| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175200 | A. Building<br>B. Wing | 11/15/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Kenwood View Healthcare and Rehabilitation Center | 900 Elmhurst Blvd<br>Salina, KS 67401 |

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|---|---|
| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29183<br><br>The facility had a census of 59 residents. The sample included 15 residents. Based on observation, record review, and interview, the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promoted maintenance or enhancement of his or her quality of life, recognizing each resident's individuality for Resident (R) 9, R46 and 5 unsampled residents during dining.<br><br>Findings included:<br><br>- On 11/10/21 at 10:50 AM, observation revealed R9 lying in her bed. Further observation revealed Licensed Nurse (LN) G in the resident's room changing a dressing to R9's feet. The resident's door was open, R9's roommate seated in a wheelchair in the room, and the room divider curtain and window curtains were open. Further observation revealed two residents in wheelchairs looking in the room from the hallway.<br><br>On 11/09/21 at 11:45 AM, during the dining observation, observation revealed five unsampled residents with coffee cups on the table and the residents each requested coffee during the meal. Further observation revealed dietary staff informed the residents requesting the coffee that only one pot of coffee was made and no more would be prepared.<br><br>On 11/09/21 at 12:00 PM, observation revealed a resident requested coffee and dietary staff informed the resident the coffee pot was broken and they were unable to prepare coffee.<br><br>On 11/09/21 at 12:10 PM, observation revealed a resident requested coffee and dietary staff informed the resident the coffee grounds stayed in the bottom of the pot and they were unable to make coffee.<br><br>On 11/09/21 at 12:30 PM, Administrative Nurse E verified the coffee maker was broken and there was no coffee for the residents.<br><br>The facility's Resident Rights policy, dated 08/01/19, stated the residents have the right to make choices about aspects of his or her life in the facility that are significant to the residents.<br><br>The facility failed to provide dignity for R9 during a dressing change and for residents who requested to drink coffee for their meals, placing these residents at risk for an undignified experience.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 32360<br><br>- R46's Quarterly Minimum Data Set (MDS), dated [DATE], documented the resident had moderately impaired cognition and required extensive assistance of one staff for dressing and limited assistance of one staff for toileting and personal hygiene.<br><br>The ADL Care Area Assessment (CAA), dated 07/09/21, documented R46 was at risk for further decline in ADLs, falls, immobility, refused therapy and remained at a functional baseline.<br><br>The ADL Care Plan, dated 08/13/21, directed staff to monitor, report a decline in abilities to assist with ADLs, and to provide assistance as needed.<br><br>On 11/10/21 at 09:45 AM, observation revealed Certified Nurse Aide (CNA) M assisted the resident to the bathroom, pulled the resident's pants down and dried feces (waste material from the bowel) was hanging from the resident's perineum (area between the genitals and the anus). CNA M changed the resident soiled incontinence product, pants and shirt, stood the resident up and stated the resident performed her own personal hygiene. Further observation revealed the resident had not performed personal hygiene on herself, and when questioned the CNA, she assisted R46 to stand up, wet a brown paper towel and wiped the resident's buttocks, pulled up the resident's pants, and sat her in her wheelchair.<br><br>On 11/15/21 at 07:55 AM, observation revealed the resident seated on the side of the bed as the CNA put a gait belt around her. The resident's shirt, pants, and pillow case were soiled with dried food and juice and the resident had her shoes on.<br><br>On 11/15/21 at 08:00 AM, CNA N stated the resident had not had breakfast yet or any personal cares done on the resident since she came on shift at 06:00 AM and was just getting the resident up for the day.<br><br>On 11/15/21 at 02:00 PM, Administrative Nurse E stated staff are to make sure R46 was treated with respect and dignity.<br><br>The facility's Promoting/Maintaining Resident Dignity policy, dated 01/01/20, documented staff members are involved in providing care to residents to promote and maintain resident dignity and respect resident rights.<br><br>The facility failed to provide cares in a manner to promote and enhance quality of life, dignity, and respect for R46. |

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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Reasonably accommodate the needs and preferences of each resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32358<br><br>The facility had a census of 59 residents. The sample included 15 residents. Based on observation, record review, and interview, the facility failed to provide reasonable accommodation of resident needs for one sampled Resident (R) 40, regarding a wheelchair footrest needing repaired or replaced.<br><br>Findings included:<br><br>- The Quarterly Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score nine, which indicated moderately impaired cognition. The MDS documented the resident required extensive assistance with activities of daily living (ADLs) except supervision with locomotion off unit and eating. The MDS documented the resident used a walker and wheelchair for mobility.<br><br>The ADL Care Plan, revised on 10/27/21, documented the resident required staff assistance with ADLs except supervision with eating. The care plan documented the resident used a wheelchair and walker for mobility.<br><br>On 11/09/21 at 11:04 AM, observation revealed the residents high back wheelchair's footrest had the edge unstitched along the front and down both sides approximately one inch with the foam padding coming out.<br><br>On 11/15/21 at 08:57 AM, Therapy Staff (TS) II verified the above finding, stated he was unaware of it, and TS II stated it was his and maintenance responsibility to maintain the resident's wheelchair. TS II stated he would notify the hospice nurse and, in the meantime, would try to find R40 a different wheelchair.<br><br>On 11/15/21 at 09:00 AM, Licensed Nurse (LN) H stated whenever staff find something that needs fixed, they write it on the clip board on the maintenance door. LN H stated if the problem was something broken staff would take it out of commission so no one would get hurt.<br><br>On 11/15/21 at 01:52 PM, Administrative Nurse E stated she was not sure if the maintenance had a schedule regarding how often they check wheelchairs, but if staff found a problem, they contact maintenance in person right away or in the morning meetings.<br><br>The facility Preventive Maintenance -Wheelchair policy, dated 10/25/19, documented it was the practice of the facility to develop and implement a preventive maintenance program to ensure wheelchairs are maintained in a safe and operable manner.<br><br>The facility failed to ensure R40's wheelchair was in good repair, placing the resident at risk for skin tears. |

