| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175124 | A. Building<br>B. Wing | 12/18/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Lakepoint El Dorado, LLC | 1313 S High Street<br>El Dorado, KS 67042 |

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|---|---|
| F 0623<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37450<br><br>The facility had a census of 55 residents. The sample included 15 residents of which seven were reviewed for hospital discharge. Based on observation, record review, and interview, the facility failed to notify the resident and/or the resident's representative in writing of the reason for the facility-initiated discharge. Further, it failed to send a copy of the notice to the State Long Term Ombudsman (LTCO) for Resident (R) 28, R33, R11, R18, R22, and R41. This placed the residents at risk for uninformed care choices and impaired rights.<br><br>Findings included:<br><br>- R28's Electronic Medical Record (EMR) documented diagnoses of retention of urine, chronic respiratory failure with hypoxia (inadequate supply of oxygen), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), congestive heart failure (CHF - a condition with low heart output and the body becomes congested with fluid), neuromuscular dysfunction of the bladder (the muscles that control the flow of urine out of the body do not relax and prevent the bladder from fully emptying), need for assistance with personal care, encounter for other specified prophylactic (preventative in nature) measures, urinary tract infections (UTI - an infection in any part of the urinary system), resistance to multiple antibiotics, sepsis (a life-threatening systemic reaction that develops due to infections that cause inflammation throughout the entire body), acute kidney failure, and infection and inflammatory reaction due to indwelling urethral catheter (tube placed in the bladder to drain urine into a collection bag).<br><br>The Minimum Data Set (MDS) portion of the EMR documented a Discharge Return Anticipated on 09/12/24, 09/23/24, and 10/31/24.<br><br>(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 0623<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | R28's Significant Change MDS dated [DATE] documented R28 had intact cognition, an acute onset of mental status change, no hallucinations (sensing things while awake that appear to be real, but the mind created) or delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue) but had inattention and disorganized thinking behavior which fluctuated. R28 had a functional range of motion impairment on both sides of lower extremities, required substantial/maximal assistance with oral hygiene and upper body dressing, and was dependent on staff for bathing, lower body dressing, personal hygiene, bed mobility, transfers, and wheeling the wheelchair. The MDS further documented R28 had an indwelling catheter, had oxygen therapy, and received injections, antidepressants (a class of medications used to treat mood disorders), antibiotics (medications used to treat infections), opioids (a class of controlled drugs used to treat pain), and an anticonvulsant (a class of drugs that treat and prevent seizures).<br><br>R28's Care Plan dated 09/16/24 documented R28 had Enhanced Barrier Precautions (EBP - infection control interventions designed to reduce transmission of resistant organisms which employ targeted gown and glove use during high contact care) related to an indwelling urinary catheter and directed staff to gown and glove during high contact resident care activities and to maintain EBP for the duration of her stay or discontinuation of the indwelling medical device.<br><br>The Progress Note dated 09/12/24 at 11:49 AM, documented the physician ordered R28 to be sent to the emergency room or the hospital for direct admission due to the diagnosis of a UTI.<br><br>The Progress Note dated 09/16/24 at 03:51 PM, documented R28 readmitted to the facility.<br><br>The Progress Note dated 09/23/24 at 03:16 AM, documented the physician on call ordered R28 to be sent to the emergency room for evaluation.<br><br>The Progress Note dated 09/26/24 at 01:26 PM, documented R28 readmitted to the facility.<br><br>The Progress Note dated 10/31/24 at 01:55 PM, documented the facility received orders to send R28 to the emergency room .<br><br>The Progress Note dated 11/04/24 at 04:35 PM, documented R28 readmitted to the facility.<br><br>R28's clinical record lacked evidence of a written notification for the transfers above. The facility failed to provide evidence that the notifications were provided to the resident and/or family members and further failed to show evidence that the LTCO was notified.<br><br>On 12/16/24 at 02:33 PM, R28 lay in bed, eyes closed, wearing oxygen nasal cannula, and a catheter drainage bag in a privacy cover which was fastened to the lower portion of the bed frame.<br><br>On 12/17/24 at 02:31 PM, Administrative Staff A and Social Service X reported the resident and residents' representative received an explanation about transfers and the bed hold policy on admission. The resident or resident representative could sign the bed hold agreement specifying bed hold until informed otherwise. The facility did not send one to the resident or representative upon transfers.<br><br>(continued on next page) |

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| F 0623<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 12/18/24 at 09:30 AM, Licensed Nurse (LN) G stated the staff nurses had sent the bed hold policy with the resident upon discharge and had the representative sign for the transfer of the resident, but the process had changed with the new administration of the facility. LN G stated the notification of discharge and bed hold policy is signed upon admission.<br><br>On 12/18/24 at 11:40 AM, Administrative Nurse D reported the facility's consultant had discontinued the notification to the resident and or residents' representative and conveyed that only a signature was required upon admission.<br><br>The facility's undated Emergency transfer of Elder to Another Health Care Facility policy documented the nurse and or neighborhood member notifying the family or legal representative, if not present at the time of the transfer, of the reason and time of the transfer. The nurse or a neighborhood team member will first attempt to contact the family or legal representative by telephone and if not successful, an e-mail and or registered letter, if an address is available. The nurse and/or neighborhood member were to record the name of the family member or legal representative and the time they were notified in the elder's clinical record.<br><br>The facility failed to notify the resident and or the residents' representative in writing of the reason for the facility-initiated transfer/discharge and further failed to notify the LTCO. This placed R28 at risk for uninformed care choices and impaired rights.<br><br>- R33's Electronic Medical Record (EMR) documented diagnoses of shortness of breath, wheezing, pain, personal history of COVID-19 (highly contagious respiratory virus), cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), hemiplegia (paralysis of one side of the body), hemiparesis (muscular weakness of one half of the body), aphasia (condition with disordered or absent language function), chronic obstructive pulmonary disease (COPD - a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), sepsis (a life-threatening systemic reaction that develops due to infections that cause inflammation throughout the entire body) due to Escherichia coli (E.coli - bacteria commonly found in the lower intestine that had the potential to cause infections in the urinary tract with inadequate incontinence care), acute respiratory failure with hypoxia (inadequate supply of oxygen), recurrent depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), bipolar disorder (a major mental illness that causes people to have episodes of severe high and low moods), schizophrenia (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought), altered mental status, and pneumonitis (inflammation of lung tissue) due to inhalation of food and vomit.<br><br>R33's Minimum Data Set (MDS) portion of the EMR documented on 11/13/24 a Discharge-Return was Anticipated.<br><br>(continued on next page) |

