STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165478	A. Building B. Wing	10/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Court	701 East Mapleleaf Drive Mount Pleasant, IA 52641

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0605 Level of Harm - Actual harm Residents Affected - Few	Ensure that each resident is free from medications that restrain them, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42440 Based on facility record review, hospital record review, and staff, family and Physician Assistant (PA-C) interviews, the facility failed to provide ongoing re-evaluation of psychotropic medications (drugs capable of affecting the mind, emotions, and behavior) to ensure the least restrictive regimen possible for 1 of 3 residents reviewed with psychotropic medication orders (Resident #4). The resident declined, became unresponsive and had been admitted to the hospital with pneumonia and acute metabolic encephalopathy secondary to medication. The facility reported a census of 56 residents. Findings include: The Admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #4 had been admitted on [DATE]. The MDS documented that the resident had diagnoses which included Parkinson's disease, repeated falls, and cognitive communication deficit. The MDS revealed a Brief Interview for Mental Status (BIMS) score of 7, which indicated severe cognitive impairment. The MDS revealed that the resident received both anti-psychotic and anti-depressant medication, and had no behaviors in the 7-day look-back period. The MDS documented that the resident required limited assistance of one staff for bed mobility, transfers, walking, dressing, and hygiene. According to the MDS the resident ate independently, had been continent of bowel and had occasional bladder incontinence. The MDS revealed that the resident weighed 206.2 pounds. The Order Recap Report dated 3/30/22 to 5/11/22 showed the resident admitted on psychotropic medications: fluoxetine (anti-depressant) 20mg daily for Parkinson's, quetiapine (anti-psychotic) 25mg daily for Parkinson's, and lorazepam (anti-anxiety) 0.5 milligrams (mg) three times a day as needed (prn) for agitation. The Care Plan, dated 5/6/22, documented Resident #4 used psychotropic medications related to anxiety and agitation and used anti-anxiety medications related to anxiety. It directed staff to: a. administer the medications as ordered and monitor for side effects and effectiveness every shift b. Consult with pharmacy, doctor to consider dosage reduction when clinically appropriate at least quarterly (continued on next page)

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.

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

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F 0605 Level of Harm - Actual harm Residents Affected - Few	c. Monitor/document/report as needed any adverse reactions of the psychotropic medications such as unsteady gait, tardive dyskinesia, EPS (shuffling gait, rigid muscles, shaking), frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideations, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, muscle cramps, nausea, vomiting, and behavior symptoms not usual to the person d. Monitor/document/report as needed any adverse reactions to anti-anxiety medications: drowsiness, lack of energy, clumsiness, slow reflexes, slurred speech, confusion and disorientation, depression, dizziness, lightheadedness, impaired thinking and judgment, memory loss, forgetfulness, nausea, stomach upset, blurred or double vision and unexpected side effects: mania, hostility, rage, aggressive or impulsive behaviors, hallucinations. The Care Plan, dated 5/6/22, documented Resident #4 required the assistance of 1 staff for hygiene, toilet use, transfers, dressing, and bed mobility, and could eat independently. The Care Plan failed to address behaviors. A Progress Note dated 4/18/22 at 9:59PM documented as follows; Certified Nurses Aid (CNA) reported to this nurse that Resident#4 pushed his roommate and hurt his roommate's right elbow. By the time this nurse and Director of Nursing (DON) responded to the scene, the resident had refused to have his brief changed and pushed the CNA away and grabbed her arms really tight. On assessment Resident #4 had a small superficial cut noted on his own right hand, which had been cleaned and a band-aid applied. Staff updated the physician and received an order to increase lorazepam to 1mg every 4 hours prn for increased agitation and aggressive behaviors. Occupational Therapy (OT) and Physical Therapy (PT) Discharge Summaries, dated 4/20/22 documented the resident continued to require assistance of one staff for mobility and could ambulate up to 200 feet with minimal assistance of 1 staff. The OT/PT discharge recommendations revealed that the resident would remain an assist of one person with waking, and could benefit from a walk to dine and restorative program. A Progress Note dated 4/22/22 at 10:22 p.m. documented as follows; Resident #4 ran down one hall to another hall, swung at the nurse, and hit the medication cart, which opened up a wound on his hand. The resident ripped his hand away from the nurse who attempted to stop the bleeding and wiped blood on the nurse's forearms. It took three staff to get the resident into a wheelchair. The on-call physician ordered a one-time dose of haloperidol (an anti-psychotic), which the resident took orally. A Progress Note dated 4/23/22 at 1:34 p.m. documented that the resident fell when he attempted to get up on his own and when staff attempted to help him to the bathroom, the resident pushed, hit, and swatted staff. The physician ordered haloperidol 1mg every 4 hours prn for increased agitation with behaviors. The resident received a dose at 11:50 a.m. and then received a dose of prn lorazepam at 12:40 p.m. when the behaviors continued. The physician then ordered haloperidol 1mg three times a day. Another Progress Note on 4/23/22 recorded the resident slid out of his recliner around 6:30 p.m. while trying to get up on his own. The resident had increased agitation, hit and kicked staff, swatted, and punched staff's noses as they tried to assist him. The resident had already received scheduled haloperidol and so received prn lorazepam. (continued on next page)

