02:34 PM, Administrative Nurse D verified staff should revise the dental care plan after the dental visit to ensure staff were aware to use the special toothpaste and provide extensive assistance with brushing.

The facility's "Care Plan Revision" policy, dated 04/20/23, stated the care plan would be revised with any change for specific interventions and

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F 657	Continued From page 10 revisions to the care plan would be communicated with all staff, all shifts. The facility failed to care plan new dental interventions ordered by the dentist for R52, placing R52 at risk to not receive dental care with specialized toothpaste due to the uncommunicated care needs.	F 657		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: The facility had a census of 76 residents. The sample included 18 residents, with four reviewed for nutrition. Based on observation, interview and record review, the facility failed to monitor and	F 692		

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record Resident(R)226's physician ordered fluid restriction (limitation of amount of liquid consumed each day). This placed the resident at risk for complications from fluid overlaod.

Findings included:
- R226's Electronic Medical Record (EMR) documented the resident admitted 10/02/23.

R226's EMR documented she had diagnoses of hemiplegia (paralysis of one side of the body), hemiparesis (muscular weakness of one half of the body), chronic kidney disease (condition characterized by a gradual loss of kidney (a pair of organs that are found on either side of the spine, just below the rib cage in the back which filter waste materials out of the blood and pass them out of the body as urine) function), and atrial fibrillation (rapid, irregular heart beat).

R226's "Admission Minimum Data Set" (MDS), dated 10/06/23, documented it was in progress.

R226's "Baseline Care Plan," dated 10/02/23, documented R226's favorite foods. The plan documented R226 had her own teeth and glasses, no skin issues, and she was continent of bladder and bowel. The care plan instructed staff to use a gait belt and two assist for transfers. The baseline care plan lacked directions to staff regarding R226's physician ordered fluid restriction.

The "Physician Order," dated 10/03/23, instructed staff to provide R226 with a 2-liter per 24 hour fluid restriction.

R226's clinical record lacked evidence staff monitored the amount of fluid intake in each 24

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F 692	Continued From page 12 hour period. On 10/04/23 at 08:30 AM, observation revealed R226 rested in bed with her eyes closed. She had a container of water, three-quarters full, on a bedside table. On 10/04/23 at 03:06 PM, Certified Nurse Aide (CNA) M stated she was unaware the resident had a fluid restriction. CNA M stated she would look at R226's care plan, or staff would pass on in report if R226 was on a fluid restriction, staff would fill out a form R226's intake for her shift and at the end of her shift would give it to the charge nurse. On 10/04/23 at 03:06 PM, Licensed Nurse (LN) G verified staff had not been monitoring and recording R226's fluid intake. LN G stated she had just noticed that day that R226 was on a fluid restriction. LN G stated she documented R226's fluid intake so far that shift. On 10/09/23 at 10:53 AM, Administrative Nurse D verified R226 had a physician order for fluid restriction and stated staff should monitor and record R226's fluid intake each shift. Upon request the facility did not provide a policy regarding fluid restriction. The facility failed to monitor and record R226's physician ordered fluid restriction. This placed the resident at risk for complications from fluid overload.	F 692		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)	F 695		

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§ 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning.
The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 76 residents. The sample included 18 residents with one reviewed for respiratory care. Based on observation, interview, and record review, the facility failed to obtain a current physician order for the use of supplemental oxygen for Resident (R)42 and failed to ensure staff provided care for R42's oxygen equipment including the tubing, humidifier and filter. The facility further failed to care plan R42's use of the supplemental oxygen. This deficient practice placed R42 at risk for respiratory issues related to oxygen use.

Findings included:

- R42's Electronic Medical Record (EMR) documented diagnoses of cerebral infarction (stroke), paroxysmal atrial fibrillation (rapid, irregular heartbeat), cardiac pacemaker (implanted device to regulate the beating of the heart), and cardiomyopathy (heart disease).

The "Significant Change Minimum Data Set" (MDS), dated 07/19/23, documented a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS documented R42 required staff supervision for eating, and limited assistance for bed mobility, walking, and

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	175044	A. BUILDING _____ B. WING _____	10/09/2023

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hygiene. R42 required extensive staff assistance for transfers, toileting, and dressing. The MDS documented R42 had no shortness of breath, and she used oxygen.

