STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165476	A. Building B. Wing	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Manors of Columbus Community	814 Springer Avenue Columbus Junction, IA 52738

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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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 45338 Based on clinical record review, staff interview, and facility policy review the facility failed to ensure admission Minimum Data Set (MDS) assessments completed timely for four of four residents reviewed for completion of comprehensive assessments (Resident #5, Resident #13, Resident #26, Resident #29). The facility reported a census of 28 residents. Findings include: 1. Review of the electronic health record for Resident #26 revealed the resident admitted to the facility 12/27/23. Review of the resident's Admission MDS assessment with Assessment Reference Date (ARD) 1/9/24 revealed the assessment completed 1/19/24. The Facility Policy titled MDS-Resident Assessment Instrument (RAI) and Care Planning, undated, revealed the following: 1. A schedule will be established by the Care Plan Coordinator. This schedule will identify the date the MDS is due and the date the plan-of-care is due. All disciplines will complete their sections within the required timeframe's. All disciplines will assist in identifying those residents who have had a change of condition. 47336 2. The Review of the electronic health record for Resident #29 revealed resident admitted to the facility on [DATE]. The Admission MDS assessment for Resident #29 revealed an Assessment Reference Date (ARD) of 5/20/24. The resident's MDS assessment completion date documented 5/30/24. 3. The Annual MDS assessment for Resident #13 revealed an ARD of 5/14/24. The resident's MDS assessment completion date documented 6/4/24. 4. The Annual MDS assessment for Resident #5 revealed an ARD of 2/26/24. The resident's MDS assessment completion date documented 3/18/24. (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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/15/24 at 1:35 PM, Staff C, LPN (Licensed Practical Nurse) acknowledged Resident #29 admission MDS assessment was submitted after the 14 day deadline and she also acknowledged Resident #13 and #5 annual MDS submitted after the 14 day deadline. During an interview on 8/15/24 at 1:39 PM, the DON (Director of Nursing) stated it would be nice if the facility got them done on time, but with the new staff and them not knowing all the answers, it didn't always happen unfortunately.

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47336 Based on record review, interviews, and the facility policy, the facility failed to accurately code the Minimum Data Set (MDS) assessment for a resident's medications they took for 1 of 5 residents reviewed for unnecessary medications (Resident #5). The facility reported a census of 28 residents. Findings include: The MDS assessment dated [DATE] revealed Resident #5 scored a 15 out of 15 on the Brief Interview for Mental Status (BIMS) exam, which indicated cognition intact. The MDS revealed the resident took a hypnotic and antidepressant. The MDS revealed a diagnosis for depression. The Care Plan revealed a focus area revised on 7/26/24 that the resident received Escitalopram, an antidepressant and Lamotrigine, an anti-convulsant for mixed obsessional thoughts, hoarding disorder, and major depressive disorder. The EHR (Electronic Health Record) lacked documentation the resident took a hypnotic medication. During an interview on 8/15/24 at 1:47 PM, Staff C, LPN (Licensed Practical Nurse) stated she didn't believe Resident #5 ever took a hypnotic and the old DON (Director of Nursing) must have clicked it by mistake. Staff C stated she expected the MDS be coded accurately. During an interview on 8/15/24 at 1:48 PM, the DON stated she expected the MDS be coded correctly. The Facility MDS - Resident Assessment Instrument (RAI) & Care Planning Policy (no date indicated) revealed the following information: a. RAI assessments were completed of each resident's needs, strengths, goals, life history and preferences residing in the facility using the RAI. Utilize RAI Manual as guidance when completing the assessments. b. Utilized the Care Area Assessments (CAA's) to further evaluate areas of potential concern for the resident. c. Provided the appropriate care and services for each resident.

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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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47336 Based on the record review, staff interview, and the facility policy, the facility failed to resubmit a PASRR (Preadmission Screening and Resident Review) with new mental health diagnoses and psychotropic medications added to the plan of care for 2 of 2 residents reviewed for PASRR (Resident #19 and Resident #20). The facility reported a census of 28 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #19 scored a 10 out of 15 on the Brief Interview for Mental Status (BIMS) exam, which indicated cognition moderately impaired. The MDS revealed diagnoses for non-Alzheimer's Dementia, anxiety disorder, depression, and psychotic disorder (other than schizophrenia). The MDS revealed the resident took an antipsychotic and an antidepressant medication. The MDS revealed the resident took antipsychotics on a routine basis. The Notice of PASRR Level 1 Screen Outcome dated 1/26/23 revealed no Level II required. The PASRR revealed no mental health diagnoses; dementia/neurocognitive disorders, and no medications taken by the resident. The Care Plan revealed a focus area dated 2/6/23 and revised on 8/6/24 for resident received psychotropic medications Escitalopram and Seroquel related to dementia with behavioral disturbance as evidenced by behaviors of agitation, aggression, and signs and symptoms of delirium vs cognitive loss. The interventions dated 2/6/23 revealed administration of psychotropic medications as ordered and reviews continued need for medication with prescriber, attempt dose reduction as warranted. The EMR (Electronic Medical Record) revealed the following medical diagnoses: a. dated 8/28/23- anxiety disorder, unspecified b. dated 8/1/23- psychotic disorder with delusions due to known psychological condition c. dated 6/8/23- unspecified dementia, mild, with other behavioral disturbance d. dated 7/12/23- major depressive