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| F 0623<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | R33's Significant Change MDS dated [DATE] documented R33 had intact cognition, no delirium (sudden severe confusion, disorientation, and restlessness) or psychosis (any major mental disorder characterized by a gross impairment in reality perception) and exhibited no behaviors. R33 was dependent on staff for oral care, upper and lower body dressing, bed mobility, and transfers. R33 had coughing or choking during meals, when swallowing medications, and had a mechanically altered diet. The MDS further documented R33 received injections, antipsychotics (a class of medications used to treat major mental conditions that cause a break from reality), antidepressants (a class of medications used to treat mood disorders), anticoagulants (a class of medications used to prevent the blood from clotting), antibiotic (medication used to treat infections) and antiplatelet (medication that prevents forming blood clots).<br><br>R33's Care Plan dated 11/18/24 documented R33 had sepsis related to E-Coli and directed staff to administer antibiotics per physician orders through the end date of 11/23/24.<br><br>The Progress Note dated 11/13/24 at 05:24 AM, documented R33 had a sudden onset of respiratory distress. Staff called Emergency Medical Service (EMS) who transported R33 to the hospital.<br><br>The Progress Note dated 11/18/24 at 03:11 PM, documented R33 readmitted to the facility.<br><br>On 12/17/24 at 07:41 AM, staff propelled R33 to the dining room via wheelchair. R33 was dressed and groomed appropriately for the day, wearing a splint to her right hand. The dietary staff provided R33 with a glass of juice and coffee.<br><br>On 12/17/24 at 02:31 PM, Administrative Staff A and Social Service X reported that the resident and residents' representative received an explanation about the transfer and bed hold policy on admission. The resident or resident's' representative could sign the bed hold agreement at admission, specifying bed hold until the facility was informed otherwise. The facility did not send one to the resident or residents' representative upon transfers.<br><br>On 12/18/24 at 09:30 AM, Licensed Nurse (LN) G stated the staff nurses had sent the bed hold policy with the resident upon discharge and had the residents' representative sign for the transfer of the resident, but the process had changed with the new administration of the facility. LN G stated the notification of discharge and bed hold policy was signed upon admission.<br><br>On 12/18/24 at 11:40 AM, Administrative Nurse D reported the facility consultant had discontinued the notification to the resident and or residents' representative and conveyed that only a signature was required upon admission.<br><br>The facility's undated Emergency transfer of Elder to Another Health Care Facility policy, documented the nurse and or neighborhood team member notified the family or legal representative, if not present at the time of the transfer, of the reason and time of the transfer. The nurse or a neighborhood team member would first attempt to contact the family or legal representative by telephone and if not successful an e-mail and or registered letter was sent if an address was available. The policy directed staff to record the time notified and the name of the person notified in the elder's clinical record.<br><br>(continued on next page) |

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| F 0623<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | The facility failed to notify the resident and or the resident's representative in writing of the reason for the facility-initiated transfer/discharge and further failed to notify the LTCO. This placed R33 at risk for uninformed care choices and impaired rights.<br><br>32360<br><br>- The Electronic Medical Record (EMR) for R11 documented diagnoses of chronic obstructive pulmonary disease (COPD - a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin) type 2, dementia (a progressive mental disorder characterized by failing memory and confusion), chronic respiratory failure (occurs when the lungs are unable to exchange oxygen and carbon dioxide in the blood properly) with hypoxia (inadequate supply of oxygen), hypertension (high blood pressure), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and congestive heart failure (CHF - a condition with low heart output and the body becomes congested with fluid).<br><br>The Admission Minimum Data Set (MDS) dated [DATE] documented R11 had intact cognition and required substantial assistance for toileting, bathing, and lower body dressing. R11 required partial staff assistance for personal hygiene, transfers, mobility, and ambulation. The MDS documented R11 had lower functional impairment on one side, shortness of breath, and received oxygen therapy.<br><br>The Significant Change MDS dated [DATE] documented R11 had intact cognition and required substantial assistance from staff for toileting, bathing, and lower body dressing. R11 required partial assistance for upper body dressing, transfers, and ambulation. The MDS documented R11 had lower functional impairment on one side, had shortness of breath, and received oxygen therapy.<br><br>R11's Care Plan dated 11/15/24 initiated on 02/27/24 directed staff to remind her to keep her oxygen on and staff to monitor her oxygen saturation (percentage of oxygen in the blood) when she had increased confusion. The update dated 11/15/24 directed staff to administer her oxygen as ordered, observe her for changes in respiratory symptoms that may indicate worsening status, and report to the physician. The care plan further directed staff to offer medications when she was short of breath due to anxiety.<br><br>The Nurse's Note, dated 09/27/24 at 10:24 PM, documented R11 felt dizzy during the evening and was taken to her room. R11 was lethargic and unable to assist staff when they laid her down. R11 was taken by Emergency Medical Services (EMS) and admitted to the hospital.<br><br>A review of R11's clinical record lacked evidence the resident or representative was provided written notice of transfer/discharge when she was transferred to the hospital.<br><br>The Nurse's Note dated 10/04/24 at 05:29 PM, documented R11 returned to the facility.<br><br>The Nurse's Note dated 12/02/24 at 10:19 AM, documented R11 felt loopy and wanted to go to the hospital. R11 stated she thought she had spoken to her family that morning and was aware she had not. Staff administered her breathing treatment and notified EMS to transport her to the hospital. R11 was admitted to the hospital with pneumonia (infection in the lungs).<br><br>(continued on next page) |