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F 0605 Level of Harm - Actual harm Residents Affected - Few	The April Medication Administration Record (MAR) documented Resident #4 received two doses of lorazepam on 4/23/22 (at 12:40 p.m. and at 7:15 p.m.) and received two doses of scheduled haloperidol on 4/23/22. The resident had received no prn lorazepam prior to 4/23/22. A Progress Note on 4/24/22 stated the resident slept most of the day but would grab staff's hands and say no during cares. It documented resident had scheduled lorazepam three times a day as well as the scheduled haloperidol. The Order Recap Report for the resident's stay showed an order for scheduled lorazepam 1mg three times per day on 4/25/22. A Correspondence with the physician dated 4/25/22 questioned the resident's orders for lorazepam 1mg three times a day, haloperidol 1mg three times a day and prn, and quetiapine 25mg every day, and the physician responded on 4/26/22 to discontinue the quetiapine. The Medication Administration Record (MAR) dated April 2022 documented Resident #4 started receiving lorazepam three times per day on 4/26/22, received haloperidol three times a day starting 4/23/22, and stopped quetiapine 25mg on 4/26/22. The Nutritional Assessment, dated 4/12/22 and locked on 4/28/22, described the resident as more drowsy with recent adjustment in medications. The resident's record contained no evaluation or assessment of the effectiveness or any side effects of the scheduled haloperidol or scheduled lorazepam from 4/24/22 to 4/29/22. A Progress Note on 4/29/22 at 8:56 p.m. stated the resident's emergency contact #2 visited the facility and expressed concern about the medication dosage. The resident appeared drowsy in the morning during the visit. The nurse could not reach the physician. The resident appeared more alert and talkative later in the day. The April 2022 MAR documented the resident refused two doses of scheduled haloperidol on 4/29/22 but otherwise received all scheduled doses of lorazepam and haloperidol. The MAR contained no guidance or orders for staff to monitor the resident's behaviors or side effects of the psychotropic medications. Progress notes on 5/1/22 documented the resident with a cough and audible congestion. An x-ray showed no abnormalities. The resident's record contained no evaluation or assessment of the effectiveness or any side effects of the scheduled haloperidol or scheduled lorazepam, outside of the cough/x-ray documentation on 5/1/22, from 4/29/22 until 5/3/22. A Progress Note on 5/3/22 at 4:09 p.m. by the facility's Advanced Registered Nurse Practitioner (ARNP), reported the family, at the facility, expressed concerns about the resident's extreme drowsiness. The documentation stated the resident started haloperidol 1mg three times a day and lorazepam 1mg three times a day due to abusive behavior to staff and other residents and a fear of him also hurting himself due to impulsive behavior. The ARNP discontinued the scheduled haloperidol. (continued on next page)

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F 0605 Level of Harm - Actual harm Residents Affected - Few	A Care Conference Note dated 5/4/22 at 3:58 p.m. documented intakes over the last 3 weeks: 26.8%, 83.4%, and 90.9%. It stated Seroquel (quetiapine) had changed to prn with continued scheduled lorazepam. The resident continued to have delusions but did not verbalize what he saw. A Progress Note dated 5/6/22 at 11:17 a.m. by Staff A, ARNP, documented staff reported no falls or behaviors following the discontinuation of the scheduled haloperidol, family present and expressed concerns over the increased drowsiness of the resident. A Progress Note on 5/6/22 at 7:30 p.m. documented an unwitnessed fall. Staff notified the physician of blood pressures 80s/50s with neurological assessments completed after the fall. The physician planned to see the resident over the weekend. After no further assessments following completion of neurological assessments on 5/7/22 at 1:41 p.m., on 5/8/22 Progress Notes stated the resident's Power of Attorney (POA) came to the facility and reported concern about the resident sleeping all the time and having a cough. The POA asked when the physician would be visiting, and the nurse contacted the physician who stated the family should make an appointment with the resident's primary Physician Assistant (PA-C) or could go to the emergency room (ER) if concerned. On 5/9/22 at 1:01 p.m., Staff recorded a blood pressure of 60/22 in the resident's record under vital signs but recorded no follow-up, progress note, or notification to the physician. On 5/10/22, a clinic visit note documented the PA-C visited the resident at the facility. The PA-C described the resident as very lethargic, acutely ill, sleeping in a chair, unable to arouse. The resident presented in a wheelchair, unable to sit up independently, with garbled speech. The resident had diminished lung bases and upper respiratory congestion, which cleared with cough. The PA-C documented the resident as lethargic, likely from lorazepam use, since haloperidol had not been used recently. The PA-C decreased the lorazepam dose to 0.5mg three times a day. A Progress Note by the PA-C on 5/10/22 documented cough with decreased air movement in the lung bases. Medication decreased due to overmedication. The May 2022 MAR revealed the resident had received lorazepam three times a day until 5/10/22 except for one dose the morning of 5/8/22. It showed no documentation of monitoring behaviors or medication side effects. Review of the Documentation Survey Reports for April and May 2022 showed the resident with increasing incontinence of bowel and bladder. The Nutrition Report for the week ending 5/10/22 showed average meal intakes decreasing: a. 81% for week ending 4/19/22 b. 52% for week ending 4/26/22 c. 41% for week ending 5/3/22 d. 27% for week ending 5/10/22 (continued on next page)

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F 0605 Level of Harm - Actual harm Residents Affected - Few	The Documentation Survey Report recorded staff's assistance with Activities of Daily Living (ADLs) and meal intakes. The April report showed the resident ate greater than 50% for at least two meals daily through 4/23/22 when the scheduled haloperidol started. Following 4/23/22, the April and May reports only documented >50% intake for two meals on of 4/26/22 and 4/27/22. From 5/1/22 to 5/10/22, the resident ate 25% or less for 18 of 30 meals and required extensive or full assistance by staff to eat for 19 of 28 meals recorded. The Documentation Survey Report documented the resident required extensive to full assistance by two or more staff for transfers from 4/20/22 until 5/10/22. Prior to that time, the resident required limited assistance of 1 staff. On 5/11/22 at 8:59 a.m. a Progress Note recorded the resident as unresponsive, even with sternal rub. The nurse noted a blood pressure of 70/50s and oxygen saturation 82% and sent the resident to the hospital. The hospital Discharge Summary for the resident's stay starting 5/11/22 recorded principal diagnoses of sepsis secondary to left lower lobe pneumonia and acute metabolic encephalopathy secondary to medications. It described the resident as very sedated due to medications at the facility. Although the family stated the resident had a low blood pressure normally, the blood pressure was likely lower than normal due to sepsis and dehydration. The resident weighed 182 pounds. The Discharge MDS dated [DATE] documented no behaviors in the 7-day look-back period and stated the resident received anti-psychotic medication 1 day and both anti-anxiety and anti-depressant medications on all 7 days. He required extensive assistance of staff for bed mobility, transfers, walking, dressing, hygiene, and eating. He was always incontinent of bowel and bladder. The facility's Psychotropic Management Guidelines, revised September 2017, listed practice guidelines: 1. Upon admission, the Licensed Nurse will implement the physician order for the medication including an approved diagnosis or target behavior and the psychoactive medication consent from the resident/responsible party. 2. The Licensed Nurse will communicate via the 24-hour report to the interdisciplinary team regarding the medication order or medication change. 3. The Interdisciplinary Team (IDT) will complete the psychoactive medication evaluation and consent on admission, quarterly, annually, and significant change. 4. The Licensed Nurse will complete the Abnormal Involuntary Movement Scale (AIMS) test upon initiation and/or change of medication and every 6 months thereafter for residents receiving antipsychotic medications. 5. The Licensed Nurse will institute the appropriate behavior monitoring form associated with the drug category to identify specific behaviors, to document the number of episodes of behaviors, and to document interventions and outcomes. 6. The IDT will individualize the resident Care Plan and address: (continued on next page)