disorder, single episode, mild The EMR Physician Orders revealed the following orders. a. dated 3/25/24- quetiapine fumarate oral tablet- give 12.5 mg (milligram) by mouth two times a day related to psychotic disorder with delusions due to known psychological condition b. dated 7/1/23- escitalopram oxalate oral tablet 10 mg- give 10 mg by mouth in the morning for depression c. dated 1/30/23- trazodone HCl (hydrochloride) oral tablet 50 mg- give 0.5 tablet by mouth at bedtime for sleep induction (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. The MDS assessment dated [DATE] revealed Resident #20 scored a 14 out of 15 on the BIMS exam, which indicated cognition intact. The MDS revealed the medical diagnoses of psychotic disorder other than schizophrenia, anxiety disorder, and depression. The MDS revealed the resident took antipsychotics and antidepressants. The Notice of PASRR Level 1 Screen Outcome dated 3/16/23 revealed no Level 2 required. The Notice revealed the the mental health diagnoses for depression/depressive disorder (including mild or situational) and the resident took Escitalopram 20 mg (milligrams) for depression. The Care Plan revealed a focus area dated 11/16/23 for resident received psychotropic medications, antidepressant Escitalopram, Wellbutrin XL, and antipsychotic medications quetiapine, related to diagnoses of unspecified disorientation with hallucinations, and depression. The EMR revealed the following medical diagnoses: a. dated 5/29/24- major depressive disorder, recurrent, mild b. dated 5/29/24- generalized anxiety disorder c. dated 8/28/23- delusional disorders d. dated 3/24/23- depression, unspecified The EMR revealed the following Physician Orders: a. start date of 5/18/23 and discontinued on 7/8/24- quetiapine fumarate oral tablet- give 12.5 mg by mouth every day and evening shift related to disorientation, unspecified b. start date of 5/18/23 and discontinued on 5/22/24- escitalopram oxalate oral tablet 20 mg- give 1 tablet by mouth every evening shift related to depression, unspecified c. start date of 5/18/24 and discontinued on 7/8/24- Bupropion HCl ER (extended release) oral tablet extended release 24 hour 300 mg- give 1 tablet by mouth every day shift related to depression, unspecified d. start dated of 5/23/24 and discontinued on 5/28/24- escitalopram oxalate oral tablet 5 mg- give 3 tablet by mouth in the evening related to depression, unspecified e. start date of 5/23/24 and discontinued on 5/29/24- Fluoxetine HCl oral capsule 10 mg- give 1 capsule by mouth in the morning for depression and anxiety f. start date 7/8/24- quetiapine fumarate oral tablet 25 mg- give 0.5 tablet by mouth two times a day related to major depressive disorder, recurrent, mild, and delusional disorders g. start date 7/9/24- Fluoxetine HCl oral capsule 10 mg- give 1 capsule by mouth one time a day related to major depressive disorder, recurrent, mild and give with 20 mg (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	h. start date 7/9/24- Fluoxetine HCl oral capsule 20 mg- give 1 capsule by mouth one time a day related to major depressive disorder, recurrent, mild and give with 10 mg i. start date 7/9/24- Bupropion HCl ER oral tablet extended release 24 hour 300 mg- give 1 tablet by mouth one time a day related to major depressive disorder, recurrent, mild and depression, unspecified During an interview on 8/15/24 at 2:05 PM, the Administrator acknowledged the PASRR for Resident #19 and Resident #20 should have been resubmitted and she was under the understanding they did get resubmitted by the previous DON (Director of Nursing). The Administrator stated she worked with psych and discussed the changes with the DON and she thought the DON updated the PASRR. The Facility PASRR Policy (no date indicated) revealed the following information: a. PASRR was updated as needed when there was a new diagnosis of schizophrenia, schizoaffective disorder, schizophreniform, psychotic, or bipolar disorder, but not due to a substantiated medical cause or dementia.

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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** 45338 Based on clinical record review, staff interview, and facility policy review the facility failed to ensure diuretic medication was included in the comprehensive Care Plan for one of five residents reviewed for unnecessary medications (Resident #26). The facility reported a census of 28 residents. Findings include: Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #26 scored 00 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated severe cognitive impairment. Per this assessment, the resident took diuretic medication. Review of the resident's Care Plan did not address diuretic medication. Review of the Physician Order dated 12/27/23, noted to be the date of the resident's admission, revealed, Furosemide (diuretic) Oral Tablet 20 MG (milligram) with directions to give 1 tablet by mouth every day shift for bilateral lower extremity edema. On 8/14/24, review of Resident #26's Physician Orders revealed the order remained current for Resident #26. On 8/15/24 at 1:40 PM, the Director of Nursing (DON) acknowledged diuretics should be on the care plan. The Facility Policy titled Comprehensive Care Plan, revised 4/21/06, revealed the following: 1. To develop quantifiable objectives for the highest level of of functioning the resident may be expected to obtain. 2. To develop care directives to maintain the optimum health status when dependent on staff for needs.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45338 Based on record review, staff interview, and facility policy review the facility failed to update the Care Plan following initiation of anticoagulant medication, failed to ensure updated fall interventions were included following resident falls, failed to include a wound, and failed to address Clostridium Difficile for four of thirteen residents reviewed for Care Plan revision (Resident #6, Resident #15, Resident #20, Resident #27). The facility reported a census of 28 residents. Findings include: 1. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was rarely to never understood, and further revealed the resident took anticoagulant medication. Review of the Care Plan for Resident #15 lacked a focus area for anticoagulant medication. The Physician Order active 2/25/22 through 12/15/22 revealed a Physician Order for Eliquis 5 mg (milligram), an anticoagulant medication. It was noted the anticoagulant medication initiated for Resident #15 in the month following the resident's admission to the facility. The current Physician Order dated 12/20/22 revealed, Apixaban (also known as Eliquis), with directions to give 1 tablet by mouth two times a day related to nonrheumatic aortic valve stenosis. 