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| F 0623<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | A review of R11's clinical record lacked evidence the resident or residents' representative was provided written notice of transfer/discharge when she was transferred to the hospital.<br><br>The Nurse's Note dated 12/05/24 at 04:28 PM, documented R11 returned to the facility.<br><br>On 12/17/24 at 08:08 AM, R11 transferred herself from her wheelchair to her recliner and had oxygen on.<br><br>On 12/17/24 at 02:13 PM, Social Service X stated she did not provide written notice to families or residents when they were discharged . Social Service X said that the nursing staff were supposed to do it.<br><br>On 12/18/24 at 09:30 AM, Licensed Nurse (LN) G stated she used to provide written notice to the families when the residents were discharged but was told staff no longer needed to do that.<br><br>On 12/17/2 at 08:50 AM, Administrative Nurse D verified staff no longer provided written notification to the families or residents when they were discharged from the facility.<br><br>The facility's undated Emergency Transfer of Elder to Another Healthcare Facility policy documented the facility would prepare a packet for the elder's transfer and notify the family or legal representative of the reason and time of the transfer. The facility would attempt to contact the family or representative by telephone and if not successful, an e-mail and or registered letter would be sent.<br><br>The facility failed to provide written notification for R11's facility-initiated transfer. This placed the resident at risk for uninformed care choices and impaired rights.<br><br>- The Electronic Medical Record (EMR) for R18 documented diagnoses of cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), hemiparesis/hemiplegia (weakness and paralysis on one side of the body), chronic obstructive pulmonary disease (COPD - a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), and dementia (a progressive mental disorder characterized by failing memory and confusion).<br><br>The Annual Minimum Data Set (MDS) dated [DATE] documented R18 had intact cognition and was dependent upon staff for toileting, transfers, and lower body dressing. R18 required substantial assistance for bathing, upper body dressing, transfers, and mobility. R18 did not ambulate. R18 had upper functional impairment on one side and lower functional impairment on both sides.<br><br>The Quarterly MDS dated [DATE] documented R18 had intact cognition and was dependent upon staff for toileting, mobility, transfers, and lower body dressing. R18 required substantial assistance with showers and partial assistance with personal hygiene. R18 did not ambulate and had upper and lower functional impairment on one side.<br><br>(continued on next page) |

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| F 0623<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | R18's Care Plan dated 10/30/24 and initiated on 03/23/24 directed staff to monitor residents for signs and symptoms of side effects from her medication and notify the physician of any changes in her level of consciousness. The care plan directed staff to encourage R18 to elevate her legs as needed for swelling. The care plan directed staff to encourage her to be up in her electric wheelchair for one hour daily. The plan directed staff to keep fluids at her bedside and within reach.<br><br>The Nurse's Note dated 09/09/24 at 11:30 AM, documented R18 went to the nurse's station and complained the left side of her head felt different. R18's face was symmetrical when smiling, had no drooping, and was not in immediate distress. The nurse's note documented at 10:00 PM, R18 felt she was about to have a stroke and stated she did not want to go to the hospital; her vital signs were taken and within normal range. The note documented at 11:00 PM, R18 changed her mind and wanted to go to the hospital. R18 was admitted to the hospital at 12:00 AM for a possible transient ischemic attack (TIA - temporary episode of inadequate blood supply to the brain).<br><br>A review of R18's clinical record lacked evidence the resident or representative was provided written notice of transfer/discharge when she was transferred to the hospital.<br><br>The Nurse's Note dated 09/12/24 at 03:41 PM, documented R18 returned to the facility.<br><br>On 12/18/24 at 09:52 AM, R18 independently maneuvered her electric wheelchair down the hall.<br><br>On 12/17/24 at 02:13 PM, Social Service X stated she did not provide written notice to families or residents when they were discharged . Social Service X stated that the nursing staff were supposed to do it.<br><br>On 12/18/24 at 09:30 AM, Licensed Nurse (LN) G stated she used to provide written notice to the families when the residents were discharged but was told staff no longer needed to do that.<br><br>On 12/17/2 at 08:50 AM, Administrative Nurse D verified staff no longer provided written notification to the families or residents when they were discharged from the facility.<br><br>The facility's undated Emergency Transfer of Elder to Another Healthcare Facility policy documented the facility would prepare a packet for the elder's transfer and notify the family or legal representative of the reason and time of the transfer. The facility would attempt to contact the family or representative by telephone and if not successful, an e-mail and or registered letter would be sent.<br><br>The facility failed to provide written notification for R18's facility-initiated transfer. This placed the resident at risk for impaired rights or advocate involvement.<br><br>- The Electronic Medical Record (EMR) documented R22 had diagnoses of diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), malignant neoplasm (an abnormal tissue growth, or tumor, that is cancerous and can spread to other parts of the body) of lung and breast, and hypotension (low blood pressure).<br><br>The Admission Minimum Data Set (MDS) dated [DATE] documented R22 had intact cognition and required partial assistance from staff for toileting, lower body dressing, and bathing. R22 required supervision from staff for ambulation and transfers. R22 was independent with mobility and R22 received oxygen therapy.<br><br>(continued on next page) |

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| F 0623<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | The Significant Change MDS dated [DATE] documented R22 had intact cognition and required partial staff assistance for toileting, and bathing. R22 required supervision from staff for upper and lower body dressing, personal hygiene, transfers, and ambulation. R22 was independent with mobility and had no functional impairment. R22 received oxygen therapy.<br><br>R22's Care Plan dated 11/15/24 and initiated on 09/30/24 directed staff to administer medications as ordered, observe for any cognitive changes, and report to the physician. The care plan directed staff to ensure R22 used her oxygen continuously and to notify the physician if she was unable to maintain her oxygen saturation (percentage of oxygen in the blood) or any changes in condition.<br><br>The Nurse's Note dated 11/04/24, documented staff attempted to get R22 out of bed for breakfast and noticed she had a small amount of white bubbly substance on her lips and mouth. Staff obtained her vital signs and were all within normal limits. Staff notified the physician and were directed to send R22 to the hospital.<br><br>A review of R22's clinical record lacked evidence the resident or representative was provided written notice of transfer/discharge when she was transferred to the hospital.<br><br>The Nurse's Note dated 11/11/24 at 04:21 PM, documented R22 returned to the facility.<br><br>On 12/17/24 at 07:35 AM, R22 sat in her recliner eating breakfast. She wore her oxygen.<br><br>On 12/17/24 at 02:13 PM, Social Service X stated she did not provide written notice to families or residents when they were discharged . Social Service X said that the nursing staff were supposed to do it.<br><br>On 12/18/24 at 09:30 AM, Licensed Nurse (LN) G stated she used to provide written notice to the families when the residents were discharged but was told staff no longer needed to do that.<br><br>On 12/17/2 at 08:50 AM, Administrative Nurse D verified staff no longer provided written notification to the families or residents when they were discharged from the facility.<br><br>The facility's undated Emergency Transfer of Elder to Another Healthcare Facility policy documented the facility would prepare a packet for the elder's transfer and notify the family or legal representative of the reason and time of the transfer. The facility would attempt to contact the family or representative by telephone and if not successful, an e-mail and or registered letter would be sent.<br><br>The facility failed to provide written notification for R22's facility-initiated transfer. This placed the resident at risk for impaired rights and uninformed care choices.<br><br>41713<br><br>- R41's Electronic Medical Record (EMR) documented diagnoses of cardiomyopathy (heart disease), congestive heart failure (CHF - a condition with low heart output and the body becomes congested with fluid), atrial fibrillation (A-fib- rapid, irregular heartbeat), and ventricular tachycardia (rapid heartbeat greater than 100 beats per minute of the hearts lower chamber).<br><br>(continued on next page) |