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| F 0582<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.<br><br>26768<br><br>The facility had a census of 59 residents. The sample included 15 residents with three sampled for Medicare Part A Liability Notices. Based on record review and interview, the facility failed to provide one of three sampled residents (or their representative) the Advance Beneficiary Notices (ABN), forms 10055 and 10123 for discharge from skilled services, Resident (R) 37.<br><br>Findings included:<br><br>- The Medicare Advanced Beneficiary Notice (ABN) informed the beneficiary that Medicare may not pay future skilled therapy services and provided a cost estimate of continued services. The form included option for the beneficiary to (1) receive specified therapy listed, and bill Medicare for an official decision on payment. I understand if Medicare does not pay, I am responsible for payment, but can appeal Medicare. (2) receive therapy listed, but do not bill Medicare, I am responsible for payment for services. (3) I do not want the listed therapy services.<br><br>The Notice of Medicare Non-Coverage (NOMNC) Form CMS-10123, and the Detailed Explanation of Non-Coverage which explained the appeals process.<br><br>The facility lacked documentation R37 had been provided with CMS 10055 or CMS 10123 forms when the resident's skilled services ended 10/28/21, which informed the resident (or their representative) the estimated cost of skilled services if an appeal to Medicare was denied, leaving the resident responsible for payment of skilled services.<br><br>On 11/15/21 at 05:15 PM, Social Services Staff X verified the facility had not provided R37 with the required Part A discharge notices.<br><br>On 11/15/21 at 05:55 PM, Administrative Staff A verified staff should have ensured the resident received the appropriate forms before the discharge from Part A therapy.<br><br>The facility failed to provide a Beneficiary Notice Requirement policy upon request.<br><br>The facility failed to provide the resident (or their representative) the CMS-10055 and CMS-10123 forms when discharged from skilled services for R37, placing the resident at risk to make uninformed decisions for their skilled services. |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26768<br><br>The facility had a census of 59 residents. The sample included 15 residents with four reviewed for accidents. Based on observation, interview and record review the facility failed to review and revise the care plan to prevent further falls for one sampled Resident (R) 36.<br><br>Findings included:<br><br>- R36's diagnoses included dementia (group of symptoms that affects memory, thinking and interferes with daily life), myelodysplastic syndrome (group of disorders resulting from poorly formed or dysfunctional blood cells. This causes tiredness, difficulty in breathing, pale skin, frequent infections, easy bruising and bleeding), osteoporosis (condition when bone strength weakens and is susceptible to fracture), and polyneuropathy (condition in which a person's peripheral nerves are damaged and affects the nerves in your skin, muscles, and organs).<br><br>R36's Annual Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 12 which indicated moderately impaired cognition. The MDS documented the resident required supervision for locomotion and eating, extensive assistance of one staff for transfers, dressing, toilet use, hygiene, and extensive assistance of two staff for bed mobility. The MDS documented poor balance and the resident used a wheelchair. The MDS documented the resident had two or more non-injury falls, and one minor injury fall since the previous assessment.<br><br>The Fall Care Area Assessment (CAA), dated 10/08/21, documented R36 had risk factors resulting from balance problems, moderately impaired cognition, and non-compliance with nursing recommendations for assistance with ADLs. R36 had falls during the assessment period, was at risk for fall related injuries, and received therapy.<br><br>The Fall Care Plan, dated 09/03/21, documented R36 was at high risk for falls related to unsteady gait, non-compliance with transfer status, history of falls and decreased safety awareness. The Care Plan directed staff to ensure R36 wore appropriate footwear. The Fall Care Plan directed staff to provide auto-locks and anti-tip devices on R36's wheelchair, and non-skid strips in the bathroom. The Care Plan further indicated staff received education for frequent monitoring of R36 due to R36's non-compliance. The care plan lacked new or revised fall interventions for falls on 07/25/21, 09/17/21, 10/01/21, and 10/14/21.<br><br>A Fall Note dated 07/10/21 at 05:53 PM recorded an unidentified nurse heard a noise in the hallway, responded and observed R36 on the floor in front of R36's wheelchair. R36's head faced downward and she had a laceration to her forehead which bled. The note recorded staff told the nurse R36 fell out of her wheelchair after she put her foot down while the staff member pushed her in the wheelchair. The note further documented R36 was sent to the emergency room for evaluation of the laceration.<br><br>The Fall Investigation dated 07/10/21 documented a review of findings which included swelling above R36's right eye and around a laceration to R36's forehead. The investigation documented staff were educated not to push R36 in the wheelchair unless footrests were in place on the chair.<br><br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A Fall Follow-Up Note dated 07/11/21 at 07:54 AM documented R36 had sutures to her forehead and mild swelling around the sutured area. It further recorded staff were educated not to push R36 in the wheelchair unless footrests were in place.<br><br>On 11/15/21 at 09:48 AM, observation revealed R36 sat in her wheelchair in the hall by the nurse's medication cart. Her head was down, and her eyes closed. She had anti-rollback and anti-tip devices on wheelchair. No footrests were on the wheelchair. At 09:57 AM, Licensed Nurse (LN) H pushed R36, in her wheelchair, backward five feet and then forward three feet without placing the footrests on. At 10:08 am, R36 self-propelled her wheelchair back to the original place by the medication cart. A minute later R36 self-propelled her wheelchair down the hall and stopped outside the nursing offices. At 10:36 AM, observation revealed Administrative Nurse E wheeled R36 down the hall without footrests on while the toe of R36's right foot slid along the floor, and the left foot was approximately one inch above the floor.<br><br>On 11/15/21 at 12:23 PM, observation revealed R36 independently propelled her wheelchair to the middle of the therapy room. Continued observation revealed Therapy Staff HH pushed R36 in her wheelchair at a moderately fast pace to the dining room, approximately 200 feet, without footrests. R36's right foot slid on floor at times, and her left foot hovered a half to one inch above the floor.<br><br>On 11/15/21 at 01:22 PM, observation revealed Activity Staff Z pushed R36, in the wheelchair, from the dining room to R36's room. R36 held her feet approximately one to two inches off the floor. Activity Staff Z stated she asked R36 to lift her feet before starting, as sometimes R36 self-propelled her wheelchair, but Activity Staff Z knew R36 was tired.<br><br>The facility's Care Plan Revision Upon Status Change policy, dated 02/01/20, documented the comprehensive care plan will be reviewed and revised as necessary when a resident experienced a status change. Care plans will be modified as needed and communicated to all staff involved in the resident's care.<br><br>The facility failed to revise the care plan after R36 experienced several falls, placing the resident at risk for further falls due to lack of staff direction to prevent falls. |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32360<br><br>The facility had a census of 59 residents. The sample included 15 residents, with seven reviewed for activities of daily living (ADLs). Based on observation, record review, and interview, the facility failed to provide the necessary services to maintain grooming, and personal hygiene for two sampled residents, Resident (R) 9, R46, and failed to provide bathing for R22.