R42's "Care Plan," dated 07/24/23, lacked any information regarding the resident's use of oxygen therapy.

R42's "Physician Order," dated 07/13/23, directed staff to provide supplemental oxygen, as needed, to maintain oxygen saturations (percentage of oxygen in the blood) above 90 percent (%), and adjust as indicated. The order directed staff to call the physician if R42's oxygen saturations were lower than 90%. The order was discontinued 08/03/23.

The "Physician Order," dated 07/14/23, directed staff to assess R42's temperature and oxygen saturations daily.

The "Physician Note," dated 08/08/23, stated the resident used oxygen therapy, supplemental oxygen, as needed, to maintain saturation above 90%.

The "Progress Note," dated 09/17/23, stated R42's oxygen saturation was 96% on room air, 97% on two liters per minute with the nasal cannula. R42 wore supplemental oxygen due to oxygen saturation percentages in the 70s earlier that day, and R42 chose to remain on oxygen due to comfort.

On 10/04/23 at 08:59 AM, observation revealed R42 sat in her wheelchair at the dining table with oxygen on per nasal cannula from an oxygen tank. She stated she was tired but "fine."

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On 10/04/23 at 10:27 AM, observation revealed Certified Nurse Aide (CNA) O assisted R42 to the dining room for exercise. R42 wore oxygen per nasal cannula and CNA O adjusted the nasal cannula. R42 asked if she could go without the oxygen and CNA O told her it would be a good idea to keep it on during exercise.

On 10/04/23 at 03:00 PM, Certified Medication Aide (CMA) R stated R42 would call for staff to come check or adjust her oxygen. R42 had her own oximeter (device used to measure oxygen saturation) and liked to monitor her own oxygen saturation.

On 10/05/23 at 01:52 PM, Licensed Nurse (LN) K stated staff provided oxygen as needed (PRN) for R42. LN K verified she could not find a current oxygen order. She stated staff changed all residents' oxygen tubing on Sundays, but she was unaware the concentrator had a filter on the side to clean. She verified care of the oxygen equipment had not been care planned or listed in the treatment record.

On 10/05/23 at 02:34 PM, Administrative Nurse D verified the physician order for oxygen had been discontinued 08/03/23 and verified staff should care plan, and document care of the oxygen equipment.

The facility's "Administration of Oxygen" policy, dated 03/08/23, directed staff to check the physician's order for flow and method of administration of oxygen, store nasal cannulas in a plastic bag when not in use, and change tubing and humidifier weekly.

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F 695	Continued From page 16 The facility failed to obtain a current physician order for the use of supplemental oxygen, failed to ensure staff provided care for the oxygen equipment including the tubing, humidifier, and filter, and failed to care plan the use of the supplemental oxygen, placing R42 at risk for respiratory issues related to oxygen use.	F 695		
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	F 732		

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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 is greater.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 76 residents. The sample included 18 residents. Based on observation, record review, and interview, the facility failed to ensure the daily staff nursing hours were posted for one day of the onsite survey.

Findings included:

- On 10/09/23 (Monday) at 11:30 AM, observation revealed the facility lacked postings of daily staff nursing hours in two of the four neighborhoods.

On 10/09/23 at 12:10 PM, Licensed Nurse (LN) H stated on the rehabilitation neighborhood, the day shift nurse or the night nurse were responsible for posting the daily staff nursing hours and verified it was not posted that day.

On 10/09/23 at 12:00 PM, LN I verified she had not filled out the daily staff nursing hours form for the Sunflower neighborhood.

On 10/09/23 at 01:25 PM, Administrative Nurse D verified staff were to post the daily staff nursing hours daily in a public visible place.

Upon request the facility did not provide a policy

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F 732	Continued From page 18 regarding daily nurse staffing hours posting. The facility failed to post the daily nurse staffing hours for one day of the onsite survey.	F 732		
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	F 758		

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§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.

§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 76 residents. The sample included 18 residents with five reviewed for unnecessary medication. Based on observation, interview, and record review, the facility failed to monitor targeted behaviors related to the use of antipsychotic drugs (class of medications used to treat major mental conditions which cause a break from reality) for Resident (R) 67, placing the resident at risk for unnecessary psychotropic (altering mood or thought) drugs.