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| F 0623<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | R41's Admission Minimum Data Set (MDS) dated [DATE] documented he had a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. R41 required partial assistance from staff for toileting and personal hygiene. R41 had impairment on one side of both the upper and lower extremities.<br><br>R41's Quarterly MDS dated [DATE] documented he had a BIMS score of 15 which indicated intact cognition. R41 had impairment of both lower extremities and used a wheelchair for assistance with mobility.<br><br>R41's Functional Abilities Care Area Assessment (CAA) dated 02/02/24 documented R41 had impaired balance and transition during transfers and had functional impairment in activity.<br><br>R41's Care Plan last revised 11/27/24 directed staff that the resident and his family were looking at assisted living if an option. Staff was directed to encourage the resident to do as much for himself as he was able. Staff was directed that physical and occupational therapy would continue to work with him to increase his strength and ability to complete his activities of daily living (ADLs) at home independently or with minimal assistance.<br><br>R41's Discharge MDS dated [DATE] documented he had an unplanned discharge to a short-term acute hospital with an anticipated return.<br><br>R41's Entry MDS dated [DATE] documented an entry from a short-term general hospital (acute).<br><br>R41's Discharge MDS dated [DATE] documented his unplanned discharge to a short-term acute hospital, with an anticipated return.<br><br>R41's Entry MDS dated [DATE] documented an entry from a short-term general hospital (acute).<br><br>R41's Discharge MDS dated [DATE] documented his unplanned discharge to a short-term acute hospital, with an anticipated return.<br><br>R41's Entry MDS dated [DATE] documented an entry from a short-term general hospital (acute).<br><br>R41's Discharge MDS dated [DATE] documented his unplanned discharge to a short-term acute hospital with an anticipated return.<br><br>R41's Entry MDS dated [DATE] documented an entry from a short-term general hospital (acute).<br><br>R41's Discharge MDS dated [DATE] documented his unplanned discharge to a short-term acute hospital, with an anticipated return.<br><br>R41's Entry MDS dated [DATE] documented an entry from a short-term general hospital (acute).<br><br>R41's Discharge MDS dated [DATE] documented his unplanned discharge to a short-term acute hospital, with an anticipated return.<br><br>R41's Entry MDS dated [DATE] documented an entry from a short-term general hospital (acute).<br><br>(continued on next page) |

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|---|---|---|---|
| | 175124 | A. Building<br>B. Wing | 12/18/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Lakepoint El Dorado, LLC | 1313 S High Street<br>El Dorado, KS 67042 |

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| F 0623<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | R41's Discharge MDS dated [DATE] documented his unplanned discharge to a short-term acute hospital, with an anticipated return.<br><br>R41's Entry MDS dated [DATE] documented an entry from a short-term general hospital (acute).<br><br>The facility failed to provide evidence that written notification of transfer was issued to R41 for the hospitalization s documented above.<br><br>On 12/17/24 at 11:25 AM, R41 sat in his wheelchair at the dining table eating lunch and visiting with other residents.<br><br>On 12/17/24 at 11:58 AM, Administrative Staff A stated the bed holds were done on admission or re-admission; staff did not complete the bed hold when a resident was discharged or sent out to the hospital.<br><br>On 12/17/24 at 02:05 PM, Social Services X stated she emailed the ombudsman when a resident was discharged or sent to the hospital, but she was not sure who completed the written notification of transfer.<br><br>On 12/18/24 at 01:31 PM, Administrative Nurse D stated she was not aware of any written notification of transfer being completed and mailed to the residents' representative when a resident was sent out to the hospital.<br><br>The undated Emergency Transfer of Elder to Another Health Care Facility policy documented that a nurse or a neighborhood team member would notify the family or legal representative, if they were not present at the time of the transfer, of the reason and time of the transfer. The nurse or neighborhood team members would first attempt to contact by telephone and if not successful would send an e-mail and or a registered letter if an address was available. Staff would record the name of the person and the time they were notified in the elder's clinical record.<br><br>The facility failed to provide written notification of transfer to R41 for his facility-initiated transfers. This deficient practice placed R41 at risk for uninformed care choices. |

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| F 0625<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37450<br><br>The facility had a census of 55 residents. The sample included 15 residents with seven residents reviewed for discharge. Based on observation, record review, and interview, the facility failed to provide six residents with written information regarding the facility bed hold policy when the residents were transferred to the hospital. This placed Resident (R) 28, R33, R11, R18, R22, and R41 at risk for not being permitted to return and resume residence in the nursing facility.<br><br>Findings included:<br><br>- R28's Electronic Medical Record (EMR) documented diagnoses of retention of urine, chronic respiratory failure with hypoxia (inadequate supply of oxygen), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), congestive heart failure (CHF - a condition with low heart output and the body becomes congested with fluid), neuromuscular dysfunction of the bladder (the muscles that control the flow of urine out of the body do not relax and prevent the bladder from fully emptying), need for assistance with personal care, encounter for other specified prophylactic (preventative in nature) measures, urinary tract infections (UTI - an infection in any part of the urinary system), and resistance to multiple antibiotics, sepsis (a life-threatening systemic reaction that develops due to infections that cause inflammation throughout the entire body), acute kidney failure, and infection and inflammatory reaction due to indwelling urethral catheter (tube placed in the bladder to drain urine into a collection bag).<br><br>The Minimum Data Set (MDS), portion of the EMR documented a Discharge Return Anticipated on 09/12/24, 09/23/24, and 10/31/24.<br><br>R28's Significant Change MDS dated [DATE] documented R28 had intact cognition, an acute onset of mental status change, no hallucinations (sensing things while awake that appear to be real, but the mind created) or delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue) but had inattention and disorganized thinking behavior which fluctuated. R28 had a functional range of motion impairment on both sides of lower extremities and required substantial to maximal assistance with oral hygiene and upper body dressing. R28 was dependent on staff for bathing, lower body dressing, personal hygiene, bed mobility, transfers, and wheeling the wheelchair. The MDS further documented R28 had an indwelling catheter, had oxygen therapy, and received injections, antidepressants (a class of medications used to treat mood disorders), antibiotics (medications used to treat infections), opioids (a class of controlled drugs used to treat pain), and an anticonvulsant (a class of drugs that treat and prevent seizures).<br><br>R28's Care Plan dated 09/16/24 documented R28 had Enhanced Barrier Precautions (EBP - infection control interventions designed to reduce transmission of resistant organisms which employ targeted gown and glove use during high contact care) related to an indwelling urinary catheter and directed staff to gown and glove during high contact resident care activities. The care plan directed to maintain EBP for the duration of R28s stay or the discontinuation of the indwelling medical device.<br><br>The Progress Note dated 09/12/24 at 11:49 AM, documented the physician ordered R28 to be sent to the emergency room or direct admission to the hospital for the diagnosis of a UTI.<br><br>(continued on next page) |