<br><br>Findings included:<br><br>- R46's Quarterly Minimum Data Set (MDS), dated [DATE], documented the resident had moderately impaired cognition and required extensive assistance of one staff for dressing and limited assistance of one staff for toileting and personal hygiene.<br><br>The ADL Care Area Assessment (CAA), dated 07/09/21, documented R46 was at risk for further decline in ADLs, falls, immobility, refused therapy and remained at a functional baseline.<br><br>The ADL Care Plan, dated 08/13/21, directed staff to monitor, report a decline in abilities to assist with ADLs, and to provide assistance as needed.<br><br>On 11/10/21 at 09:45 AM, observation revealed Certified Nurse Aide (CNA) M assisted the resident to the bathroom, pulled the resident's pants down and dried feces (waste material from the bowel) was hanging from the resident's perineum (area between the genitals and the anus). CNA M changed the resident soiled incontinence product, pants and shirt, stood the resident up and stated the resident performed her own personal hygiene. Further observation revealed the resident had not performed personal hygiene on herself, and when questioned the CNA, she assisted R46 to stand up, wet a brown paper towel and wiped the resident's buttocks, pulled up the resident's pants, and sat her in her wheelchair.<br><br>On 11/15/21 at 07:55 AM, observation revealed the resident seated on the side of the bed as the CNA put a gait belt around her. The resident's shirt, pants, and pillow case were soiled with dried food and juice and the resident had her shoes on.<br><br>On 11/15/21 at 08:00 AM, CNA N stated the resident had not had breakfast yet or any personal cares done on the resident since she came on shift at 06:00 AM and was just getting the resident up for the day.<br><br>On 11/15/21 at 02:00 PM, Administrative Nurse E stated staff are to make sure the resident was clean prior to going to bed and staff should assist the resident with proper personal cares.<br><br>The facility's ADL policy, dated 08/01/19, documented the facility would ensure a resident's abilities in adl's do not deteriorate unless deterioration was unavoidable and included the resident's ability to bathe, dress and groom themselves.<br><br>The facility failed to ensure R46 received proper personal hygiene and care, placing the resident at risk for poor hygiene.<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | - R22's Quarterly Minimum Data Set (MDS), dated [DATE], documented the resident had intact cognition and required extensive assistance of one staff for bed mobility, transfers, toileting, and personal hygiene. The MDS documented bathing did not occur during the seven day lookback period.<br><br>The ADL Care Area Assessment (CAA), dated 03/09/21, documented the resident was dependent upon staff for mobility and recently admitted due to a stroke. The CAA documented the resident was at risk for further decline in ADLs.<br><br>The revised ADL Care Plan, dated 10/06/21, initiated on 08/17/21, documented the resident often refused showers and directed staff to continue to offer bathing and remind the resident on the importance of hygiene.<br><br>The September 2021 Bathing Record documented the resident did not receive a bath or shower for the following days:<br><br>09/13/21-09/30/21- (18 days)<br><br>The October and November 2021 Bathing Record documented the resident did not receive a bath or shower for the following days:<br><br>10/01/21-10/22/21- (22 days)<br><br>10/24/21-11/15/21- (22 days)<br><br>On 11/09/21 at 09:56 AM, observation revealed the resident, covered up and in bed eating potato chips. Further observation revealed the resident's hair uncombed and the back smashed against her head.<br><br>On 11/10/21 at 01:20 PM, observation revealed the resident, covered up in bed drinking a strawberry milkshake. Further observation revealed the resident's hair uncombed and dirty.<br><br>On 11/10/21 at 09:45 AM, Certified Nurse Aide (CNA) M stated the resident often refused showers and staff would continue to ask her.<br><br>On 11/15/21 at 02:00 PM, Administrative Nurse E stated the resident often refused showers and staff documented the refusals and offered a bed bath.<br><br>The facility's ADL policy, dated 08/01/19, documented the facility would ensure a resident's abilities in adl's do not deteriorate unless deterioration was unavoidable and included the resident's ability to bathe, dress and groom themselves.<br><br>The facility failed to provide R22 bathing services, placing the resident at risk for poor hygiene.<br><br>29183<br><br>- Resident (R) 9's Significant Change Minimum Data Set (MDS), dated [DATE], recorded R9 had a Brief Interview for Mental Status (BIMS) score of four which indicated severely impaired cognition. The MDS recorded R9 required extensive assistance with bed mobility, transfers and personal hygiene.<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The Activities of Daily Living (ADL) Care Area Assessment (CAA), dated 10/27/21, recorded R9 required moderate to extensive assistance with all ADL's.<br><br>The Care Plan, dated 10/27/21 informed staff R9 required two assist with bed mobility, transfers and one assist with personal hygiene. The staff were to wash the resident's hands and face and change her clothing.<br><br>Review of the ADL documentation for the months of August, September, October and November 1-10 recorded the staff provided personal hygiene for the resident.<br><br>On 11/10/21 at 09:00 AM, observation revealed R9 seated in her wheelchair in the hallway. Further observation revealed R9 with brown dried stains on her purple sweatshirt, tops of both hands with brown dried substance, and fingernails jagged with a brown substance under the nails.<br><br>On 11/10/21 at 01:40 PM, observation revealed R9 seated in her wheelchair in her room. Further observation revealed the resident still wearing purple sweatshirt with dried brown stains and dried yellow substance surrounding her mouth.<br><br>On 11/15/21 at 08:30 AM, observation revealed R9 lying in her bed, the head of the bed slightly elevated, and a bed side table in front of the resident which had a carton of chocolate milk with a straw. Further observation revealed the carton of chocolate milk had spilled on the resident's hands and chest, and R9 stated, I need help. The surveyor informed the Certified Nurse Aide (CNA) N that R9 required assistance.<br><br>On 11/15/21 at 09:05 AM, observation revealed R9 lying in her bed with the opened carton of chocolate milk which had spilled and was lying in R9's bed on its side. Further observation revealed R9's hands with brown substance on them and her shirt with brown stains.<br><br>On 11/15/21 at 11:30 AM, observation revealed R9 seated in her wheelchair in the hallway. Further observation revealed R9 had on a shirt with brown stains, both hands with a brown substance and her hair uncombed.<br><br>On 11/15/21 at 09:50 AM, CNA N verified R9 required assistance from direct care staff to wash her hands and face and change her clothing.<br><br>On 11/15/21 at 10:40 PM, Administrative Nurse E verified the expectation of care for R9 was for the staff to assist R9 with washing her hands and face and changing her clothing as needed.<br><br>The facility's Activities of Daily Living policy, dated 08/01/19, stated a resident who is unable to carry out ADL's will receive the necessary services to maintain grooming, and personal hygiene.<br><br>The facility failed to provide personal hygiene for R9, placing her at risk for poor hygiene and an undignified appearance. |