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F 0605 Level of Harm - Actual harm Residents Affected - Few	a. the diagnosis and specific behavior for the drug b. appropriate interventions to include nonpharmacological interventions c. goal for reducing/eliminating the drug if not contraindicated d. outcomes On 9/26/22 at 2:30 p.m., the POA reported either she, the Emergency Contact #2, or both, visited the resident at the facility daily over the last 2 weeks of his stay. She reported the resident sat in a recliner in the community room and would barely open his eyes. He would mutter if needing to use the bathroom. When staff assisted him, he would be soaked. It took two to four staff to get him out of the chair at the end. When he admitted to the facility, he ate on his own. The last two weeks, staff had to feed him. When the POA tried to feed the resident, he did not do well. When he arrived to the hospital, he could not swallow or talk. The hospital held the psychotropic medications, and he began to talk but could never swallow safely. When the POA asked the facility not to give the psychotropic medications, they said they had to give them because the physician had ordered them. Staff said the physician would come see the resident, but he never did. The POA had to call in the resident's prior primary care provider. The ARNP who came into the facility eventually stopped the haloperidol but stated the physician needed to cut medications back further. On 9/26/22 at 2:00 p.m., the Emergency Contact #2 reported visiting the resident often at the facility, especially in the last two weeks when he was more unresponsive. The family tried to get the medications stopped, but the facility would not budge. At home, the resident had lorazepam and took a half a tablet at night only. He took a whole tablet three times a day at the facility. He did not open his eyes. He would squeeze hands in response to talking. The ARNP finally took him off one medication. The physician never saw him. Staff had to assist him to eat the last couple of weeks. The resident would have his eyes shut and staff would poke food down him. The resident had trouble swallowing pills. In the end it took 3-4 staff to move him out of his wheelchair or recliner. On 10/3/22 at 11:35 a.m., Staff A, CNA, stated Resident #4 punched her in the face and gave her a concussion. He would have sudden, angry outbursts and seemed confused and unaware of his surroundings. The medications helped, and he calmed down. He took naps but still interacted with staff. The last two weeks of his stay, he would not do much of anything for himself. Staff had to assist with everything, including feeding him. He did not eat well. On 10/3/22 at 12:00 p.m., Staff B, CNA, reported Resident #4 initially walked with a walker but had more difficulty due to his Parkinson's and shuffling gait and so then used the wheelchair. He may have used a mechanical lift for transfers at the end of his stay. His dementia worsened, and he started to need more assistance and started hitting. He seemed more settled at the end of his stay. (continued on next page)

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F 0605 Level of Harm - Actual harm Residents Affected - Few	On 10/3/22 at 12:15 p.m., Staff C, Registered Nurse (RN), recalled the resident could be physical. She described his behaviors as bad. He hit his roommate and a CNA, who went to the hospital with a concussion. He was a big guy, and female staff had a hard time handling him. The behaviors often came out of nowhere with no known triggers. He could have been overstimulated at times since he spent the majority of his time in the day room for monitoring and safety due to behaviors and falls. The day room could be loud. The haloperidol and lorazepam calmed him. His Emergency Contact #2 expressed concern with doses of lorazepam and haloperidol on a weekend, and Staff C attempted to contact the physician. The resident declined at the end of the stay, but Staff C could not say if from medications or just overall decline. Without the medications, the resident would be all over the place. The MAR should contain a psych reactive assessment, which asked about medication side effects and behaviors. On 10/3/22 at 1:40 p.m., Staff D, Certified Medication Aide (CMA), described Resident #4's behaviors as wild and stated they happened so fast. He could be standing still and then running down the hall. He slammed his hand on a medication cart and wiped blood all over and tried to knock over a CNA with a bedside table. Staff D recalled no triggers or indications prior to behaviors. The medications calmed the behaviors down so not as bad or as frequent. The resident was more tired and seemed to fall asleep right before family came in. He would be up prior to their visits. The facility decreased the medication towards the end of the resident's stay since family felt he took too much. The resident's transfers and walking declined. He would not walk, and it took two people to get him into a chair. Eating depended on the day. He would eat if he wanted to. Staff assisted him at the end of his stay. His incontinence increased. At the end, he needed his pills crushed or he would spit them out. He drank water OK with a straw. On 10/3/22 at 2:35 p.m., Staff E, Licensed Practical Nurse (LPN), reported the resident could become violent. She obtained a one dose order for haloperidol when he became agitated and pounded his hand on a medication cart while she tried to wrap a bleeding cut on his hand. The resident had confusion with his Parkinson's and dementia diagnoses and seemed to adjust with some medication changes. The medications made him relax so he could sleep, but he would easily wake if asked about snacks, drinks, or using the bathroom. His family thought he slept too much, but they always visited after meals or medications when he would nap. The facility changed the medications because the family did not want him overly drowsy. The resident had to be fed by staff towards the end of his stay, and his intakes may have decreased. He went from taking pills whole, to taking them whole in pudding, and then to crushed in pudding. His transfers declined, and staff may have used a mechanical lift. It appeared to be a gradual decline. He never wanted to be in the facility and seemed to give up. On 10/3/22 at 4:00 p.m., the PA-C who saw the resident in the facility on 5/10/22 reported she felt the resident received too much medication. She described the resident as awake but unable to speak on 5/10/22. He would try but nothing came out or he mumbled. She had seen him prior to his admission to the facility, and he could walk and talk. She felt medications may have initially been warranted for his behaviors. She could not say if the least restrictive alternative had been used for the least amount of time since she had not seen him prior in the nursing facility, but when she saw him, he appeared overmedicated. He could not speak, and he drooled. His pills sat in his mouth, showing he had no control. (continued on next page)

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F 0605 Level of Harm - Actual harm Residents Affected - Few	On 10/3/22 at 4:15 p.m., the Director of Nursing (DON) reported she had been concerned with all the scheduled psychotropic medications and had portalled (messaged) the physician. The physician had responded to continue the scheduled lorazepam and haloperidol. The resident could be sleepy when the family visited but had been up a lot at night. The family voiced concern for safety when the DON discussed a plan to get the resident off the psychotropic medications. The DON felt the resident was declining from day one of his admission with his Parkinson's and dementia. He accepted more help from staff later in his stay than he would allow earlier.