2. Review of the MDS assessment for Resident #9 dated 7/29/24 revealed the resident scored 5 out of 15 on a BIMs exam, which indicated severely impaired cognition. Per this assessment, the resident had two or more falls with no injury since admit, entry, or reentry. Review of the Care Plan dated 12/8/20 and 4/3/23 revealed, [Resident #9] is at risk for falls r/t (related to) Incontinence and BLE (bilateral lower extremity) knee pain. Review of interventions revealed interventions last revised 4/3/23, with no additional interventions added past the date of 4/3/23. Review of Incident/Accident Reports for Resident #9 revealed the resident had fallen on 3/8/24, 7/8/24, and 7/18/24. On 8/15/24 at 1:40 PM, the Director of Nursing (DON) acknowledged anticoagulants and fall interventions should be on the Care Plan. The Facility Policy titled Comprehensive Care Plan, revised 4/21/06, revealed the following: 4. Develop realistic interventions which will work towards reaching the established goals. 47336 (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. The MDS assessment dated [DATE] revealed Resident #20 scored a 14 out of 15 on the BIMS exam, which indicated cognition intact. The MDS revealed the medical diagnoses of Methicillin Susceptible Staphylococcus Aureus infection, unspecified site, pressure ulcer of the left heel, unspecified stage, and venous insufficiency (chronic and peripheral). The MDS revealed the resident took an antibiotic. The MDS revealed one Stage 3 pressure ulcer not present on entry, admission, or reentry. The Care Plan lacked documentation of a pressure ulcer or diabetic ulcer. The EMR (Electronic Medical Record) revealed: a. a pressure ulcer of the left heel, unspecified stage dated 7/8/24 The EMR Physician Orders revealed: a. start date of 6/21/24- thin hydrocolloid dressing to left heel then loosely wrap with rolled gauze to hold in place PRN (as needed) until resident seen on 6/28/2024. No directions specified for order. b. start date of 6/25/24- culture of left heel wound- every day shift for drainage and odor for 2 days. c. start date of 6/28/24 and discontinued on 7/8/24- clindamycin HCl oral capsule 300 mg (milligram)- give 1 capsule by mouth four times a day d. start date 7/8/24 and discontinued on 7/19/24- vancomycin HCl Intravenous Solution- use 500 mg intravenously every 24 hours for 11 Days e. start date 7/10/24- Cleanse left heel with NS (normal saline) pat dry. Use skin prep on peri-wound. cut Medi-honey to size apply sticky side to wound bed. Cover with gauze and wrap with kerlix secure with paper tape. Perform the following every Monday, Wednesday, and Friday. May change kerlix if it becomes soiled but leave Medi-honey in place. f. start date of 7/20/24 and discontinued on 7/29/24- vancomycin HCl intravenous solution- use 750 mg intravenously every day shift g. start date of 7/30/24- Mepilex AG (or equiv) to wound left heel; change every 72 hours or if greater than 60% saturated. Visualize daily. Secure with gauze. The Progress Note dated 6/21/24 at 2:35 PM , revealed the resident requested a breakfast tray, stated her left heel felt painful when propelling in the wheelchair. Left heel noted to be soft and discolored. No open areas noted. Heel protector applied and resident encouraged to keep leg/heel elevated on pillow when in recliner or in bed. [Name redacted] Provider's office called and resident needed seen in the office. Appointment made for 6/28 at 11 am. Both daughters aware of heel and appointment. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Progress Note dated 6/24/24 at 10:54 AM, revealed increased odor and scant drainage noted from left heel. Slough tissue visible. Resident encouraged to wear heel proctors and elevate foot with foot pedal when propelling self in wheelchair. Resident noted to have foot on the floor behind pedal. Spoke with [name redacted] provider's nurse and new order received for culture of left heel wound. During an interview on 8/12/24 at 10:09 AM, Resident #20 stated she had a wound on her left heel and it happened at the facility. She stated she was treated for MRSA in the wound. She stated she wore moon boots in bed and in her recliner and wore special shoes the doctor ordered for her. She stated she didn't know how it happened except she put a lot of pressure on her heels when she walked before. During an interview on 8/15/24 at 1:50 PM, the DON stated yes, the heel wound needed to be care planned. She stated skin issued needed addressed on the care plan. 4. The MDS assessment dated [DATE] revealed Resident #6 scored a 15 out of 15 on the BIMS exam, which indicated cognition intact. The MDS revealed the medical diagnoses for enterocolitis due to clostridum difficile (C. diff), not specified as recurrent. The MDS revealed the resident took an antibiotic. The Care Plan lacked documentation of an infection of C. diff. The EMR revealed a Medical Diagnoses for C. diff, not specified as recurrent The Physician Orders revealed a. start date 5/31/24 and stop date 6/9/24- vancomycin HCl (hydrochloride) oral capsule 125 mg- give 1 capsule by mouth four times a day for C. diff for 9 Days b. start date 6/24/24 and stop date 7/8/24- vancomycin HCl oral capsule 125 mg- give 1 capsule by mouth four times a day related to enterocolitis due to C. diff not specified as recurrent for 14 Days c. start date 7/9/24 and stop date 8/7/24- vancomycin HCl Oral Capsule 125 mg- give 1 capsule by mouth two times a day related to enterocolitis due to C. diff not specified as recurrent for 7 Days may extend for 6 additional weeks for total of 8 weeks therapy to be determined by PCP (primary care provider) then give 1 capsule by mouth one time a day related to enterocolitis due to C. diff not specified as recurrent for 7 Days may extend for 6 additional weeks for total of 8 weeks therapy to be determined by PCP then give 1 capsule by mouth every 48 hours related to enterocolitis due to C. diff not specified as recurrent for 14 Days may extend for 6 additional weeks for total of 8 weeks therapy to be determined by PCP. d. start dated 7/19/24 and stop date 7/29/24- Dificid Oral Tablet 200 mg (fidaxomicin)- give 200 mg by mouth every day and evening shift related to enterocolitis due to C. diff not specified as recurrent for 10 days The Progress Note dated 5/31/24 at 3:17 PM, revealed resident returned from overnight observation at local hospital for new diagnosis of C. diff infection. New orders received and processed. Resident in good spirits, questions regarding how long she would be observed for infection control/isolation processes. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/12/24 at 2:39 PM, Resident #6 stated she had diverticulosis and had a bacteria issue that lasted 2 months. During an interview on 8/15/24 at 1:52 PM, the DON acknowledged Resident #6 C. diff needed addressed on the Care Plan.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 45338 Based on observation, interview, and record review, the facility failed to ensure diuretic medication administered per physician order for one of two residents reviewed for edema (Resident #7). The facility reported a census of 28 residents. Findings include: Review of the Minimum Data Set (MDS) assessment for Resident #7 dated 7/29/24 revealed the resident scored 15 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated intact cognition. Per this assessment, the resident took diuretic medication. The Care Plan for Resident #7 dated 2/10/20, revised 4/2/23, revealed the following: [Resident #7] utilizes diuretic therapy Furosemide r/t (related to) diagnoses of hypertension and unspecified heart failure. The intervention dated 4/2/23 revealed, Weight daily in AM per PCP (Primary Care Physician) orders. Report gains of 3 lbs. or greater in 24 hours to PCP. The Physician Order dated 8/30/21 revealed, Lasix Tablet 40 MG (Furosemide) with instruction to give 40 mg (milligram) by mouth in the morning related to heart failure, unspecified. The Physician Order dated 7/28/20 revealed, Furosemide Tablet 20 MG with instruction to give 1 tablet by mouth every 24 hours as needed - give daily as needed for weight gain of 3 or more pounds related to heart failure, unspecified. Review of Resident #7's weights per the weight summary section of the electronic health record revealed the following: a. 3/4/24 at 1:03 PM: 115.6 pounds b. 3/5/24 at 1:17 PM: 119.4 pounds c. 5/6/24 at 1:42 PM: 117.4 pounds d. 5/7/24 at 1:35 PM: 120.6 pounds e 7/15/24 at 1:38 PM: 115.4 pounds f. 7/16/24 at 1:27 PM: 121.6 pounds Review of the resident's Medication Administration Record (MAR) dated July 2024 revealed the resident did not receive any doses of PRN Furosemide for March, May, or July 2024. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/15/24 at 1:07 PM during an interview with Staff B, Certified Medication Aide (CMA), Staff B queried about residents who required daily weights, and acknowledged there were residents with daily weights. Staff B explained went by the doctor's orders or lasix. When queried who on the [hall redacted] had daily weights, Staff B acknowledged, in part, Resident #7. When queried who got the weights, Staff B explained the CNAs got the weights, would give to the charge, and charted in the computer system. Per Staff B, it had been awhile since the PRN Lasix was given, and explained the resident's weight didn't change that much. During an interview on 8/15/24 at 2:03 PM with Staff C, Licensed Practical Nurse (LPN) and the Director of Nursing (DON), Staff C explained Certified Nursing Assistants (CNAs) did the daily weights, and would tell the nurse or med aide who wrote it in the Medication Administration Record. On 8/15/24 at 2:15 PM, the DON explained she knew from previous experience 3 pound weight gain or loss to tell the nurse. The Facility Policy titled Medications, Administrations, undated, revealed the following per the Purpose: To assure each resident receives the proper medications at the correct time as ordered by their Physician.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47336 Based on record review, resident interview, and the staff interviews, the facility failed to provide a shower twice a week for 1 of 1 residents reviewed for ADLs (Activities of Daily Living) (Resident #13). The facility reported a census of 28 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #13 scored a 11 out of 15 on the Brief Interview for Mental Status (BIMS) exam, which indicated cognition moderately impaired. The MDS revealed the resident dependent with shower/bathing self and tub/shower transfers. The MDS revealed the diagnosis for Parkinson, unspecified. The Care Plan revealed a focus area revised on 4/2/23 for the resident's ability to complete ADLs had deteriorated related to advanced Parkinson's disease symptoms. The interventions dated 11/14/23 revealed the resident required a mechanical lift for transfer. The interventions revised on 4/2/23 revealed not to rush the resident and allow extra time to complete ADLs. The POC (Plan of Care) Response History Report for ADL bathing task revealed the resident received a bath with total dependence on 7/24/24; 7/31/24; 8/3/24; and 8/10/24. During an interview on 8/12/24 at 2:25 PM, Resident #13 stated she was supposed to get a shower twice a week but she didn't always get them. She stated she missed one day last week. Resident #13 stated that it bothered her that she didn't receive a shower twice weekly. She stated they didn't have enough staff to come back on another day to get the shower caught back up. During an observation on 8/12/24 at 2:32 PM, Resident #13 laid on her bed with an incontinent brief and pink shirt on. During an interview on 8/15/24 at 12:51 PM, Staff A, CNA (Certified Nurse Aide) stated they gave Resident #13 a bed bath or shower twice weekly and if she received a bed bath they washed her hair in the beauty salon. Staff A stated there were a few times the resident didn't receive a bath on her scheduled day due to low staffing and she tried to make it up the next day. Staff A stated she would chart on POC when she gave the resident a bath. Staff A stated the only place they charted baths was on POC. During an interview on 8/15/24 at 2:25 PM, Staff D, CNA stated Resident #13 received baths twice a week and she never forgot to chart when she gave a shower. Staff D stated the only place they charted showers was on POC. During an interview on 8/15/24 at 2:51 PM, the DON (Director of Nursing) stated the residents received showers twice a week and they documented them in POC. The DON stated she expected the residents received showers twice a week.