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| F 0625<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | The Progress Note dated 09/16/24 at 03:51 PM, documented R28 readmitted to the facility.<br><br>The Progress Note dated 09/23/24 at 03:16 AM, documented the physician on call ordered R28 to be sent to the emergency room for evaluation.<br><br>The Progress Note dated 09/26/24 at 01:26 PM, documented R28 readmitted to the facility.<br><br>The Progress Note dated 10/31/24 at 01:55 PM, documented the facility received orders to send R28 to the emergency room .<br><br>The Progress Note dated 11/04/24 at 04:35 PM, documented the R28 readmitted to the facility.<br><br>R28's clinical record lacked evidence a bed hold policy was provided for the transfers above. The facility was unable to provide evidence the bed-hold policy was provided.<br><br>On 12/16/24 at 02:33 PM, R28 lay in bed, eyes closed, wearing an oxygen nasal cannula, and a catheter drainage bag in a privacy cover, fastened to the lower portion of the bed frame.<br><br>On 12/17/24 at 02:31 PM, Administrative Staff A and Social Service X reported that the resident and residents' representative received an explanation about the transfer and bed hold policy on admission and the resident or resident representative could sign the bed hold agreement specifying bed hold until informed otherwise. The facility did not send one to the resident or representative upon transfers.<br><br>On 12/18/24 at 09:30 AM, Licensed Nurse (LN) G stated the staff nurses had sent the bed hold policy with the resident upon discharge and had the representative sign for the transfer of the resident, but the process had changed with the new administration of the facility. LN G stated that the notification of discharge and bed hold policy was signed upon admission.<br><br>On 12/18/24 at 11:40 AM, Administrative Nurse D reported that the facility consultant had discontinued the notification to the resident and or residents' representative and conveyed that only a signature was required upon admission.<br><br>The facility's Bed Hold policy dated May 2024 documented that the resident and or representatives were informed in writing of the facility and state bed-hold policies, which addressed holding or reserving a resident's bed during periods of absence (hospitalization or therapeutic leave). Residents, regardless of payor source, were provided written notice about these policies upon admission. Reissuance of notice must occur if either the bed-hold policy under the state plan or facility policy changes after the notice is issued.<br><br>The facility failed to provide R28 with a copy of the facility bed hold policy when R28 was transferred to the hospital. This placed the resident at risk for not being permitted to return and resume residence in the nursing facility.<br><br>(continued on next page) |

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| F 0625<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | - R33's Electronic Medical Record (EMR) documented diagnoses of shortness of breath, wheezing, pain, personal history of COVID-19 (highly contagious respiratory virus), cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), hemiplegia (paralysis of one side of the body) and hemiparesis (muscular weakness of one half of the body), aphasia (condition with disordered or absent language function), chronic obstructive pulmonary disease (COPD - a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), sepsis (a life-threatening systemic reaction that develops due to infections that cause inflammation throughout the entire body) due to Escherichia coli (E.coli - bacteria commonly found in the lower intestine that had the potential to cause infections in the urinary tract with inadequate incontinence care), acute respiratory failure with hypoxia (inadequate supply of oxygen), recurrent depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), bipolar disorder (a major mental illness that causes people to have episodes of severe high and low moods), schizophrenia (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought), altered mental status, and pneumonitis (inflammation of lung tissue) due to inhalation of food and vomit.<br><br>R33's Minimum Data Set (MDS) portion of the EMR documented on 11/13/24 a Discharge-Return was Anticipated.<br><br>R33's Significant Change MDS dated [DATE] documented R33 had intact cognition, no delirium (sudden severe confusion, disorientation, and restlessness) or psychosis (any major mental disorder characterized by a gross impairment in reality perception) and exhibited no behaviors. R33 was dependent on staff with oral care, upper and lower body dressing, bed mobility, and transfers. R33 had coughing or choking during meals or when swallowing medications and had a mechanically altered diet. The MDS further documented R33 received injections, antipsychotics (a class of medications used to treat major mental conditions that cause a break from reality), antidepressants (a class of medications used to treat mood disorders), anticoagulants (a class of medications used to prevent the blood from clotting), antibiotic (medication used to treat infections) and antiplatelet (medication that prevents forming blood clots).<br><br>R33's Care Plan dated 11/18/24 documented R33 had sepsis related to E-Coli and directed staff to administer antibiotics per physician orders through the end date of 11/23/24.<br><br>The Progress Note dated 11/13/24 at 05:24 AM, documented R33 had a sudden onset of respiratory distress. Staff called Emergency Medical Service (EMS) who transported R33 to the hospital.<br><br>The Progress Note dated 11/18/24 at 03:11 PM, documented R33 readmitted to the facility.<br><br>R33's clinical record lacked evidence a bed hold policy was provided for the transfers above. The facility was unable to provide evidence the bed-hold policy was provided.<br><br>On 12/17/24 at 07:41 AM, staff propelled R33 to the dining room via wheelchair. R33 was dressed and groomed appropriately for the day, wearing a splint to her right hand. The dietary staff provided R33 with a glass of juice and coffee.<br><br>(continued on next page) |