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F 0636 Level of Harm - Potential for minimal harm Residents Affected - Many	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42440 Based on record review, staff interviews, and Resident Assessment Instrument (RAI) Manual review, the facility failed to complete comprehensive Minimum Data Sets (MDS- a federally mandated assessment) accurately and within 14 calendar days following admission for 4 of 5 residents reviewed (Residents # 1, #4, #5, and #9). The facility reported a census of 56 residents. Findings include: 1. Review of Resident #1's medical record documented an admitted [DATE]. Staff completed the Admission MDS on 8/29/22, day 7 of the resident's admission. Staff documented in the resident's progress notes: a. On 8/24/22 staff observed Resident #1 groping another resident. b. On 8/25/22 staff observed Resident #1 in the hallway, without pants on, looking into another resident's room. c. On 8/26/22 staff observed Resident #1 peeking into a female resident's room while she slept during the night. On 9/22/22 at 2:30 p.m., Staff A, Certified Nurse Aide (CNA), stated on 8/24/22 she observed Resident #1 rub in a circular movement over a female resident's breasts, over her shirt. Staff immediately separated the two residents. Resident #1's Admission MDS, dated [DATE], documented no behavioral symptoms in the 7-day look-back period. It documented no physical behavioral symptoms directed towards others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually), no verbal behavioral symptoms, and no other behavioral symptoms not directed towards others (e.g., physical symptoms such as hitting or scratching self, packing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds). Hospital History and Physical Reports, dated 8/9/22, documented Resident #1 presented to the emergency room after a fall at home. He stood up, got dizzy, passed out, and lost consciousness. Hospital Consultation Notes, documented on 8/12/22 family stated the resident fell at home 3 times within an hour and then again on Monday morning. The facility's Nursing Admission Screening/History, dated 8/22/22, documented the reason for admission from paperwork: falls, dementia, low blood pressure, dizzy, and passed out. The Admission MDS dated [DATE] documented unable to determine falls in the month prior to admission and no falls 2-6 months prior to admission. (continued on next page)

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F 0636 Level of Harm - Potential for minimal harm Residents Affected - Many	2. An Admission MDS for Resident #4's dated 4/6/22 documented an admitted [DATE]. Staff completed the Admission MDS on 4/14/22, day 16 of the resident's admission. 3.The MDS Summary Report for Resident #5 documented an admitted [DATE]. Staff completed the Admission MDS on 11/24/21, on day 23 of the resident's admission. The Medical Diagnosis area of the health record listed diagnoses as of 11/2/21: encephalopathy, cerebral infarction, disorder of thyroid, hypertension, sleep apnea, and diabetes. The Admission MDS, dated [DATE] for Resident #5 listed only stroke/cerebral infarction as a diagnosis. 4. The MDS Summary Report for Resident #9 documented an admitted [DATE]. Staff completed the Admission MDS on 8/29/22, on day 18 of the resident's admission. On 10/3/22 at 1:40 p.m., the Social Services Director reported she completed sections B, C, D, E, and Q of the MDS. She could not recall why she would not have documented Resident #1's behaviors in the MDS. The facility had not retained a consistent MDS Coordinator and so a corporate MDS Coordinator often completed much of the MDS, locked, and submitted it. The corporate MDS Coordinator worked mostly off-site and also completed MDSs for other facilities. On 10/3/22 at 4:15 p.m., the Director of Nursing stated the corporate MDS Coordinator frequently worked remotely. The facility recently hired a new MDS Coordinator. Review of the RAI Manual, dated October 2019, on page 2-16, documented Admission MDS assessments must be completed by the 14th calendar day of the resident's admission (admitted + 13 calendar days).

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Arbor Court	701 East Mapleleaf Drive Mount Pleasant, IA 52641