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F 0684 Level of Harm - Minimal harm or potential for 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** 45338 Based on observation, interview, and record review the facility failed to ensure daily weights obtained per Physician Order for two of two residents reviewed for edema (Resident #7, Resident #9), and failed to ensure timely, consistent follow up after documentation of no bowel movement (BM) for greater than three days for one of one resident reviewed for bowel and bladder (Resident #9), and failed to ensure thorough assessment completion for a resident's heel wound for one of two residents reviewed for wounds (Resident #20). The facility reported a census of 28 residents. Findings include: 1. Review of the Minimum Data Set (MDS) assessment for Resident #7 dated 7/29/24 revealed the resident scored 15 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated intact cognition. Per this assessment, the resident took diuretic medication. The Care Plan for Resident #7 dated 2/10/20, revised 4/2/23, revealed the following: [Resident #7] utilizes diuretic therapy Furosemide r/t (related to) diagnoses of hypertension and unspecified heart failure. The intervention dated 4/2/23 revealed, Weight daily in AM per PCP (Primary Care Physician) orders. Report gains of 3 lbs. or greater in 24 hours to PCP. Review of the resident's signed Physician's Order sheets for July 2024 and August 2024 both included the following: 8/20/21 check weight daily. Resident #7's Physician Orders in the electronic health record lacked an order for daily weights. Review of Resident #7's Weight Summary documentation present in the electronic health record revealed the following dates in July 2024 and August 2024 which lacked documentation of the resident's weight: a. July 2024: 7/6/24, 7/9/24, 7/10/24, 7/12/24, 7/13/24, 7/20/24, 7/21/24, 7/22/24, 7/25/24, 7/30/24, and 7/31/24. b. August 2024: 8/2/24, 8/3/24, 8/4/24, 8/6/24, 8/7/24, 8/8/24, and 8/11/24. 2. Review of the MDS assessment for Resident #9 dated 7/29/24 revealed a BIMs score of 5 out of 15, which indicated severely impaired cognition. The assessment revealed the resident took diuretic medication, and was frequently incontinent of bowel. Review of the resident's medical diagnoses included heart failure. a. The Care Plan dated 9/22/21, revised on 3/28/23, revealed the following: [Resident #9] has a diagnosis of congestive heart failure. The Intervention, dated 9/22/21 and revised 2/27/24, revealed the following: Weigh daily, report weight gain >3 lb/day to PCP (Primary Care Physician). Review of Resident #9's signed Physician's Order Sheet for July 2024 included the following: 11/12/21 check weight daily. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #9's documentation of weights per the paper chart and the electronic health record lacked documentation of the resident's weight for the following dates in July 2024: 7/2/24, 7/5/24, 7/6/24, 7/9/24, 7/10/24, 7/20/24. 7/21/24. b. The Care Plan for Resident #9 dated 5/16/24 revealed, [Resident #9] utilizes Morphine Concentrate daily for dyspnea r/t (related to) CHF (Congestive Heart Failure). The Interventions dated 5/16/24 revealed the following: Follow facility bowel management guidelines, and monitor for side effects including: constipation, nausea, vomiting, slowed respirations, sedation, confusion, or pruritis (itching). Review of Physician Orders for the resident revealed the following: i. (12/11/19 Physician Order in electronic health record (EHR)): Magnesium Hydroxide Suspension 400 MG (milligram)/5 ML (milliliter) with instructions to give 30 ml by mouth every 24 hours as needed for Constipation. ii. (2/10/24 Physician Order in EHR): Morphine Sulfate (Concentrate) Oral Solution 100 MG/5 ML (100 milligram per 5 milliliter) with instructions to give 0.25 ml by mouth two times a day for dyspnea related to heart failure, unspecified, and to give 0.25 ml by mouth every 1 hours as needed for pain/dyspnea. iii. (Telephone Order dated 7/1/24 signed 7/1/24): Fleet's Enema if no BM x 72 hrs (hours). iv. (Telephone Order dated 7/1 signed 7/18/24): Bisacodyl 10 mg (milligram) Suppository with directions for 1 supp PR Q (every) 3 days PRN (as needed) constipation. v. (Telephone Order dated 7/30/24 signed 7/31/24): Bisacodyl 10 mg Suppository. 1 Suppository PR Q3 days PRN constipation. Review of the resident's Bowel and Bladder Elimination Record revealed no BM 7/16/24 through 7/20/24. Review of the resident's paper Medication Administration Record (MAR) dated July 2024 revealed the following: i. Bisacodyl 10 mg suppository once every 3 days PRN administered one time on 7/1/24. No additional administrations of this medication charted for the month. ii. Milk of Mag (MOM) 400 MG/5 ML on 7/18/24 at 3:40 PM for general discomfort, and next on 7/20/24 at 1:00 AM for constipation. iii. The Fleet's enema order dated 7/1/24 on the paper MAR with documentation to administer if no BM x 72 hours had been charted as administered on 7/30 only for the month, the row had been crossed off across the paper MAR, and an additional order present dated 7/30/24 which documented, Fleets Enema use one PRN (as needed) after no results from bisacodyl c (with) bowel protocol. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/15/24 at 1:02 PM during an interview with Staff A, Certified Nursing Assistant (CNA), Staff A explained she would ask the resident if they had a BM, if they did there was a paper staff would write down what size they had, and if the resident had dementia, would go behind the toilet and turn the water off or unhook the toilet. Staff A explained they would chart in the electronic health record and there was a section for incontinent of urine, incontinent bowel movement, and if had BM the size. On 8/15/24 at 1:07 PM during an interview with Staff B, Certified Medication Aide (CMA), Staff B queried about residents who required daily weights, and acknowledged there were residents with daily weights. Staff B explained they went by the doctor's orders or lasix. When queried who on the [hall redacted] had daily weights, Staff B acknowledged, in part, both Resident #7 and Resident #9. When queried who got the weights, Staff B explained the CNAs got the weights, would give to the charge nurse, and charted in the computer system. During an interview on 8/15/24 at 2:03 PM with Staff C, Licensed Practical Nurse (LPN) and the Director of Nursing (DON), Staff C explained Certified Nursing Assistants (CNAs) did the daily weights, and would tell the nurse or med aide who wrote it in the Medication Administration Record. On 