Findings included:

- R67's Electronic Medical Record documented diagnoses of epilepsy (brain disorder characterized by repeated seizures), dementia (progressive mental disorder characterized by failing memory, confusion), and metabolic encephalopathy (condition in which brain function is disturbed either temporarily or permanently due to different diseases or toxins in the body).

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The "Admission Minimum Data Set" (MDS), dated 08/09/23, documented a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. The MDS documented R67 required supervision for eating, and extensive staff assistance with all other activities of daily living. The MDS documented R67 received antipsychotic medication seven days of the lookback period.

The "Psychotropic Drug Use Care Area Assessment" (CAA), dated 08/09/23, documented R67 took psychotropic medications to assist with social phobia and behavioral disturbances and was at risk for adverse side effects and complications as outlined in the medications black box warning.

The "Medication Care Plan," dated 08/12/23, stated R67 took psychotropic medication to assist with social phobia and behavioral disturbances and was at risk for adverse side effects and complications as outlined in the medications black box warning. The care plan directed staff to administer psychotropic medications as ordered by the physician, monitor for side effects and effectiveness every shift. The care plan directed staff to review R67's behaviors, interventions and alternate therapies attempted and their effectiveness as per facility policy. The plan directed staff to allow R67 time to answer questions and to verbalize feelings, perceptions, and fears. The care plan stated R67 was known to exhibit episodes of angry outbursts and yelling when he wanted something or wanted something done and he did not want to wait. The plan directed staff during those times, provide R67 immediate assistance if possible, reassure and explain to him staff were there to assist him.

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When conflict arose, remove R67 to a calm, safe environment and allow him to vent or share feelings. Social Services would provide R67 one to one support as needed and monitor for changes in mood and cognition.

The "Physician Order," dated 08/03/23, directed staff to administer risperidone (antipsychotic drug), 0.5 milligram (mg) twice daily, and monitor targeted behaviors.

The "Physician Order," dated 08/04/23, directed staff to administer risperidone, 2 mg, daily.

R67's EMR lacked documentation of monitoring of targeted behaviors related to the use of risperidone.

On 10/04/23 at 11:07 AM, observation revealed R67 sat in a dining chair at activities. He visited with staff and sat quietly. His mouth moved as if he was chewing gum.

On 10/05/23 at 01:40 PM, Licensed Nurse (LN) K stated staff had not monitored or documented R67's behaviors. She stated after admission, R67 was irritable and cursed staff.

On 10/09/23 at 01:28 PM, Administrative Nurse D verified staff should have monitored R67's behaviors related to the use of risperidone, as ordered.

The facility's "Antipsychotic Drugs" policy, dated 03/18/23, stated all physician orders for antipsychotic drugs will be clear, accurate, and include a diagnosis, condition, or indication for use.

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F 758	Continued From page 22 The facility failed to monitor targeted behaviors related to the use of risperidone for R67, placing the resident at risk for continued antipsychotic drugs without monitoring for effectiveness and continued need.	F 758		
F 868 SS=F	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c) §483.75(g) Quality assessment and assurance. §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (iv) The infection preventionist. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (i) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are necessary. §483.80(c) Infection preventionist participation on quality assessment and assurance committee.	F 868		

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The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is not met as evidenced by:

The facility had a census of 76 residents. The sample included 18 residents. Based on record review and interview, the facility lacked evidence the required committee members attended the Quality Assessment and Assurance (QAA) Committee quarterly meetings. This placed the residents who resided in the facility at risk for decreased quality of care.

Findings included:

- On 10/09/23 at 12:50 PM, the facility's Quality Assurance Performance Improvement (QAPI) meeting attendance sheets lacked signatures of attendees/committee members on the sheets. The sheets had just committee members names who were expected to attend listed.

On 12/05/22 at 02:30 PM, Administrative Staff A stated staff do not sign in at the meetings; she recorded the attendees, but did not have them sign in.

The facility's "Quality Assurance Improvement Plan," revised 04/20/23, documented the purpose was to provide excellent quality resident/patient care and services. Quality was defined as meeting or exceeding the needs, expectations, and requirements of the residents cost-effectively while maintain good resident outcomes and perceptions of patient care. The plan documented the QAPI would meet monthly and maintain

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F 868	Continued From page 24 minutes of all activity. The facility failed to retain evidence the required QAA and QAPI members attended meetings at least quarterly which placed residents at risk of unidentified quality care services.	F 868		