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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32360<br><br>The facility had a census of 59 residents. The sample included 15 residents. Based on observation, record review, and interview, the facility failed to provide the necessary care and services to ensure the resident wore her leg immobilizer (a leg brace is a device used to immobilize a joint or body segment, restrict movement in a given direction, reduce weight bearing forces, or correct the shape of the body) during transfers as physician ordered for Resident (R) 33.<br><br>Findings included:<br><br>- R33's Quarterly Minimum Data Set (MDS), dated [DATE], documented the resident had severely impaired cognition, required extensive assistance of two staff for bed mobility, and dependent upon two staff for transfers. The MDS documented the resident did not ambulate.<br><br>The Activities of Daily Living (ADLs) Care Plan, dated 11/03/21, directed staff to place the knee immobilizer to the residents left lower extremity during transfers and check skin integrity at least daily.<br><br>The Physician's Order, dated 08/27/21, directed staff to place the knee immobilizer to left lower extremity during transfers only and may remove it when the resident was in the bed or chair.<br><br>On 11/10/21 at 10:40 AM, observation revealed Certified Nurse Aide (CNA) M and CNA O attached the sling (a flexible strap or belt used in the form of a loop to support or raise a weight) to the full mechanical lift (used to move those who are unable to stand on their own or whose weight makes it unsafe to move or lift them manually), lifted the resident and transferred her to her bed. Further observation revealed the leg immobilizer was not placed on the resident's leg.<br><br>On 11/15/21 at 12:50 PM, observation revealed CNA N and CNA P attached the sling to the full mechanical lift, lifted the resident and transferred her to her bed. Further observation revealed the leg immobilizer was not placed on the resident's leg and the immobilizer was on top of the resident's dresser.<br><br>On 11/15/21 at 12:50 PM, CNA N stated she had not used the immobilizer for over a month because she thought the resident did not use it anymore.<br><br>On 11/15/21 at 02:20 PM, Licensed Nurse (LN) G stated the resident wore the immobilizer during transfers and documented in the medical record skin checks three times a day to make sure the immobilizer was not rubbing the resident's skin.<br><br>On 11/15/21 at 02:00 PM, Administrative Nurse E stated if the immobilizer was ordered by the physician, staff were to follow the order.<br><br>Upon request, a policy for following physician's order was not provided by the facility.<br><br>The facility failed to follow a physician's order to use a leg immobilizer on R33 during transfers, placing her at risk for injury. |

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|---|---|---|---|
| | 175200 | A. Building<br>B. Wing | 11/15/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Kenwood View Healthcare and Rehabilitation Center | 900 Elmhurst Blvd<br>Salina, KS 67401 |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26768<br><br>The facility had a census of 59 residents. The sample included 15 residents with four reviewed for accidents. Based on observation, interview and record review, the facility failed to implement interventions to prevent falls for Resident (R)36. This placed R36 at increased risk for falls and injuries related to falls.<br><br>Findings included:<br><br>- R36's diagnoses included dementia (group of symptoms that affects memory, thinking and interferes with daily life), myelodysplastic syndrome (group of disorders resulting from poorly formed or dysfunctional blood cells. This causes tiredness, difficulty in breathing, pale skin, frequent infections, easy bruising and bleeding), osteoporosis (condition when bone strength weakens and is susceptible to fracture), and polyneuropathy (condition in which a person's peripheral nerves are damaged and affects the nerves in your skin, muscles, and organs).<br><br>R36's Annual Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 12 which indicated moderately impaired cognition. The MDS documented the resident required supervision for locomotion and eating, extensive assistance of one staff for transfers, dressing, toilet use, hygiene, and extensive assistance of two staff for bed mobility. The MDS documented poor balance and the resident used a wheelchair. The MDS documented the resident had two or more non-injury falls, and one minor injury fall since the previous assessment.<br><br>The Fall Care Area Assessment (CAA), dated 10/08/21, documented R36 had risk factors resulting from balance problems, moderately impaired cognition, and non-compliance with nursing recommendations for assistance with ADLs. R36 had falls during the assessment period, was at risk for fall related injuries, and received therapy.<br><br>The Fall Care Plan, dated 09/03/21, documented R36 was at high risk for falls related to unsteady gait, non-compliance with transfer status, history of falls and decreased safety awareness. The Care Plan directed staff to ensure R36 wore appropriate footwear. The Fall Care Plan directed staff to provide auto-locks and anti-tip devices on R36's wheelchair, and non-skid strips in the bathroom. The Care Plan further indicated staff received education for frequent monitoring of R36 due to R36's non-compliance.<br><br>A Fall Note dated 07/10/21 at 05:53 PM recorded an unidentified nurse heard a noise in the hallway, responded and observed R36 on the floor in front of R36's wheelchair. R36's head faced downward and she had a laceration to her forehead which bled. The note recorded staff told the nurse R36 fell out of her wheelchair after she put her foot down while the staff member pushed her in the wheelchair. The note further documented R36 was sent to the emergency room for evaluation of the laceration.<br><br>The Fall Investigation dated 07/10/21 documented a review of findings which included swelling above R36's right eye and around a laceration to R36's forehead. The investigation documented staff were educated not to push R36 in the wheelchair unless footrests were in place on the chair.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A Fall Follow-Up Note dated 07/11/21 at 07:54 AM documented R36 had sutures to her forehead and mild swelling around the sutured area. It further recorded staff were educated not to push R36 in the wheelchair unless footrests were in place.<br><br>On 11/15/21 at 09:48 AM, observation revealed R36 sat in her wheelchair in the hall by the nurse's medication cart. Her head was down, and her eyes closed. She had anti-rollback and anti-tip devices on wheelchair. No footrests were on the wheelchair. At 09:57 AM, Licensed Nurse (LN) H pushed R36, in her wheelchair, backward five feet and then forward three feet without placing the footrests on. At 10:08 am, R36 self-propelled her wheelchair back to the original place by the medication cart. A minute later R36 self-propelled her wheelchair down the hall and stopped outside the nursing offices. At 10:36 AM, observation revealed Administrative Nurse E wheeled R36 down the hall without footrests on while the toe of R36's right foot slid along the floor, and the left foot was approximately one inch above the floor.<br><br>On 11/15/21 at 12:23 PM, observation revealed R36 independently propelled her wheelchair to the middle of the therapy room. Continued observation revealed Therapy Staff HH pushed R36 in her wheelchair at a moderately fast pace to the dining room, approximately 200 feet, without footrests. R36's right foot slid on floor at times, and her left foot hovered a half to one inch above the floor.<br><br>On 11/15/21 at 01:22 PM, observation revealed Activity Staff Z pushed R36, in the wheelchair, from the dining room to R36's room. R36 held her feet approximately one to two inches off the floor. Activity Staff Z stated she asked R36 to lift her feet before starting, as sometimes R36 self-propelled her wheelchair, but Activity Staff Z knew R36 was tired.