8/15/24 at 2:07 PM, when queried about the daily weight order on the paper Physician's Order Sheet and not in the orders in the [electronic health record], Staff C explained there was no reason to be on paper and not in the computer. The DON was not sure why this occurred. On 8/15/24 at 2:15 PM, the Director of Nursing (DON) explained third shift would look up to see how long it had been since the last BM, and would make a list so the med aide knew in the morning who needed a slurry, MOM, etc. The DON acknowledged if MOM was not effective, a suppository would be next. On 8/15/24 at 2:20 PM, Staff C, LPN explained standing orders at the facility would be for 14 days, and then would re-implement or call the doctor. The Facility Policy titled Regular Bowel dated 11/5/23 revealed, The evening shift nurse will check the BM record at the beginning of their shift. If it is noted a resident is on the second day with no recorded bowel movement, the nurse or med. aide will check the appropriate medication sheet. The usual protocol which will be followed (unless otherwise ordered by the physician): On the morning of the second day of no recorded bowel movement, resident will be served a 4-ounce glass of slurry. If no results, on the evening of the second day of no recorded bowel movement, bowel assessment will be performed, and MOM will be given per dose on the MAR. If there are no results that night, the resident will receive an additional bowel assessment and a laxative suppository the next a.m. This will be administered by the night nurse with the early a.m. med. pass. If 4 days pass without recorded bowel movement, obtain bowel assessment and contact the PCP for further treatment such as an enema. 47336 3. The MDS assessment dated [DATE] revealed Resident #20 scored a 14 out of 15 on the BIMS exam, which indicated cognition intact. The MDS revealed the medical diagnoses of Methicillin Susceptible Staphylococcus Aureus infection, unspecified site, pressure ulcer of the left heel, unspecified stage, and venous insufficiency (chronic and peripheral). The MDS revealed the resident took an antibiotic. The MDS revealed one Stage 3 pressure ulcer not present on entry, admission, or reentry. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Care Plan lacked documentation of a pressure ulcer or diabetic ulcer. The EMR (Electronic Medical Record) revealed: a. a pressure ulcer of the left heel, unspecified stage dated 7/8/24 The EMR Physician Orders revealed: a. start date of 6/21/24- thin hydrocolloid dressing to left heel then loosely wrap with rolled gauze to hold in place PRN (as needed) until resident seen on 6/28/2024. No directions specified for order. b. start date of 6/25/24- culture of left heel wound- every day shift for drainage and odor for 2 days. c. start date of 6/28/24 and discontinued on 7/8/24- clindamycin HCl oral capsule 300 mg (milligram)- give 1 capsule by mouth four times a day d. start date 7/8/24 and discontinued on 7/19/24- vancomycin HCl Intravenous Solution- use 500 mg intravenously every 24 hours for 11 days e. start date 7/10/24- Cleanse left heel with NS (normal saline) pat dry. Use skin prep on peri-wound. cut Medi-honey to size apply sticky side to wound bed. Cover with gauze and wrap with kerlix secure with paper tape. Perform the following every Monday, Wednesday, and Friday. May change kerlix if it becomes soiled but leave Medi-honey in place. f. start date of 7/20/24 and discontinued on 7/29/24- vancomycin HCl intravenous solution- use 750 mg intravenously every day shift g. start date of 7/30/24- Mepilex AG (or equiv) to wound left heel; change every 72 hours or if greater than 60% saturated. Visualize daily. Secure with gauze. The Physician Written Orders revealed: a. dated 6/21/240 - thin hydrocolloid dressing to left heel then loosely wrap with rolled gauze to hold in place as needed thru appointment on 6/28. b. dated 6/24/24- culture of the left heel wound c. dated 6/27/240 Bactrim DS- 1 tablet orally bid x 10 days d. dated 6/28/24- discontinue Bactrim. start clindamycin 300 mg four times a day for 10 days e. dated 6/28/24- go to ER for cellulitis of left heel (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	f. dated 7/8/24- cleanse left heel with normal saline. pat dry. apply no sting barrier wipe periwound skin. cut Medihoney to fit wound. remove plastic backing, apply sticky side to wound bed. cover with gauze and wrap with Kerlix. secure with paper tape, Mon/Wed/Fri, if Kerlix soiled or loose change it leaving the Medi-honey in place g. dated 7/17/24- discontinue Mepilex silver, to wound on left heel: cleanse with normal saline and apply collagenase/Santyl ointment to center of wound to 2 mm thickness of a nickel, and protect healthy surrounding tissue with petroleum jelly; apply gauze pad, wrap with gauze, BID h. dated 7/29/24- discontinue Santyl, return care to [name redacted] provider; Mepilex AG (or equivalent) to wound left heel and change every 72 hours or if greater than 60 percent saturated. visualized daily. secure with gauze. i. dated 8/1/24- discontinue wound wash, Santyl, petroleum jelly, and gauze 4x4 to left heel wound. The Progress Note dated 6/21/24 at 2:35 PM , revealed the resident requested a breakfast tray, stated her left heel felt painful when propelling in the wheelchair. Left heel noted to be soft and discolored. No open areas noted. Heel protector applied and resident encouraged to keep leg/heel elevated on pillow when in recliner or in bed. [Name redacted] Provider's office called and resident needed to be seen in the office. Appointment made for 6/28 at 11 am. Both daughters aware of heel and appointment. The Progress Note dated 6/24/24 at 10:54 AM, revealed increased odor and scant drainage noted from left heel. Slough tissue visible. Resident encouraged to wear heel proctors and elevate foot with foot pedal when propelling self in wheelchair. Resident noted to have foot on the floor behind pedal. Spoke with [name redacted] provider's nurse and new order received for culture of left heel wound. The Facility Non-Pressure report revealed the following information for the left heel wound: a. dated 6/24/24 (wound type not specified); 1. 6 cm length x 6 cm width 2. serosanguinous scant exudate 3. moderate odor slough and wound bed not seen. b. dated 6/26/24 - unable to assess due to current treatment c. dated 7/10/24 1. 4 cm length x 3 cm width 2. small amount of discharge mostly scabbed 3. serous exudate d. dated 7/31/24- unable to assess due to current treatment- continue treatment (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	e. dated 8/7/24 1. 