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42440 Based on record reviews, observations, and resident and staff interviews, the facility failed to develop comprehensive Care Plans timely following admission for 2 of 3 residents reviewed (Residents #1 and #4). The facility reported a census of 56 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated [DATE], and completed 9/6/22, revealed Resident #1 admitted on [DATE] with diagnoses including: diabetes, difficulty in walking, orthostatic hypotension, hypertension, and atrial fibrillation. A Brief Interview for Mental Status (BIMS) documented a score of 13, indicating intact cognition. He received anti-depressant medication as well as insulin. Resident #1's Care Plan had focus areas and related goals and interventions initially added on 9/21/22, 30 days after admission, and 15 days after completion of the MDS. a. Activities of daily living (ADL) self-care performance deficit, which included how the resident completed bed mobility, dressing, eating, personal hygiene, toileting, and transfers b. Potential impairment to skin c. Diagnosis of hypertension d. Potential or history of pain e. Bladder incontinence f. Impaired visual function g. Risk for falls h. Antidepressant medication use The Care Plan, dated 8/31/22, recorded a nutritional problem, and on 9/21/22 added related to type 2 diabetes, hyperlipidemia, hypertension, and coronary artery disease. The Care Plan did not include that the resident received insulin or any monitoring of blood sugars or symptoms of high or low blood sugars. Review of the Medication Administration Records (MARs) for August and September 2022 revealed the resident had his blood sugar checked three times a day and received lantus insulin daily as well as an oral medication for diabetes. Hospital History and Physical Reports, dated 8/9/22, documented Resident #1 presented to the emergency room after a fall at home. He stood up, got dizzy, passed out, and lost consciousness. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Hospital Consultation Notes, documented on 8/12/22 family stated the resident fell at home 3 times within an hour and then again on Monday morning. The facility's Nursing Admission Screening/History, dated 8/22/22, documented the reason for admission from paperwork: falls, dementia, low blood pressure, dizzy, and passed out. An observation on 9/20/22 at 1:15 p.m., revealed Resident #1 with a yellow band stating fall risk on his wrist, seated on the seat of a walker, scooting himself down the hall using his feet. On 9/22/22 at 2:00 p.m., the resident reported he fell that morning and had his call light on to ask for some pain medication. 2. The MDS assessment dated [DATE], and completed on 4/14/22, revealed Resident #4 admitted on [DATE] with diagnoses including Parkinson's disease, repeated falls, and cognitive communication deficit. A BIMS documented a score of 7, indicating severe cognitive impairment. He received both anti-psychotic and anti-depressant medication. He required limited assistance of one staff for bed mobility, transfers, walking, dressing, and hygiene. He ate independently, was continent of bowel and had occasional bladder incontinence. Resident #4's Care Plan had focus areas and related goals and interventions initially added on 5/6/22, 37 days after admission, and 22 days after completion of the MDS. a. Limited physical mobility related to Parkinson's disease b. Actual/potential or history of pain c. Use of anti-anxiety medications d. Use of antidepressant medication e. Use of psychotropic medications f. Bladder incontinence g. Potential impairment to skin h. Parkinson's i. ADL self-care performance deficit, which included how the resident completed bed mobility, dressing, eating, personal hygiene, toileting, and transfers In addition, the Care Plan added the focus area of nutritional problem on 4/28/22. The Care Plan failed to address behaviors. The Order Recap Report showed the resident admitted on psychotropic medications: fluoxetine (anti-depressant) 20mg daily for Parkinson's, quetiapine (anti-psychotic) 25mg daily for Parkinson's, and lorazepam (anti-anxiety) 0.5mg three times a day as needed (prn) for agitation. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/18/22, a Progress Note documented Resident #4 pushed his roommate, grabbed a Certified Nurse Aide (CNA) by the arms tightly, and pushed staff. On 4/22/22, a Progress Note documented Resident #4 ran down one hall to another, swung at the nurse, and hit the medication cart, which opened up a wound on his hand. The resident ripped his hand away from the nurse who attempted to stop the bleeding and wiped blood on the nurse's forearms. It took three staff to get the resident into a wheelchair. On 4/23/22, a Progress Note documented the resident fell while attempting to get up on his own. When staff attempted to help him to the bathroom, the resident pushed, hit, and swatted staff. Another Progress Note on 4/23/22 recorded the resident slid out of his recliner around 6:30 p.m. while trying to get up on his own. The resident had increased agitation, hitting and kicking staff, swatting, and punching staff's noses as they tried to assist him. The April 2022 MAR documented Resident #4 started receiving lorazepam (an anti-anxiety medication) three times per day on 4/26/22 and received haloperidol (an anti-psychotic medication) three times a day starting 4/23/22. On 10/3/22 at 11:35 a.m., Staff A, Cerified Nurse Aide (CNA), stated Resident #4 punched her in the face and gave her a concussion. He would have sudden, angry outbursts and seemed confused and unaware of his surroundings. The medications helped, and he calmed down. On 10/3/22 at 12:15 p.m., Staff C, Registered Nurse (RN), recalled the resident could be physical. She described his behaviors as bad. He hit his roommate and a CNA, who went to the hospital with a concussion. He was a big guy, and female staff had a hard time handling him. The behaviors often came out of nowhere with no known triggers. He could have been overstimulated at times since he spent the majority of his time in the day room for monitoring and safety due to behaviors and falls. The day room could be loud. The haloperidol and lorazepam calmed him. On 10/3/22 at 1:40 p.m., Staff D, Certified Medication Aide (CMA), described Resident #4's behaviors as wild and stated they happened so fast. He could be standing still and then running down the hall. He slammed his hand on a medication cart, wiped blood all over, and tried to knock over a CNA with a bedside table. Staff D recalled no triggers or indications prior to behaviors. The medications calmed the behaviors down so not as bad or as frequent. On 10/3/22 at 2:35 p.m., Staff E, Licensed Practical Nurse (LPN), reported the resident could become violent. She obtained a one-dose order for haloperidol when he became agitated and pounded his hand on a medication cart while she tried to wrap a bleeding cut on his hand. The resident had confusion with his Parkinson's and dementia diagnoses and seemed to adjust with some medication changes. On 10/3/22 at 1:40 p.m., the Social Services Director reported care planning anything that triggered for sections B, C, D, E, and Q of the MDS as well as code status. The facility had employed numerous MDS Coordinators, who had not stayed. The corporate MDS Coordinator often filled in. On 10/3/22 at 4:15 p.m., the Director of Nursing (DON) stated she tried to keep up with the Care Plans, along with the MDS Coordinator. Keeping up with the Care Plans had been difficult with no consistency of staff, but they recently hired a new MDS Coordinator. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Psychotropic Management Guidelines, revised September 2017, stated the interdisciplinary team would individualize the resident Care Plan and address: a. the diagnosis and specific behavior for the drug b. appropriate interventions to include nonpharmacological interventions c. goal for reducing/eliminating the drug if not contraindicated d. outcomes The facility's Comprehensive Person-Centered Care Plan policy, last reviewed 10/23/19, defined the Comprehensive Person Centered Care Plan as containing services provided, preference, ability, and goals for admission, desired outcomes, and care level guidelines. The interdisciplinary team should fully develop the Care Plan within 7 days after completion of the Admission MDS Assessment.