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| F 0625<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 12/17/24 at 02:31 PM, Administrative Staff A and Social Service X reported that the resident and residents' representative received an explanation about the transfer and bed hold policy on admission and that the resident or residents' representative could sign the bed hold agreement specifying bed hold until informed otherwise. The facility did not send one to the resident or residents' representative upon transfers.<br><br>On 12/18/24 at 09:30 AM, Licensed Nurse (LN) G stated the staff nurses had sent the bed hold policy with the resident upon discharge and had the residents' representative sign for the transfer of the resident, but the process had changed with the new administration of the facility. LN G stated the notification of discharge and bed hold policy is signed upon admission.<br><br>On 12/18/24 at 11:40 AM, Administrative Nurse D reported the facility's consultant had discontinued the notification to the resident and or representative and conveyed that only a signature was required upon admission.<br><br>The facility's Bed Hold policy dated May 2024 documented that the resident and or representatives were informed in writing of the facility and state bed-hold policies, which addressed holding or reserving a resident's bed during periods of absence (hospitalization or therapeutic leave). Residents, regardless of payor source, were provided written notice about these policies upon admission. Reissuance of notice must occur if either the bed-hold policy under the state plan or facility policy changes after the notice is issued.<br><br>The facility failed to provide R33 with a copy of the facility bed hold policy when R33 transferred to the hospital. This placed the resident at risk for not being permitted to return and resume residence in the nursing facility.<br><br>32360<br><br>- The Electronic Medical Record (EMR) for R11 documented diagnoses of chronic obstructive pulmonary disease (COPD - a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin) type 2, dementia (a progressive mental disorder characterized by failing memory and confusion), chronic respiratory failure (occurs when the lungs are unable to exchange oxygen and carbon dioxide in the blood properly) with hypoxia (inadequate supply of oxygen), hypertension (high blood pressure), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid).<br><br>The Admission Minimum Data Set (MDS) dated [DATE] documented R11 had intact cognition and required substantial assistance for toileting, bathing, and lower body dressing. R11 required partial staff assistance for personal hygiene, transfers, mobility, and ambulation. The MDS documented R11 had lower functional impairment on one side, shortness of breath, and received oxygen therapy.<br><br>The Significant Change MDS dated [DATE] documented R11 had intact cognition and required substantial assistance from staff for toileting, bathing, and lower body dressing. R11 required partial assistance for upper body dressing, transfers, and ambulation. The MDS documented R11 had lower functional impairment on one side, had shortness of breath, and received oxygen therapy.<br><br>(continued on next page) |

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| F 0625<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | R11's Care Plan dated 11/15/24, initiated on 02/27/24, directed staff to remind her to keep her oxygen on and staff to monitor her oxygen saturation (percentage of oxygen in the blood) when she had increased confusion. The update dated 11/15/24 directed staff to administer her oxygen as ordered, observe her for changes in respiratory symptoms that may indicate worsening status, and report to the physician. The care plan further directed staff to offer medications when she was short of breath due to anxiety.<br><br>The Nurse's Note, dated 09/27/24 at 10:24 PM documented R11 felt dizzy during the evening and was taken to her room. R11 was lethargic and unable to assist staff when they laid her down. R11 was taken by Emergency Medical Services (EMS) and admitted to the hospital.<br><br>A review of R11's clinical record lacked evidence a copy of the bed hold policy was provided to the resident upon discharge.<br><br>The Nurse's Note dated 10/04/24 at 05:29 PM documented R11 returned to the facility.<br><br>The Nurse's Note dated 12/02/24 at 10:19 AM documented R11 felt loopy and wanted to go to the hospital. R11 stated she thought she had spoken to her family that morning and was aware she had not. Staff administered her breathing treatment and notified EMS to transport her to the hospital. R11 was admitted to the hospital with pneumonia (infection in the lungs).<br><br>A review of R11's clinical record lacked evidence a copy of the bed hold policy was provided to the resident upon discharge.<br><br>The Nurse's Note, dated 12/05/24 at 04:28 PM documented R11 returned to the facility.<br><br>On 12/17/24 at 08:08 AM, R11 transferred herself from her wheelchair to her recliner and had oxygen on.<br><br>On 12/17/24 at 02:13 PM, Social Service X stated upon admission the resident or representative was given the bed hold policy but did not provide the policy every time a resident was discharged .<br><br>On 12/17/2 at 08:50 AM, Administrative Nurse D verified the facility provided the bed hold policy upon admission and did not provide it for every discharge or transfer from the facility.<br><br>The facility's Bed Hold policy dated May 2024 documented that the resident and or representatives were informed in writing of the facility and state bed-hold policies, which addressed holding or reserving a resident's bed during periods of absence (hospitalization or therapeutic leave). Residents, regardless of payor source, were provided written notice about these policies upon admission. Reissuance of notice must occur if either the bed-hold policy under the state plan or facility policy changes after the notice is issued.<br><br>The facility failed to provide R11 with a copy of the facility bed-hold policy when she was transferred to the hospital. This placed the resident at risk for not being permitted to return and resume residence in the nursing facility.<br><br>(continued on next page) |

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| F 0625<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | - The Electronic Medical Record (EMR) for R18 documented diagnoses of cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), hemiparesis/hemiplegia (weakness and paralysis on one side of the body), chronic obstructive pulmonary disease (COPD - a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), and dementia (a progressive mental disorder characterized by failing memory and confusion).<br><br>The Annual Minimum Data Set (MDS) dated [DATE] documented R18 had intact cognition and was dependent upon staff for toileting, transfers, and lower body dressing. R18 required substantial assistance for bathing, upper body dressing, transfers, and mobility. R18 did not ambulate. R18 had upper functional impairment on one side and lower functional impairment on both sides.<br><br>The Quarterly MDS dated [DATE] documented R18 had intact cognition and was dependent upon staff for toileting, mobility, transfers, and lower body dressing. R18 required substantial assistance with showers and partial assistance with personal hygiene. R18 did not ambulate and had upper and lower functional impairment on one side.<br><br>R18's Care Plan dated 10/30/24 and initiated on 03/23/24 directed staff to monitor residents for signs and symptoms of side effects from her medication and notify the physician of any changes in her level of consciousness. The care plan directed staff to encourage R18 to elevate her legs as needed for swelling and encourage her to be up in her electric wheelchair for one hour daily. The plan directed staff to keep fluids at her bedside and within reach.<br><br>The Nurse's Note dated 09/09/24 at 11:30 AM, documented R18 went to the nurse's station and complained the left side of her head felt different. R18's face was symmetrical when smiling, had no drooping, and was not in immediate distress. The nurse's note documented at 10:00 PM, R18 felt she was about to have a stroke and stated she did not want to go to the hospital; her vital signs were taken and within normal range. The note documented at 11:00 PM, R18 changed her mind and wanted to go to the hospital. R18 was admitted to the hospital at 12:00 AM for a possible transient ischemic attack (TIA - temporary episode of inadequate blood supply to the brain).<br><br>A review of R18's clinical record lacked evidence a copy of the bed hold policy was provided to the resident upon discharge.<br><br>The Nurse's Note dated 09/12/24 at 03:41 PM, documented R18 returned to the facility.<br><br>On 12/18/24 at 09:52 AM, R18 independently maneuvered her electric wheelchair down the hall.<br><br>On 12/17/24 at 02:13 PM, Social Service X stated upon admission the resident or representative was given the bed hold policy but did not provide the policy every time a resident was discharged .<br><br>On 12/17/2 at 08:50 AM, Administrative Nurse D verified the facility provided the bed hold policy upon admission and did not provide it for every discharge or transfer from the facility.<br><br>(continued on next page) |