<br><br>On 11/15/21 at 12:30 PM, Therapy Staff HH verified she and staff should place the resident's feet on footrests when pushing the resident in the wheelchair.<br><br>On 11/15/21 at 02:16 PM, Administrative Nurse F verified staff should at least attempt to place R36's feet on footrests when they pushed or wheeled R36 in the wheelchair.<br><br>On 11/15/21 at 03:09 PM, Administrative Nurse D verified staff should use footrests when pushing a resident in the wheelchair.<br><br>The facility's Fall Prevention Program policy, dated 02/01/20, documented each resident would be assessed for the risks of falling and would receive care and services in accordance with the level of risk to minimize the likelihood of falls. The residents would be placed on the fall prevention program if high risk, and the plan of care would include frequent visual checks, interventions that address unique risk factors, and provide additional interventions including but not limited to assistive devices. Risk factors and hazards would be evaluated when developing the plan of care, interventions monitored for effectiveness, and plan of care revised as needed.<br><br>The facility failed to ensure staff implemented footrests for R36 after identifying the lack of footrests and a contributing factor to a fall which resulted in a laceration. This deficient practice placed R36 at increased risk for additional falls and injuries related to falls. |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide enough food/fluids to maintain a resident's health.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32358<br><br>The facility had a census of 59 residents. The sample included 15 residents, with five reviewed for nutrition. Based on observation, interview and record review, the facility failed to provide Resident (R) 21, who had a history of weight loss, her breakfast meal and physician ordered supplement with meals on a consistent basis. This placed R21 at risk for further weight loss and complications related to decreased nutrition. The facility failed to provide the correct diet to R33, who received a regular diet and had a physician order pureed diet. This placed R33 at risk for choking and aspiration.<br><br>Findings included:<br><br>- R21's Physician Order Sheet, dated 10/08/21, documented the resident had a diagnosis of protein calorie malnutrition.<br><br>The Admission Minimum Data Set Assessment (MDS), dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score 10, which indicated moderately impaired cognition. The MDS documented the resident required extensive staff assistance with activities of daily living (ADLS). The MDS documented the resident had no or unknown weight loss or gain, and no swallowing or dental problems.<br><br>The Nutritional Care Area Assessment (CAA), dated 04/28/21, documented the resident had a low body mass index (BMI-a measure of body fat based on height and weight). The CAA documented the resident had a surgical incision to her left hip and knee, received a regular diet, and was referred to the registered dietician (RD).<br><br>The ADL Care Plan, revised on 10/27/21, documented the resident required staff assistance with set up when eating.<br><br>The Continued Weight Loss Care Plan, revised on 10/27/21, instructed staff to honor the resident's food choices, provide her with a regular diet, regular texture, thin liquid with fortified food diet, and provide supplements as ordered.<br><br>The Food Intake Form, from 10/15/21 to 11/12/21 documented the resident consumed the following at meals:<br><br>breakfast-lack of documentation x 8 and 10. 51-75% x 10, 76-100% x 9, refused x 1<br><br>lunch- no refusals, lack of documentation x 6, 25-50% x 1, 51-75% x 7, 76-100% x 13<br><br>supper- no refusals, lack of documentation x 1, 26-50% x 1, 51-75% x 13, 76-100% x 8<br><br>The Snack Intake Form, from 10/16/21 to 11/12/21 documented the resident was offered a snack one time daily, on evening shift. The form documented the resident consumed the following:<br><br>not applicable x 4, 0-25% x 19, refused x 3 and resident not available x 1.<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The Weight Tab in point click care documented the resident following weights:<br><br>08/03/2021 12:17 94.2 Lbs<br><br>09/06/2021 11:33 87.4 Lbs<br><br>10/04/2021 10:07 90.0 Lbs<br><br>11/05/2021 14:07 92.8 Lbs<br><br>A Physician Order dated 09/03/21 at 12:00 PM, instructed staff to provide the resident a magic cup (a frozen protein and calorie supplement) with meals for weight management.<br><br>A Physician Order dated 10/08/21 at 08:00 PM, instructed staff to offer the resident a high protein/high calorie snack between meals, three times a day, for weight loss management.<br><br>On 11/10/21 at 08:30 AM, observation revealed the dietary cook handed a dietary aide a meal tray for the resident. The CNA reported the resident was not in the dining room and handed the tray back to a dietary aide through the kitchen entrance door. The dietary aide covered the items on the tray and placed the tray in the refrigerator.<br><br>On 11/10/21 at 09:00 AM, observation revealed R21 sat in a wheelchair in her room and put her shoes on. No meal tray was observed.<br><br>On 11/10/21 at 09:30 AM, observation revealed R21 sat in a wheelchair by her bed, fixed the bedspread, and moved items on her bed side table. No meal tray was observed in her room.<br><br>On 11/10/21 at 09:43 AM, observation revealed R21 sat in a wheelchair, at the east side nurses' station, by the medication administration cart. R21 stated she was hungry to Certified Medication Aide (CMA) S and CMA S told R21 breakfast was over. CMA S informed R21 she would have to wait until lunch to eat, and it would be lunchtime soon. CMA S did not offer R21 a snack.<br><br>On 11/10/21 at 09:47 AM, observation revealed Housekeeping Staff (HS) U and R21 in the dining room. HS U asked R21 if her breakfast was good this morning and R21 replied yes, she did not know what to do. HS U put the television on a cooking show, offered R21 a cup of coffee, and told Dietary Staff (DS) BB the resident would like some coffee. DS BB brought R21 a cup of coffee but did not offer the resident her breakfast meal tray or a snack.<br><br>On 11/10/21 at 09:59 AM, observation revealed CMA T came to R21's table, visited with her but did not offer her anything to eat.<br><br>On 11/10/21 at 10:28 AM, observation revealed R21 propelled in a wheelchair behind another resident, down the west hall. R21 stated out loud she would like something to eat, and she was so hungry. At 10:32 AM an unidentified therapist walked past both residents carrying a clipboard. R21 turned and asked the other resident was that food?<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 11/10/21 at 12:44 PM, observation revealed R21 sat in a wheelchair at a dining room table. Staff served R21 broccoli, breaded fish, fried potato slices, 240 cubic centimeters (cc) lemonade, 200 cc coffee, and a brownie with whipped cream on top. R21 independently ate her noon meal without placing her fork down until she was done eating. No magic cup was served.<br><br>On 11/15/21 at 08:24 AM, observation revealed R21 sat at the dining room table, and staff served her 200 cc coffee, 240 cc orange juice, a bowl of cream of wheat, scrambled eggs with sausage in them and one slice of toast. No magic cup was served.<br><br>On 11/15/21 at 08:49 AM, review of R21's dietary card revealed the words magic cup in the left hand corner.<br><br>On 11/10/21 at 11:00 AM, CMA T stated if a resident missed a meal, dietary staff would tell nursing staff. CMA T stated she was aware R21 did not have breakfast because R21 slept in. CMA T stated the resident refused her breakfast frequently and only took a couple of bites at lunch.