3 cm in length x 2.5 cm width 2. serous scant amount of exudate 3. scabbed wound bed drainage noted on dressing. scabbed over. f. dated 8/13/24 1. 2.0 cm length x 2.0 cm width and less than <2.0 cm in depth 2. no exudate or odor 3. normal wound bed with normal for skin surrounding, and surrounding tissue/wound edges normal for skin with soft tissue in center outside hard with scab superior to wound. 4. wound improved and continued treatment. The Radiology Results dated 7/3/24 at 6:00 PM revealed the following Impression/Plan: a. left lower extremity ulceration likely due to neuropathy and small vessel disease. Secondary cellulitis noted and concern for deeper infection and deeper ulceration also needed. Resident placed on inpatient level of care and placed on IV (intravenous) Zosyn and vancomycin. Podiatry consulted to review the patient in the morning to see if debridement needed. The Wound/Ostomy Progress Note dated 7/8/24 at 11:46 AM revealed resident seen as requested for evaluation and recommendations for wound care. Resident left heel remains very dry in wound bed. Small non-blanchable dark area in the periwound. Difficult to assess wound due to resident positioning, but wound appears clean. Resident likely to discharge today back to her facility, wound care instructions provided in AVS, additional supplies left in room. Wound clinic to call to schedule appointment with patient as there currently on a waiting list. Resident remains incontinent of urine and inner things, bilateral buttocks, and gluteal cleft very macerated. The Wound assessment dated [DATE] at 11:10 AM revealed the following: a. suspected etiology- Pressure b. Pressure Injury Stage- Stage 3 c. thickness- full d. undermining- absent e. tunneling- absent f. wound description- red; slough g. wound edges- defined (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	h. drainage- none i. drainage characteristics- none- wound tissue dry j. odor- absent k. periwound skin- erythemic < or equal 2 cm l. recommendations for wound care: Medi-honey three times per week to left heel and cover with Mepilex border dressing The Physician Note dated 7/10/24 revealed antibiotics for an ulcer in her left heel. She initially had an ulcer that seemed to get out of control and treated with IV Zosyn and vancomycin. Resident seen by podiatry and they didn't recommend surgery. The wound specialist and ID specialist stated she was considered to be at high risk for worsening of this wound. The left heel showed ulcer which looked like it was healing. At more dry no drainage not having any deep recesses visualized. The primary diagnosis diabetic ulcer of left heel associated with Type II DM, with other ulcer severity. The Progress Note dated 7/26/24 at 2:44 PM, revealed the resident upset her dressing wasn't changed this morning. The resident was told she needed to be in bed in order to properly dress her wound. The resident got into bed shortly after breakfast but failed to notify nurse of doing so then resident had therapy and chose to go to bingo after therapy so dressing to left heel was not changed this morning. The resident was made aware she should've put on her call light to let nurse know she was in bed. This isn't the first time we've asked resident to notify staff when she's ready for treatment as she attends many activities and participates in therapy and it can be very difficult to catch her in order to do said treatments. The July TAR (Treatment Administration Record) revealed the treatment for the collagenase external ointment application to the left heel topically BID (twice daily) blank. The wound treatment completed on the evening shift. During an interview on 8/12/24 at 10:09 AM, Resident #20 stated she had a wound on her left heel and it happened at the facility. She stated she was treated for MRSA in the wound. She stated she wore moon boots in bed and in her recliner and wore special shoes the doctor ordered for her. She stated she didn't know how it happened except she put a lot of pressure on her heels when she walked before. During an observation on 8/12/24 at 10:47 AM, Resident #20 self propelled herself in the wheelchair down the hall and her left foot on a foot pedal and the right foot lifted off the ground as she propelled down the hall. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/15/24 at 9:16 AM, Staff E, LPN (Licensed Practical Nurse) stated they discovered the wound on her shift and documented it and called the doctor for a treatment plan and a couple days later they sent a sample of the wound in to culture. Staff E stated the facility completed weekly measurements. Staff E stated they would put unable to assess when the doctor wanted to do the wound dressing changes himself. Staff E stated at times the resident refused treatments, and when she did, the nurse would document the treatment. Staff E queried about the Progress Note that revealed a dressing change not completed and she stated she communicated with staff that the resident needed to be put in bed for her to assess and do the wound dressing. Staff E stated then she got busy and after that the resident got up for lunch, then therapy, and went to Bingo and the wound dressing didn't get done. Staff E stated she chose to do those things instead of having the treatment done. Staff E stated she passed on to the oncoming shift that the resident didn't get her morning dressing change. During an interview on 8/15/24 at 1:55 PM, Staff C, LPN stated the facility did the wound sheets once a week unless the wound was brand new. Staff C stated they needed to start the wound sheets the day the wound was discovered. During an interview on 8/15/24 at 2:54 PM, the DON (Director of Nursing) queried on her thoughts of documenting unable to visualize on a wound measurement sheet for the weekly wound measurements and she stated she didn't know how she felt, she stated they need to assess the wound but sometimes the doctors wanted the dressings left in place. The DON informed on 6/24, the doctor had not assess the wound yet and the dressings were completed by the facility and she stated she expected the staff to look at the wound. The DON asked if Wednesday were the only day the nurse could do wound measurements and she stated no, it didn't need to be a specific day, the facility normally just did them on Wednesdays. The DON queried if a resident ordered a dressing change every 72 hours and the dressing completed on Tuesday, when did the facility assess and measure the wound and she stated she didn't have an answer and would ask the nurse consultant. The DON stated the facility didn't normally deal with wounds like Resident #20 had.