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|---|---|
| F 0625<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | The facility's Bed Hold policy dated May 2024 documented that the resident and or representatives were informed in writing of the facility and state bed-hold policies, which addressed holding or reserving a resident's bed during periods of absence (hospitalization or therapeutic leave). Residents, regardless of payor source, were provided written notice about these policies upon admission. Reissuance of notice must occur if either the bed-hold policy under the state plan or facility policy changes after the notice is issued.<br><br>The facility failed to provide R18 with a copy of the facility bed-hold policy when she was transferred to the hospital. This placed the resident at risk for not being permitted to return and resume residence in the nursing facility.<br><br>- The Electronic Medical Record (EMR) documented R22 had diagnoses of diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), malignant neoplasm (an abnormal tissue growth, or tumor, that is cancerous and can spread to other parts of the body) of lung and breast, and hypotension (low blood pressure).<br><br>The Admission Minimum Data Set (MDS) dated [DATE] documented R22 had intact cognition and required partial assistance from staff for toileting, lower body dressing, and bathing. R22 required supervision from staff for ambulation, transfers, and was independent with mobility. R22 received oxygen therapy.<br><br>The Significant Change MDS dated [DATE] documented R22 had intact cognition and required partial staff assistance for toileting, and bathing. R22 required supervision from staff for upper and lower body dressing, personal hygiene, transfers, and ambulation. R22 was independent with mobility and had no functional impairment. R22 received oxygen therapy.<br><br>R22's Care Plan dated 11/15/24 and initiated on 09/30/24 directed staff to administer medications as ordered, observe for any cognitive changes, and report to the physician. The care plan directed staff to ensure R22 used her oxygen continuously and to notify the physician if she was unable to maintain her oxygen saturation (percentage of oxygen in the blood) or any changes in condition.<br><br>The Nurse's Note dated 11/04/24 documented that staff attempted to get R22 out of bed for breakfast and noticed she had a small amount of white bubbly substance on her lips and mouth. Staff obtained her vital signs and were all within normal limits. Staff notified the physician and was directed to send R22 to the hospital.<br><br>A review of R22's clinical record lacked evidence a copy of the bed hold policy was provided to the resident upon discharge.<br><br>The Nurse's Note, dated 11/11/24 at 04:21 PM, documented R22 returned to the facility.<br><br>On 12/17/24 at 07:35 AM, R22 sat in her recliner eating breakfast. She wore her oxygen.<br><br>On 12/17/24 at 02:13 PM, Social Service X stated upon admission the resident or representative was given the bed hold policy but did not provide the policy every time a resident was discharged .<br><br>On 12/17/2 at 08:50 AM, Administrative Nurse D verified the facility provided the bed hold policy upon admission and did not provide it for every discharge or transfer from the facility.<br><br>(continued on next page) |

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|---|---|---|---|
| | 175124 | A. Building<br>B. Wing | 12/18/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Lakepoint El Dorado, LLC | 1313 S High Street<br>El Dorado, KS 67042 |

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| F 0625<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | The facility's Bed Hold policy dated May 2024 documented that the resident and or representatives were informed in writing of the facility and state bed-hold policies, which addressed holding or reserving a resident's bed during periods of absence (hospitalization or therapeutic leave). Residents, regardless of payor source, were provided written notice about these policies upon admission. Reissuance of notice must occur if either the bed-hold policy under the state plan or facility policy changes after the notice is issued.<br><br>The facility failed to provide R22 with a copy of the facility bed-hold policy when she was transferred to the hospital. This placed the resident at risk for not being permitted to return and resume residence in the nursing facility.<br><br>41713<br><br>- R41's Electronic Medical Record (EMR) documented diagnoses of cardiomyopathy (heart disease), congestive heart failure (CHF - a condition with low heart output and the body becomes congested with fluid), atrial fibrillation (A-fib - rapid, irregular heartbeat), and ventricular tachycardia (rapid heartbeat greater than 100 beats per minute of the hearts lower chamber).<br><br>R41's Admission Minimum Data Set (MDS) dated [DATE] documented he had a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. R41 required partial assistance from staff for toileting and personal hygiene. R41 had impairment on one side of both the upper and lower extremities.<br><br>R41's Quarterly MDS dated [DATE] documented he had a BIMS score of 15 which indicated intact cognition. R41 had impairment of both lower extremities and used a wheelchair for assistance with mobility.<br><br>R41's Functional Abilities Care Area Assessment (CAA) dated 02/02/24 documented R41 had impaired balance and transition during transfers and had functional impairment in activity.<br><br>R41's Care Plan last revised on 11/27/24 directed staff that the resident and his family were looking at assisted living as an option. Staff were directed to encourage the resident to do as much for himself as he could. Staff were directed that physical and occupational therapy continue to work with him to increase his strength and ability to complete his activities of daily living (ADLs) at home independently or with minimal assistance.<br><br>R41's Discharge MDS dated [DATE] documented he had an unplanned discharge to a short-term acute hospital with an anticipated return.<br><br>R41's Entry MDS dated [DATE] documented an entry from a short-term general hospital (acute).<br><br>R41's Discharge MDS dated [DATE] documented his unplanned discharge to a short-term acute hospital, with an anticipated return.<br><br>R41's Entry MDS dated [DATE] documented an entry from a short-term general hospital (acute).<br><br>R41's Discharge MDS dated [DATE] documented his unplanned discharge to a short-term acute hospital, with an anticipated return.<br><br>(continued on next page) |