<br><br>On 11/10/21 at 10:18 AM, CMA R stated staff did not pass snacks to residents during the day shift. She further stated if a resident asked for a snack, staff provided one. CMA R stated the evening shift staff passed snacks.<br><br>On 11/15/21 at 08:47 AM, DS BB verified R21 was not served a magic cup with her breakfast meal. DS BB stated she missed it on R21's dietary card .<br><br>On 11/15/21 at 10:42 AM, CMA T stated if a resident was supposed to receive a magic cup, dietary staff placed it on the residents' meal tray.<br><br>On 11/15/21 at 12:24 PM, Licensed Nurse (LN) I stated the nurse was responsible for recording the resident's magic cup consumption. LN I stated she did not visualize the amount consumed by the residents, the CNA reported the amount to the nurse and the nurse recorded it on the Medication Administration Record (MAR).<br><br>On 11/15/21 at 01:54 PM, Administrative Nurse E verified staff did not pass snacks during the day shift. Administrative Nurse E said if a resident asked for a snack, staff provided the snack. She further stated there was always snacks available. Administrative Nurse E stated if a resident had a physician order to receive a snack, it should show up for the nurse to administer and the nurse should give the resident one. Administrative Nurse E stated the kitchen was responsible for providing R21 with her magic cup.<br><br>The facility's Weight Monitoring policy, dated 02/01/20, documented the facility would utilize a systemic approach to optimize a resident's nutritional status including: identifying and assessing each resident's nutritional status and risk factors, evaluating/ analyzing the assessment information, developing and consistently implementing pertinent approaches, monitoring the effectiveness of interventions, and revising them as necessary.<br><br>The facility failed to consistently provide R21 with a physician ordered high protein/high calorie snack between meals, three times a day and a magic cup with meals, which placed R21 at risk for further weight loss.<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 32360<br><br>- R33's Quarterly Minimum Data Set (MDS), dated [DATE], documented the resident had severely impaired cognition, required extensive assistance of two staff for bed mobility, and dependent upon two staff for transfers. The MDS documented the resident required supervision of one staff for eating.<br><br>The Nutrition Care Area Assessment (CAA), dated 04/30/21, documented the resident required assistance for meals and received a mechanically altered diet.<br><br>The Nutrition Care Plan, dated 11/03/21, directed staff to monitor intake and dietary compliance, provide and serve the resident's diet as ordered, and monitor for pocketing, choking, coughing, and concerns during meals.<br><br>The Physician's Order, dated 04/26/21, directed staff to serve the resident a regular diet with pureed (food that has been ground or blended into a creamy paste or liquid) texture.<br><br>On 11/09/21 at 12:00 PM, observation revealed the noon meal consisted of hamburger gravy over mashed potatoes and zucchini medley.<br><br>On 11/09/21 at 12:30 PM, observation revealed Certified Nurse Aide (CNA) Q took the resident's regular diet meal away and stated, This is the wrong tray and brought her another plate of pureed food. Further observation revealed the resident had eaten half of the regular diet and did not have any choking or coughing while eating.<br><br>On 11/09/21 at 12:40 PM, Certified Nurse Aide (CNA) Q stated there were two trays to be delivered and she had accidentally grabbed the wrong tray which was a regular diet and not pureed. CNA Q verified the resident's diet order was on the tray and she should have made sure she grabbed the correct tray.<br><br>On 11/15/21 at 02:00 PM, Administrative Nurse E stated staff should make sure the resident received the appropriate tray and the correct diet.<br><br>The facility's Transmission of Diet Orders policy, dated 2017, documented the food and nutrition service department would receive written notification of a resident's diet order and staff follow the diet order.<br><br>The facility failed to serve R22 the appropriate diet, placing her at risk for choking. |

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| F 0726<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26768<br><br>The facility had a census of 59 residents. The sample included 15 residents with one reviewed for feeding tube (medical device used to provide nutrition to people who cannot obtain nutrition by mouth, are unable to swallow safely, or need nutritional supplementation) care and services. Based on observation, interview, and record review the facility failed to ensure competent nursing practice during the administration of medications via the feeding tube for sampled Resident (R) 34.<br><br>Findings included:<br><br>- R34's Quarterly Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status score of 11, indicating moderately impaired cognition. The MDS documented the resident required extensive assistance of one staff for eating, weighed 181 pounds, and received 51% or more of his total calories through tube feeding. The MDS documented the resident received antidepressive (drug to mitigate depression) and opioid (narcotic pain drugs) medications.<br><br>The Tube Feeding Care Plan, dated 10/06/21, directed staff to provide diet as ordered, total assistance with tube feeding and water flushes, and check placement of feeding tube before each use. R34 preferred to have his morning medication pass given via feeding tube as he was not fully awake at the time of administration. He preferred to have all other medications given by mouth. R34 received continuous tube feedings from 07:00 PM to 07:00 AM.<br><br>The Physician Order, dated 08/22/21, directed staff may crush medications and give together.<br><br>The Physician Orders, dated 10/08/21, included the following medications:<br><br>Clonidine (for blood pressure control), 0.1 milligram (mg), via feeding tube<br><br>Cyclobenzaprine (used short-term to treat muscle spasms), 5 mg, via feeding tube<br><br>Gabapentin (for nerve pain), 300 mg, via feeding tube<br><br>Plavix (anti blood clot drug), 75 mg, via feeding tube<br><br>Lisinopril (for blood pressure control), 20 mg, via feeding tube<br><br>Sertraline (anti depressive), 25 mg, via feeding tube<br><br>Iron (mineral), 65 mg, via feeding tube<br><br>ASA (mild pain reliever), 81 mg, via feeding tube<br><br>Keppra (for seizures), 10 mg liquid, via feeding tube<br><br>Prostat (liquid protein), 30 ml, via feeding tube<br><br>(continued on next page) |

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| F 0726<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Miralax (laxative), 17 grams, via feeding tube<br><br>Tramadol (for pain), 15 mg, via feeding tube<br><br>On 11/10/21 at 08:20 am, observation revealed Certified Medication Aide (CMA) R set up (took the medications out of their containers and placed together in a cup) R34's medications. Further observation revealed she crushed the pills, and mixed them with the liquid medication per Licensed Nurse (LN) H's direction. CMA R added 60 milliliters (ml) water to the medications. Continued observation revealed at 08:35 AM, CMA R took the medication mixture to LN H, who had been providing care in another area, and handed the medication mix to LN H. Observation revealed LN H took the medication mix to R34's room, checked placement of the feeding tube and flushed the feeding tube with 30 ml of water. LN H administered the mix of medications, which CMA R had given her, with 100 ml water to thin the mix. She flushed the tubing with 30 ml water after the medications.<br><br>On 11/15/21 at 12:46 PM, Consultant Pharmacist (CP) GG stated all R34's medications were okay to be crushed and none of R34's medications would pose a concern when mixed. CP GG stated it was a best standard practice to only administer medications set up by yourself.<br><br>On 11/15/21 at 03:09 PM, Administrative Nurse D stated the nurse should have prepared R34's medications herself, per professional standards.<br><br>Upon request the facility did not provide a Medication Administration policy.<br><br>The facility failed to ensure competent nursing practice during the administration of medications via the feeding tube for R34, when the nurse administered medications which had not been under her observation when set up. |