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F 0756 Level of Harm - Minimal harm or potential for actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47336 Based on record review, staff interview, and the facility policy, the facility failed to have the physician respond to the pharmacist GDR (Gradual Dosage Reduction) recommendation letter in a timely manner for 1 of 5 residents reviewed for unnecessary medications (Resident #19). The facility reported a census of 28 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #19 scored a 10 out of 15 on the Brief Interview for Mental Status (BIMS) exam, which indicated cognition moderately impaired. The MDS revealed diagnoses for non-Alzheimer's Dementia, anxiety disorder, depression, and psychotic disorder (other than schizophrenia). The MDS revealed the resident took an antipsychotic and antidepressant medications. The MDS revealed the resident took antipsychotics on a routine basis. The Care Plan revealed a focus area revised on 8/6/24 for resident received psychotropic medications escitalopram and Seroquel related to dementia with behavioral disturbance as evidenced by behaviors of agitation, aggression, and signs and symptoms of delirium vs cognitive loss. The interventions dated 2/6/23 revealed administration of psychotropic medications as ordered and reviews continued need for medication with prescriber, attempt dose reduction as warranted. The EMR (Electronic Medical Record) revealed the following medical diagnoses: a. dated 8/28/23- anxiety disorder, unspecified b. dated 8/1/23- psychotic disorder with delusions due to known psychological condition c. dated 6/8/23- unspecified dementia, mild, with other behavioral disturbance d. dated 7/12/23- major depressive disorder, single episode, mild The EMR Physician Orders revealed the following orders. a. dated 3/25/24- quetiapine fumarate oral tablet- give 12.5 mg (milligram) by mouth two times a day related to psychotic disorder with delusions due to known psychological condition b. dated 7/1/23- escitalopram oxalate oral tablet 10 mg- give 10 mg by mouth in the morning for depression c. dated 1/30/23- trazodone HCl (hydrochloride) oral tablet 50 mg- give 0.5 tablet by mouth at bedtime for sleep induction (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165476	A. Building B. Wing	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Manors of Columbus Community	814 Springer Avenue Columbus Junction, IA 52738

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Progress Note dated 12/29/23 at 10:07 AM, revealed the current psychotropic regimen: trazodone 25 mg at bedtime for anxiety, escitalopram 10 mg in the morning for depression and anxiety, and quetiapine 12. 5 mg at bedtime for psychiatric disorder with delusions, dementia with behaviors. Flowstate Psychiatry follows: Since last review, appeared to have tolerated switch (from risperidone to quetiapine) without concern - no AE (adverse effects) identified with no agitation/delusional behaviors noted. Seen by ARNP (Advanced Registered Nurse Practitioner) [name redacted] on 12/14. A/P (Assessment/Plan): Will evaluate escitalopram and quetiapine for GDR - letter generated. The Progress Note dated 1/25/24 at 10:31, revealed the current psychotropic regimen: trazodone 25 mg at bedtime anxiety, escitalopram 10 mg in the morning for depression and anxiety, and quetiapine 12.5 mg at bedtime for psychiatric disorder with delusions, dementia with behaviors. Flowstate Psychiatry follows. No medication changes since last review. Mood has been stable; seen by flowstate on 1/11 with no medication changes made - no agitation/delusional behaviors noted over review period. A/P: Will evaluate escitalopram and quetiapine for GDR - letter generated. The Progress Note dated 2/22/24 at 11:15, revealed the current psychotropic regimen: trazodone 25 mg at bedtime for anxiety, escitalopram 10 mg in the morning for depression and anxiety, and quetiapine 12.5 mg at bedtime for psychiatric disorder with delusions, dementia with behaviors. Flowstate Psychiatry follows. Mood has been stable; will evaluate psychotropic regimen for GDR - letter generated. The pharmacist sent a GDR on 2/25/24 at 4:14 PM for a GDR evaluation for trazodone, escitalopram and quetiapine and the provider declined on 2/27/24 due to dose reduction likely impair the resident's function. During an interview on 8/15/24 at 2:10 PM, the Administrator stated the pharmacist came to the facility and reviewed the medications and then sent the provider a letter and she had issues not getting responses so the pharmacist started sending the letters to the provider and to the DON (Director of Nursing) so we could keep track of them. The Administrator stated she expected the provider to respond to the recommendations and send it back to the facility. The Facility Pharmacy Services Policy (no date indicated) revealed the following information: a. The drug regimen of each resident reviewed at least once a month by a licensed pharmacist. b. The pharmacist reported an irregularities to the attending physician, and the facility's medical director and the DON, and these reports must be acted upon. 1. The attending physician documented in the resident's medical record that the identified irregularity reviewed and what, if any, action taken to address it. If no changes to the medication, the attending physician should document their rational in the medical record. c. Unnecessary Drugs each resident's drug regimen will be free from unnecessary drugs. d. Psychotropic Drugs- Based on a comprehensive assessment of a resident, the facility will ensure that (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. residents who use psychotropic drugs received gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.

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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 0865 Level of Harm - Potential for minimal harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. 47336 Based on staff interview, review of CMS-2567 reports, and facility QAPI (Quality Assurance and Performance Improvement) Plan, the facility failed to ensure an effective QAPI (Quality Assurance Performance Improvement) process to address previously identified quality deficiencies, resulting in multiple repeat deficiencies identified on the facility's current recertification and complaint survey previously identified during surveys completed in the last ten months. The facility reported a census of 28 residents. Findings include: a. The CMS-2567 form from a recertification survey dated 10/9/23 to 10/12/23 revealed received a no actual harm level citation for care plan revision, assessment/intervention, and drug regimen review. b. The facility's current recertification survey, entrance date 8/12/24, resulted in a no harm level deficient practice for assessment and intervention of residents; care plan revision; comprehensive care plans; and drug regimen reviews. During an interview on 8/15/24 at 3:14, the Administrator queried on how they knew a process was still working and she stated they went back and looked at the process and if it wasn't working they would try different things. The Administrator informed the facility would be cited for care plan revision, assessment/intervention, and the drug regimen review like they were last year. The Administrator asked how she thought the plan of correction went and she stated she thought the last year was difficult with the old DON (Director of Nursing) retiring and getting new staff. She stated she felt they had a good plan of correction, good things in place, just not good follow through. The Facility QAPI Policy for 2024 (no date indicated) revealed the following information: a. The facility put in place systems to monitor care and services, drawing data from multiple sources. Feedback systems actively incorporated input from staff, residents, families, and others as appropriate. It included using performance indicators to monitor a wide range of care processes and outcomes, and reviewing findings against benchmarks and/or goals the facility established for performance. It also included tracking, investigating, and monitoring adverse events every time they occur, and action plans implemented through the plan, do, study, act (PDSA) cycle of improvement to prevent recurrences.