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42440 Based on facility record review, hospital record review, and staff, family and Physician Assistant (PA-C) interviews, the facility failed to assess, update providers, and obtain interventions when a resident had a significant decline in activities of daily living (ADLs) and a decreased blood pressure reading (Resident #4) and when a resident had a pending abdominal x-ray with abdominal distension (Resident #10) for 2 of 3 residents reviewed for assessment. Resident #4 admitted to the hospital with pneumonia and acute metabolic encephalopathy secondary to medication. Resident #10 admitted to the hospital with sigmoid volvulus with signs of ischemia. The facility reported a census of 56 residents. Findings include: 1. The Minimum Data Set (MDS) assessment, dated 4/6/22, revealed Resident #4 admitted on [DATE] with diagnoses of Parkinson's disease, repeated falls, and cognitive communication deficit. A Brief Interview for Mental Status (BIMS) documented a score of 7, indicating severe cognitive impairment. He required limited assistance of one staff for bed mobility, transfers, walking, dressing, and hygiene. He ate independently, was continent of bowel and had occasional bladder incontinence. He weighed 206.2 pounds. The Care Plan, dated 5/6/22, documented Resident #4 used psychotropic medications related to anxiety and agitation and used anti-anxiety medications related to anxiety. It directed staff to administer the medications as ordered and monitor for side effects and effectiveness every shift. The Care Plan, dated 5/6/22, documented Resident #4 required the assistance of 1 staff for hygiene, toilet use, transfers, dressing, and bed mobility, and could eat independently. Occupational Therapy (OT) and Physical Therapy (PT) Discharge Summaries, dated 4/20/22 documented the resident continued to require assistance of one staff for mobility and could ambulate up to 200 feet with minimal assistance of 1 staff. On 4/23/22, a Progress Note documented the resident fell while attempting to get up on his own and when staff attempted to help him to the bathroom, the resident pushed, hit, and swatted staff. The physician ordered haloperidol 1mg every 4 hours prn for increased agitation with behaviors. The resident received a dose at 11:50 a.m. and then received a dose of prn lorazepam at 12:40 p.m. when the behaviors continued. The physician then ordered haloperidol 1mg three times a day. A Progress Note on 4/24/22 at 9:17 p.m. stated the resident slept most of the day but would grab staff's hands and say no during cares. It documented resident had scheduled lorazepam three times a day as well as the scheduled haloperidol. The April 2022 MAR documented Resident #4 started receiving lorazepam three times per day on 4/26/22 and received haloperidol three times a day starting 4/23/22. The Nutritional Assessment, dated 4/12/22 and locked on 4/28/22, described the resident as more drowsy with recent adjustment in medications. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	The resident's record contained no evaluation or assessment of the effectiveness or any side effects of the scheduled haloperidol or scheduled lorazepam from 4/24/22 to 4/29/22. A Progress Note on 4/29/22 8:56 p.m. stated the resident's emergency contact #2 visited the facility and expressed concern about the medication dosage. The resident appeared drowsy in the morning during the visit. The nurse could not reach the physician. The resident appeared more alert and talkative later in the day. The April MAR documented the resident refused two doses of scheduled haloperidol on 4/29/22 but otherwise received all scheduled doses of lorazepam and haloperidol. The MAR contained no guidance or orders for staff to monitor the resident's behaviors or side effects of the psychotropic medications. Progress notes on 5/1/22 documented the resident with a cough and audible congestion. An x-ray showed no abnormalities. The resident's record contained no evaluation or assessment of the effectiveness or any side effects of the scheduled haloperidol or scheduled lorazepam, outside of the cough/x-ray documentation on 5/1/22, from 4/29/22 until 5/3/22. A Progress Note on 5/3/22 at 7:50 p.m. by the facility's Advanced Registered Nurse Practitioner (ARNP), reported the family, at the facility, expressed concerns about the resident's extreme drowsiness. The documentation stated the resident started haloperidol 1mg three times a day and lorazepam 1mg three times a day due to abusive behavior to staff and other residents and a fear of him also hurting himself due to impulsive behavior. The ARNP discontinued the scheduled haloperidol. On 5/4/22, a Care Conference note documented intakes over the last 3 weeks: 26.8%, 83.4%, and 90.9%. On 5/6/22 at 7:30 p.m., a Progress Note documented an unwitnessed fall. Staff notified the physician of blood pressures 80s/50s with neurological assessments completed after the fall. The physician planned to see the resident over the weekend. After no further assessments following completion of neurological assessments on 5/7/22 at 1:41 p.m., on 5/8/22 Progress Notes stated the resident's Power of Attorney (POA) came to the facility and reported concern about the resident sleeping all the time and having a cough. The POA asked when the physician would be visiting, and the nurse contacted the physician who stated the family should make an appointment with the resident's primary Physician Assistant (PA-C) or could go to the emergency room (ER) if concerned. On 5/9/22 at 1:01 p.m., Staff recorded a blood pressure of 60/22 in the resident's record under vital signs but recorded no follow-up, progress note, or notification to the physician. On 5/10/22, a clinic visit note documented the PA-C visited the resident at the facility. The PA-C described the resident as very lethargic, acutely ill, sleeping in a chair, unable to arouse. The resident presented in a wheelchair, unable to sit up independently, with garbled speech. The resident had diminished lung bases and upper respiratory congestion, which cleared with cough. The PA-C documented the resident as lethargic, likely from lorazepam use, since haloperidol had not been used recently. The PA-C decreased the lorazepam dose to 0.5mg three times a day. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	The May 2022 MAR revealed the resident had received lorazepam three times a day until 5/10/22 except for one dose the morning of 5/8/22. It showed no documentation of monitoring behaviors or medication side effects. Review of the Documentation Survey Reports for April and May 2022 showed the resident with increasing incontinence of bowel and bladder. The Nutrition Report for the week ending 5/10/22 showed average meal intakes decreasing: a. 81% for week ending 4/19/22 b. 52% for week ending 4/26/22 c. 41% for week ending 5/3/22 d. 27% for week ending 5/10/22 The Documentation Survey Report recorded staff's assistance with Activities of Daily Living (ADLs) and meal intakes. The April report showed the resident ate greater than 50% for at least two meals daily through 4/23/22 when the scheduled haloperidol started. Following 4/23/22, the April and May reports only documented >50% intake for two meals on of 4/26/22 and 4/27/22. From 5/1/22 to 5/10/22, the resident ate 25% or less for 18 of 30 meals and required extensive or full assistance by staff to eat for 19 of 28 meals recorded. The Documentation Survey Report documented the resident required extensive to full assistance by two or more staff for transfers from 4/20/22 until 5/10/22. Prior to that time, the resident required limited assistance of 1 staff. On 5/11/22 at 8:59 a.m. a Progress Note recorded the resident as unresponsive, even with sternal rub. The nurse noted a blood pressure of 70/50s and oxygen saturation 82% and sent the resident to the hospital. The hospital Discharge Summary for the resident's stay starting 5/11/22 recorded principal diagnoses of sepsis secondary to left lower lobe pneumonia and acute metabolic encephalopathy secondary to medications. It described the resident as very sedated due to medications at the facility. Although the family stated the resident had a low blood pressure normally, the blood pressure was likely lower than normal due to sepsis and dehydration. The resident weighed 182 pounds. The Discharge MDS dated [DATE] documented the resident required extensive assistance of staff for bed mobility, transfers, walking, dressing, hygiene, and eating. He was always incontinent of bowel and bladder. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 9/26/22 at 2:30 p.m., the resident's power of attorney (POA) reported either she, the Emergency Contact #2, or both, visited the resident at the facility daily over the last 2 weeks of his stay. She reported the resident sat in a recliner in the community room and would barely open his eyes. He would mutter if needing to use the bathroom. When staff assisted him, he would be soaked. It took two to four staff to get him out of the chair at the end. When he admitted to the facility, he ate on his own. The last two weeks, staff had to feed him. When the POA tried to feed the resident, he did not do well. When he arrived to the hospital, he could not swallow or talk. The hospital held the psychotropic medications, and he began to talk but could never swallow safely. When the POA asked the facility not to give the psychotropic medications, they said they had to give them because the physician had ordered them. Staff said the physician would come see the resident, but he never did. The POA had to call in the resident's prior primary care provider. The ARNP who came into the facility eventually stopped the haloperidol but stated the physician needed to cut medications back further. On 9/26/22 at 2:00 p.m., the Emergency Contact #2 reported visiting the resident often at the facility, especially in the last two weeks