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| F 0732<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Many | Post nurse staffing information every day.<br><br>32358<br><br>The facility had a census of 59 residents. The sample included 15 residents. Based on observation, record review, and interview, the facility failed to ensure the daily staff nursing schedule was posted for two of three days of the onsite survey.<br><br>Findings included:<br><br>- On 11/09/21 at 08:00 AM and 11/15/21 at 09:49 AM (had Friday 11/12/21), the daily nurse staffing schedule was not posted for the correct day.<br><br>On 11/15/21 at 11:02 AM, Certified Medication Aide (CMA) T verified the daily nurse staffing schedule had not been posted for the correct day and stated she was responsible for posting it during the week and on the weekend the nurse was responsible .<br><br>On 11/15/21 at 02:18 PM, Administrative Nurse E stated the nurse staffing should be posted daily including the weekends.<br><br>The facility's undated Nurse Staffing Posting Information policy, documented the policy of this facility was to make staffing information readily available in a readable format to residents and visitors at any given time. The nurse staffing information would be posted on a daily basis and would contain the following information: facility name, the current date, facility's current resident census, the total number and the actual hours worked by the following categories of licensed and unlicensed staff directly responsible for resident care per shift which includes registered nurse, licensed practical nurse/licensed vocational nurse.<br><br>The facility failed to post the correct daily nurse staffing schedule for two of three days of the onsite survey, which placed the resident's at risk for not knowing how many staff would be providing them care. |

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|---|---|---|---|
| | 175200 | A. Building<br>B. Wing | 11/15/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Kenwood View Healthcare and Rehabilitation Center | 900 Elmhurst Blvd<br>Salina, KS 67401 |

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| F 0756<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29183<br><br>The facility had a census of 59 residents. The sample included 15 residents, with five reviewed for unnecessary medications. Based on observation, record review, and interview, the facility's Consultant Pharmacist failed to identify and report to the Director of Nursing, facility medical director, and physician an inappropriate diagnosis for the use of an antipsychotic medication (class of medications used to treat any major mental disorder characterized by a gross impairment in reality testing and other mental emotional conditions) for one of five sampled residents, Resident (R) 53.<br><br>Findings included:<br><br>- R53's Medicare Five Day Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of 10 which indicated moderately impaired cognition. MDS further documented R53 received an antipsychotic medication routinely.<br><br>The Psychotropic Drug Use Care Area Assessment (CAA), dated 11/02/21, documented the resident had a diagnosis of dementia with behavioral disturbances (progressive mental disorder characterized by failing memory, confusion, with increased agitation)and received an antipsychotic medication routinely.<br><br>The Medication Care Plan, dated 08/27/21, stated to monitor/document/report any changes in cognitive function, specifically changes in decision making ability, memory, recall and general awareness when receiving the antipsychotic medication.<br><br>The Physician's Order, dated 08/27/21, directed staff to administer Seroquel (antipsychotic medication) 75 milligrams (mg) PO (by mouth) at bedtime for agitation (a state of anxiety or nervous excitement).<br><br>Review of the Registered Pharmacist Monthly Review documented on 08/31/21 a recommendation to decrease the dose of the Seroquel but no recommendation of an appropriate diagnosis.<br><br>The Black Box Warning (BBW-warning to alert consumers about serious or life-threatening medication side effects) documented this medication should not be used to treat behavioral problems in the elderly who have a diagnosis of dementia. Elderly residents with dementia have an increased risk for death with the use of Seroquel. It is to be used for Schizophrenia (a serious mental condition that affects how a person thinks, feels, and behaves) and Tourette's (a nervous system disorder involving repetitive movements or unwanted sounds).<br><br>On 11/10/21 at 07:40 AM, observation revealed R53 lying on his low bed in his room with his eyes closed.<br><br>On 11/15/21 at 09:10 AM, Administrative Nurse E verified R53 received Seroquel on a routine basis and the diagnosis for the use of the Seroquel was agitation. Administrative Nurse E verified agitation was not an appropriate diagnosis for the use of the Seroquel.<br><br>(continued on next page) |

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| F 0756<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The facility's Use of Psychotropic Drugs policy, dated 01/01/20, stated residents who use antipsychotic medications must have appropriate diagnosis for the use of the medication.<br><br>The facility's Pharmacy Drug Regimen Review policy, dated 01/01/20 stated the drug regimen of each resident is reviewed at least once a month by a licensed pharmacist and includes a review of the residents' medical record. The pharmacist shall communicate any irregularities to the facility with written or verbal communication to the physician regarding the irregularities.<br><br>The facility's Consultant Pharmacist failed to identify and report to the Director of Nursing, facility medical director, and physician, an inappropriate diagnosis for the use of Seroquel, placing the resident at risk for inappropriate use of an antipsychotic medication. |

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| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29183<br><br>The facility had a census of 59 residents. The sample included 15 residents, with five reviewed for unnecessary medications. Based on observation, record review, and interview, the facility failed to identify an inappropriate diagnosis for the use of an antipsychotic medication (class of medications used to treat any major mental disorder characterized by a gross impairment in reality testing and other mental emotional conditions) for one of five sampled residents, Resident (R) 53.<br><br>Findings included:<br><br>- The Medicare Five Day Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of ten which indicated moderately impaired cognition. MDS further documented R53 received an antipsychotic medication routinely.<br><br>The Psychotropic Drug Use Care Area Assessment (CAA), dated 11/02/21, documented the resident had a diagnosis of dementia with behavioral disturbances (progressive mental disorder characterized by failing memory, confusion, with increased agitation)and received an antipsychotic medication routinely.<br><br>The Medication Care Plan, dated 08/27/21, stated to monitor/document/report any changes in cognitive function, specifically changes in decision making ability, memory, recall and general awareness when receiving the antipsychotic medication.