when he was more unresponsive. The family tried to get the medications stopped, but the facility would not budge. At home, the resident had lorazepam and took a half a tablet at night only. He took a whole tablet three times a day at the facility. He did not open his eyes. He would squeeze hands in response to talking. The ARNP finally took him off one medication. The physician never saw him. Staff had to assist him to eat the last couple of weeks. The resident would have his eyes shut and staff would poke food down him. The resident had trouble swallowing pills. In the end it took 3-4 staff to move him out of his wheelchair or recliner. On 10/3/22 at 11:35 a.m., Staff A, Certified Nurse Aide (CNA), stated Resident #4 punched her in the face and gave her a concussion. He would have sudden, angry outbursts and seemed confused and unaware of his surroundings. The medications helped, and he calmed down. He took naps but still interacted with staff. The last two weeks of his stay, he would not do much of anything for himself. Staff had to assist with everything, including feeding him. He did not eat well. On 10/3/22 at 12:00 p.m., Staff B, CNA, reported Resident #4 initially walked with a walker but had more difficulty due to his Parkinson's and shuffling gait and so then used the wheelchair. He may have used a mechanical lift for transfers at the end of his stay. His dementia worsened, and he started to need more assistance and started hitting. He seemed more settled at the end of his stay. On 10/3/22 at 12:15 p.m., Staff C, Registered Nurse (RN), recalled the resident could be physical. She described his behaviors as bad. He hit his roommate and a CNA, who went to the hospital with a concussion. He was a big guy, and female staff had a hard time handling him. The behaviors often came out of nowhere with no known triggers. He could have been overstimulated at times since he spent the majority of his time in the day room for monitoring and safety due to behaviors and falls. The day room could be loud. The haloperidol and lorazepam calmed him. His Emergency Contact #2 expressed concern with doses of lorazepam and haloperidol on a weekend, and Staff C attempted to contact the physician. The resident declined at the end of the stay, but Staff C could not say if from medications or just overall decline. Without the medications, the resident would be all over the place. The MAR should contain a psych reactive assessment, which asked about medication side effects and behaviors. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 10/3/22 at 1:40 p.m., Staff D, Certified Medication Aide (CMA), described Resident #4's behaviors as wild and stated they happened so fast. He could be standing still and then running down the hall. He slammed his hand on a medication cart and wiped blood all over and tried to knock over a CNA with a bedside table. Staff D recalled no triggers or indications prior to behaviors. The medications calmed the behaviors down so not as bad or as frequent. The resident was more tired and seemed to fall asleep right before family came in. He would be up prior to their visits. The facility decreased the medication towards the end of the resident's stay since family felt he took too much. The resident's transfers and walking declined. He would not walk, and it took two people to get him into a chair. Eating depended on the day. He would eat if he wanted to. Staff assisted him at the end of his stay. His incontinence increased. At the end, he needed his pills crushed or he would spit them out. He drank water OK with a straw. On 10/3/22 at 2:35 p.m., Staff E, Licensed Practical Nurse (LPN), reported the resident could become violent. She obtained a one dose order for haloperidol when he became agitated and pounded his hand on a medication cart while she tried to wrap a bleeding cut on his hand. The resident had confusion with his Parkinson's and dementia diagnoses and seemed to adjust with some medication changes. The medications made him relax so he could sleep, but he would easily wake if asked about snacks, drinks, or using the bathroom. His family thought he slept too much, but they always visited after meals or medications when he would nap. The facility changed the medications because the family did not want him overly drowsy. The resident had to be fed by staff towards the end of his stay, and his intakes may have decreased. He went from taking pills whole, to taking them whole in pudding, and then to crushed in pudding. His transfers declined, and staff may have used a mechanical lift. It appeared to be a gradual decline. He never wanted to be in the facility and seemed to give up. On 10/3/22 at 4:00 p.m., the PA-C who saw the resident in the facility on 5/10/22 reported she felt the resident received too much medication. She described the resident as awake but unable to speak on 5/10/22. He would try but nothing came out or he mumbled. She had seen him prior to his admission to the facility, and he could walk and talk. She felt medications may have initially been warranted for his behaviors. She could not say if the least restrictive alternative had been used for the least amount of time since she had not seen him prior in the nursing facility, but when she saw him, he appeared overmedicated. He could not speak, and he drooled. His pills sat in his mouth, showing he had no control. On 10/3/22 at 4:15 p.m., the Director of Nursing (DON) reported she had been concerned with all the scheduled psychotropic medications and had portalled (messaged) the physician. The physician had responded to continue the scheduled lorazepam and haloperidol. The resident could be sleepy when the family visited but had been up a lot at night. The family voiced concern for safety when the DON discussed a plan to get the resident off the psychotropic medications. The DON felt the resident was declining from day one of his admission with his Parkinson's and dementia. He accepted more help from staff later in his stay than he would allow earlier. 2. The Quarterly MDS assessment, dated 7/19/22, revealed Resident #10 had an ostomy for her bowels. She had both long- and short-term memory problems. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of Progress notes revealed that on 6/17/22, the resident had an emesis (vomited) at breakfast. Resident #10 reported feeling fine. Staff documented active bowel sounds in all quadrants and vital signs checked and within normal limits. Later on 6/17/22, at 6:02 p.m., a note documented the resident had nausea, vomiting, and diarrhea that day. The resident had hypoactive bowel sounds on the right side and a distended, firm abdomen. Staff obtained an abdominal x-ray order. On 6/18/22 at 2:56 a.m., a Progress Note recorded the completion of an abdominal x-ray around 10:40 p.m. on 6/17/22. The resident had been closely monitored with vital signs within normal limits. Bowel sounds continued to be hypoactive. The abdomen remained firm, tender, and distended. The X-ray Report, with date of service 6/17/22 and fax stamp 6/18/22 at 10:55 a.m., documented moderate colonic distension without evidence of pathologic calcification or obvious soft tissue mass. It listed an impression: moderate colonic dilatation, may be subacute obstruction or ileus, recommend follow up in 2 days. The Progress Notes lacked any follow-up on the x-ray report or any assessment of the resident, after the 6/18/22 2:56 a.m. note, until 6/19/22 at 11:58 a.m. when staff charted giving a bisacodyl suppository. At 3:27 p.m., staff documented the physician ordered the suppository when updated on the x-ray report. The resident had become sweaty with slurred speech, and the facility sent her to the hospital. Review of the hospital History and Physical Report, dated 6/19/22, revealed the resident presented with a sigmoid volvulus with significant signs of ischemia. The note described the abdomen as quite distended. Surgical Documentation, dated 6/20/22, recorded a post-operative diagnosis of sigmoid volvulus. The hospital completed an exploratory laparotomy, sigmoidectomy, and end colostomy. On 10/3/22 at 12:15 p.m., Staff C, RN, stated the nurses and certified medication aides (CMAs) primary check vital signs. Staff wrote concerns for follow-up assessment or charting on a hot charting paper at the desk. On 10/3/22 at 2:35 p.m., Staff E, LPN, said nurses gave verbal and/or written report to the next shift. The DON reviewed the hot charting paper at the desk and updated it as needed. Nurses completed skilled residents' assessments daily, otherwise any assessments would be documented in the progress notes. Staff E recalled she called the physician multiple times for Resident #10 during the day shift on 6/19/22 due to the resident not acting right and having stomach distension and pain. Staff E stated when she finally checked Resident #10's vital signs, the resident had a low blood pressure and a high pulse and needed to be sent out. On 10/3/22 at 4:15 p.m., the DON stated staff add to the hot charting sheet, and she also updated it based on the staff's documentation in the residents' charts.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165478	A. Building B. Wing	10/05/2022

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)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42440 Based on facility record review, hospital record review, and staff and family interviews, the facility failed to maintain nutritional and hydration status or place interventions when a resident's intakes and ability to feed himself declined (Resident #4). The facility reported a census of 56 residents. Findings include: The Admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #4 admitted on [DATE] with diagnoses including Parkinson's disease and dysphagia (swallowing difficulties). A Brief Interview for Mental Status (BIMS) documented a score of 7, which indicated severe cognitive impairment. He ate independently and weighed 206.2 pounds. The Care Plan, dated 5/6/22, documented Resident #4 could eat independently. The Care Plan, dated 4/28/22, documented Resident #4 had a nutritional problem related to a history of dysphagia with a goal to maintain adequate nutritional status by maintaining his current weight, having no symptoms of malnutrition, and consuming 75-100% at meals. It directed staff to monitor/document/report as needed any signs or symptoms of dysphagia such as pocketing, choking, coughing, drooling, holding food in mouth, or refusing to eat. It further directed staff to weigh and record weight per facility protocol and monitor/record/report to MD, as needed, significant weight loss: 3 pounds in 1 week, greater than 5% in one month. The facility's Weight and Hydration Management Practice Guidelines document, dated February 2016, instructed staff to weigh all residents upon admission, weekly for four weeks, and then monthly or as indicated by physician orders and/or the medical status of the resident. Staff should re-weigh residents with weight variance (change of 5 pounds from previous weight) within 24 hours. A 5% weight loss in one month or 7.5% loss in three months indicated a significant weight loss. The facility assigned staff members to: a. Obtain weight and re-weight b. Determine residents that should be re-weighed c. Enter the final, validated weight data into the electronic health record Resident #4's electronic health record from 3/30/22 to 5/11/22 showed two weights: 206.6 pounds on 3/30/22 and 206.2 pounds on 4/12/22. The Nutritional Assessment, dated 4/12/22 and locked on 4/28/22, described the resident as more drowsy with recent adjustment in medications. The resident consumed 75-100% of food and 360 ccs (cubic centimeters/milliliters- approximately 1.5 cups) of liquids at most meals. The resident fed himself, made needs known, and had no problems chewing or swallowing. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/4/22, a Care Conference note documented intakes over the last 3 weeks: 26.8%, 83.4%, and 90.9%. The Nutrition Report for the week ending 5/10/22 showed average meal intakes decreasing: a. 81% for week ending 4/19/22 b. 52% for week ending 4/26/22 c. 41% for week ending 5/3/22 d. 27% for week ending 5/10/22 The Documentation Survey Report recorded meal intakes and staff's assistance. The April report showed the resident ate greater than 50% for at least two meals daily through 4/23/22, and except for 4/22/22, fed himself independently. From 5/1/22 to 5/10/22, the resident ate 25% or less for 18 of 30 meals and required extensive or full assistance by staff to eat for 19 of 28 meals recorded. On 5/11/22 at 8:59 a.m. a Progress Note recorded the resident as unresponsive, even with sternal rub. The nurse noted a blood pressure of 70/50s and oxygen saturation 82% and sent the resident to the hospital. On 5/11/22, the Emergency Department report documented urine color as orange, and high lab values monitoring kidney function: blood urea nitrogen (BUN) 38 and creatinine 1.6, which can indicate dehydration. The hospital Discharge Summary for the resident's stay starting 5/11/22 recorded that although the family stated the resident had a low blood pressure normally, the blood pressure was likely lower than normal due to sepsis and dehydration. The resident weighed 182.5 pounds on admission to the hospital, an 11.5% decrease from his last recorded weight in his electronic health record at the facility on 4/12/22. On 9/26/22 at 2:30 p.m., the POA reported either she, the Emergency Contact #2, or both, visited the resident at the facility daily over the last 2 weeks of his stay. She reported the resident sat in a recliner in the community room and would barely open his eyes. The last two weeks, staff had to feed him. When the POA tried to feed the resident, he did not do well. When he arrived to the hospital, he could not swallow or talk. On 9/26/22 at 2:00 p.m., the Emergency Contact #2 reported visiting the resident often at the facility, especially in the last two weeks when he was more unresponsive. Staff had to assist him to eat the last couple of weeks. The resident would have his eyes shut and staff would poke food down him. The resident had trouble swallowing pills. On 10/3/22 at 11:35 a.m., Staff A, Certified Nurse Aide (CNA), stated Resident #4 would not do much of anything for himself the last 2 weeks of his stay. Staff had to assist with everything, including feeding him. He did not eat well. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/3/22 at 1:40 p.m., Staff D, Certified Medication Aide (CMA), stated Resident #4's intakes depended on the day. He would eat if he wanted to. Staff assisted him at the end of his stay. At the end, he needed his pills crushed or he would spit them out. He drank water OK with a straw. Staff tried to obtain weights on shower days. Residents' Medication Administration Records (MAR) contained daily and weekly weights. Nurses and CMAs made lists of who needed weighed from the MAR, and the CNAs got the weights. The nurses and CMAs would then enter the weights into the electronic health record and ask staff to re-weigh if noting a major difference. On 10/3/22 at 2:35 p.m., Staff E, Licensed Practical Nurse (LPN), reported the resident had to be fed by staff towards the end of his stay, and his intakes may have decreased. He went from taking pills whole, to taking them whole in pudding, and then to crushed in pudding. On 10/3/22 at 4:15 p.m., the Director of Nursing (DON) reported the nurses and CMAs pulled from the MAR's supplemental documentation who needed weekly weights. The DON stated she had been working on a system to get them all in the MARs consistently on one day of the week. On 10/4/22 at 10:00 a.m., the Administrator provided bath sheets with hand-written weights of 204 pounds on 4/23/22 and 198 pounds on 5/7/22.