<br><br>The Physician's Order, dated 08/27/21, directed staff to administer Seroquel (antipsychotic medication) 75 milligrams (mg) PO (by mouth) at bedtime for agitation (a state of anxiety or nervous excitement).<br><br>The Black Box Warning (BBW-warning to alert consumers about serious or life-threatening medication side effects) documented this medication should not be used to treat behavioral problems in the elderly who have a diagnosis of dementia. Elderly residents with dementia have an increased risk for death with the use of Seroquel. It is to be used for Schizophrenia (a serious mental condition that affects how a person thinks, feels, and behaves) and Tourette's (a nervous system disorder involving repetitive movements or unwanted sounds).<br><br>On 11/10/21 at 07:40 AM, observation revealed R53 lying on his low bed in his room, eyes closed.<br><br>On 11/15/21 at 09:10 AM, Administrative Nurse E verified R53 received Seroquel on a routine basis and the diagnosis for the use of the Seroquel was agitation. Administrative Nurse E verified agitation was not an appropriate diagnosis for the use of the Seroquel.<br><br>The facility's Use of Psychotropic Drugs policy, dated 01/01/20, stated residents who use antipsychotic medications must have appropriate diagnosis for the use of the medication.<br><br>(continued on next page) |

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|---|---|
| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The facility failed to identify the inappropriate use of Seroquel for R53, placing the resident at risk for side effects with the use of an antipsychotic medication. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>32360<br><br>The facility had a census of 59 residents. Based on observation, interview, and record review, the facility failed to store, prepare, and serve foods in a sanitary manner for the 42 residents who received food from the facility kitchen and in the dining room.<br><br>Findings included:<br><br>- On 11/09/21 at 08:00 AM, observation in the facility's kitchen revealed the three-door refrigerator contained the following items.<br><br>a gallon sized bag with 1/2 a ham-undated<br><br>a gallon sized bag with ham chunks-undated<br><br>a gallon sized bag with uncooked roast dated 11/01/21<br><br>On 11/10/21 at 11:00 AM, observation revealed the refrigerator and freezer Temperature Logs missing temperatures for the days of 11/06, 11/07, 11/08/21. Further observation revealed the stove with black, baked on food particles inside the oven, various food particles on the bottom of the three-door refrigerator and three door freezer. Continued observation revealed dried brown liquid on the wall above the trash can.<br><br>On 11/10/21 at 12:00 PM, observation revealed Dietary Staff (DS) DD used her gloved hands to touch the food on numerous resident plates and touch her mask, plate warmers and food cart without changing gloves.<br><br>On 11/09/21 at 08:30 AM, Dietary Staff (DS) BB verified the food in the refrigerator was undated and removed the ham and the roast beef.<br><br>On 11/10/21 at 01:00 PM, DS BB stated she had not made a cleaning schedule and was in the process of making one for dietary staff. DS BB stated DS DD should change her gloves before touching each plate of food and stated staff should take temperatures of the refrigerators and freezers every day.<br><br>The facility's Cleaning and Sanitation of Dining and Food Service Areas policy, dated 2017, documented the nutrition and food services staff will maintain the cleanliness and sanitation of the dining and food service areas through compliance with a written comprehensive cleaning schedule.<br><br>The facility's Food Storage policy, dated 2017 documented leftover food would be stored in covered containers or wrapped carefully and securely. Each item would be clearly labeled ad dated before refrigerated. All refrigerator units and all freezer units will always be kept clean and in good working condition.<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | The facility failed to store food in a safe and sanitary manner for the 59 residents that resided in the facility and received meals from the facility kitchen, placing the residents at risk for food borne illness.<br><br>32358<br><br>- On 11/09/21 at 11:43 AM, observation revealed during noon meal service, Certified Nurse Aide (CNA) N, with ungloved hands, took the paper wrapper off R37's straw, touched the end of the straw where the resident placed her mouth, after touching other residents' plates, her shirt and other residents clothing.<br><br>On 11/10/21 at 12:30 PM, observation revealed during noon meal service, CNA N with ungloved hands, took the paper wrapper off R51's straw, touched the end of the straw where the resident placed her mouth, after touching other residents' plates, her clothing , and another residents' clothing.<br><br>On 11/15/21 at 02:50 PM, Dietary Staff (DS) BB stated staff are to wash their hands after touching potentially contaminated surfaces such as clothing, meal trays, wheelchairs or people, before handling another resident's meal service.<br><br>Upon request the facility failed to provide a policy regarding touching contaminated objects before handling residents' meal service.<br><br>The facility failed to distribute food in accordance with professional standards for food service safety for the residents who ate in the dining room, placing them at risk for foodborne illness.<br><br>26768<br><br>- On 11/09/21 at 11:40 AM, observation revealed Dietary Staff (DS) DD set up beverage glasses on a cart and then moved them by handling them with her fingertips on the rim and inside the top rim. Continued observation revealed at 11:43 AM, she picked up a used beverage pitcher she had dropped on the floor, did not wash her hands, and continued to set beverages on the dining tables for residents, handling the glasses by the top rim. DS DD readjusted the clothing protector for one resident and continued handing out beverages to other residents without washing her hands. During the dining service she adjusted her face mask several times between serving beverages, handled beverages by the top rim, without disinfecting her hands. After serving the residents in the dining room, she rearranged the glasses still on the cart by handling them by the top rim.<br><br>At 11:52 AM, observation revealed DS DD wheeled a resident in a wheelchair to a table, touched the resident's back and another resident's back, and then served another resident his beverage without washing her hands.<br><br>On 11/09/21 at 12:10 PM, observation revealed Certified Medication Aide (CMA) S touched a resident, held hands with one, and then handled three resident beverages by the lip surface without washing her hands first.<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | On 11/09/21 at 12:38 PM, observation revealed DS DD adjusted her clothing, her face mask, touched her forehead, gathered three empty, soiled beverage glasses, then picked up the lemonade pitcher with her finger in the spout. She then served a resident his meal, handling his silverware and glass with her contaminated hands. The nurse manager in the dining room then reminded her to wash her hands.<br><br>On 11/15/21 at 02:50 PM, DS BB verified staff are not to handle resident's glasses by the top rim or lip surface and staff are to wash their hands after touching potentially contaminated surfaces such as wheelchairs or people, before handling another resident's meal service.<br><br>The facility's Food Safety and Sanitation policy, dated 2017, documented employees will follow sanitary practices and good personal hygiene at all times.<br><br>The facility failed to serve meals to residents in the dining room in a sanitary manner, placing those residents at risk for infection. |