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| F 0625<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | R41's Entry MDS dated [DATE] documented an entry from a short-term general hospital (acute).<br><br>R41's Discharge MDS dated [DATE] documented he had an unplanned discharge to a short-term acute hospital with an anticipated return.<br><br>R41's Entry MDS dated [DATE] documented an entry from a short-term general hospital (acute).<br><br>R41's Discharge MDS dated [DATE] documented his unplanned discharge to a short-term acute hospital, with an anticipated return.<br><br>R41's Entry MDS dated [DATE] documented an entry from a short-term general hospital (acute).<br><br>R41's Discharge MDS dated [DATE] documented his unplanned discharge to a short-term acute hospital, with an anticipated return.<br><br>R41's Entry MDS dated [DATE] documented an entry from a short-term general hospital (acute).<br><br>R41's Discharge MDS dated [DATE] documented his unplanned discharge to a short-term acute hospital, with an anticipated return.<br><br>R41's Entry MDS dated [DATE] documented an entry from a short-term general hospital (acute).<br><br>The facility was unable to provide evidence that the bed hold policy was provided to R41 for the hospitalization s documented above.<br><br>On 12/17/24 at 11:25 AM, R41 sat in his wheelchair at the dining table eating lunch and visiting with other residents.<br><br>On 12/17/24 at 11:58 AM, Administrative Staff A stated the bed holds were done on admission or re-admission; staff do not complete the bed hold when a resident is sent out to the hospital.<br><br>On 12/17/24 at 02:05 PM, Social Services X stated bed holds were completed on admission and re-admission but not when a resident was sent out to the hospital.<br><br>On 12/18/24 at 01:31 PM, Administrative Nurse D stated she had thought that the bed hold should be provided when a resident was sent out of the facility to the hospital, but the facility had not been doing so.<br><br>The facility's Bed Hold policy dated May 2024 documented that the resident and or the residents' representative would be informed in writing of the facility and stated bed hold policies. The requirement that residents be permitted to return to the facility following hospitalization or therapeutic leave was applied to all residents regardless of payer source. The policy lacks guidance on when the bed hold should be provided to the resident or resident representative.<br><br>The facility failed to provide a bed hold policy to R41 or his representative for his transfers. This deficient practice placed R41 at risk for inability to return to the facility and to the same room. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41713<br><br>The facility identified a census of 55 residents. The sample included 15 residents reviewed for care plans. Based on observation, record review, and interview, the facility failed to ensure staff developed and implemented a comprehensive care plan for Resident (R) 29 that included care and interventions for dialysis (a procedure where impurities or wastes are removed from the blood). The facility failed to develop and implement a comprehensive care plan for R36 to address diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin) and insulin use. This placed R29 and R36 at risk of impaired care due to uncommunicated care needs.<br><br>Findings included:<br><br>- R29's Electronic Medical Record (EMR) documented diagnoses of end-stage renal disease (ESRD - a terminal disease of the kidneys), dependence on renal dialysis, diabetes mellitus, and hypertension (HTN - elevated blood pressure).<br><br>R29's Admission Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. R29 had impairment to both lower extremities and required set up to partial assistance from staff for her activities of daily living (ADLs). R29 used a walker or wheelchair for mobility assistance. R29 received dialysis services.<br><br>R29's Nutritional Status Care Area Assessment (CAA) dated 10/14/24 documented R29 had a high body mass index (BMI). R29's risk factors included weight instability, impaired fluid balance, abnormal lab values, and impaired skin integrity. R29's care plan would be initiated and maintained to maximize dietary and hydration status and monitor dietary and fluid intake.<br><br>R29's Care Plan initiated on 10/15/24 directed staff that she was on a carbohydrate control, regular texture diet, thin liquids, and a 1200 cubic centimeters (cc) fluid restriction. R29's Care Plan lacked a care focus and staff direction for her dialysis care.<br><br>R29's Orders tab in the EMR documented a physician's order for dialysis on Monday, Wednesday, and Friday at 12:00 PM. Obtain her weight and vital signs before and after.<br><br>Review of R29's Progress Notes in the EMR lacked staff documentation of R29 compliance with her fluid restriction.<br><br>On 12/17/24 at 11:45 AM, R29 sat in her wheelchair in her room, near her bedside table. R29 had a large mug beside her on the table and a supply of soda pop in her room. R29 stated she knew that she had the fluid restriction but really did not follow it as she should. R29 stated she enjoyed her pop and was going to drink it even though she should not be due to being on dialysis.<br><br>On 12/18/24 at 10:49 AM, Certified Nurse Aide (CNA) N stated she could not say for certain if R29's care plan addressed her dialysis.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 12/18/24 at 12:13 PM, Licensed Nurse (LN) H stated that after looking over R29's care plan she did not see a care area that addressed and had interventions for her dialysis needs.<br><br>On 12/18/24 at 01:31 PM, Administrative Nurse D stated she had been made aware that R29's care plan lacked a care area for her dialysis and interventions. Administrative Nurse D stated that R29's care plan had been revised to address her dialysis needs.<br><br>The facility's Resident Directed Care Plans undated policy documented it was the policy of the facility to provide an individualized, interdisciplinary plan of care for all residents that was appropriate to the resident's needs, strengths, limitations, and goals based on initial, recurrent, and continual needs of the resident. Care planning would be implemented through the integration of assessment findings, the consideration of the prescribed treatment plan, and the development of goals for the resident that were reasonable and measurable.<br><br>The facility failed to ensure staff developed and implemented a comprehensive care plan for R29 that included care and interventions for dialysis. This placed R29 at risk of impaired care due to uncommunicated care needs.<br><br>37450<br><br>- R36's Electronic Medical Record (EMR) documented diagnoses of edema (swelling resulting from an excessive accumulation of fluid in the body tissues), adult failure to thrive (includes not doing well, feeling poorly, weight loss, and poor self-care that could be seen in elderly individuals), repeated falls, type 2 DM with ketoacidosis (a complication of diabetes in which acids build up in the blood that can be life-threatening), cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), altered mental status, metabolic encephalopathy (a condition in which brain function is disturbed either temporarily or permanently due to different diseases or toxins in the body), sepsis (a life-threatening systemic reaction that develops due to infections that cause inflammation throughout the entire body), chronic pain syndrome and a need for assistance with personal care.<br><br>R36's Quarterly Minimum Data Sheet (MDS) dated [DATE] documented R36 had intact cognition. R36 had no functional range of motion impairments, used a walker, and required setup or clean-up assistance with toileting. R36 was independent with upper and lower body dressing, personal hygiene, and mobility. R36 was frequently incontinent of urine and was continent of bowel. The MDS documented that R36 received a scheduled pain medication regimen, injections of insulin (a hormone that lowers the level of glucose in the blood), diuretic (medication to promote the formation and excretion of urine), opioid (a class of controlled drugs used to treat pain), antiplatelet (medication that prevents forming blood clots), and a hypoglycemic (medication used to lower blood sugar).<br><br>R36's Care Plan dated 12/13/24 documented R36 had a carbohydrate-controlled diet, would have lab work drawn, and results were reported to the physician. The care plan noted R36 had medications administered as ordered and the resident would be offered choices at meals. The care plan lacked direction for diabetic conditions and insulin use.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A History and Physical hospital note dated 08/31/24 documented R36 had a history of severely uncontrolled diabetes mellitus. R36's family reported R36 was diagnosed with a urinary tract infection two to three days prior, had been noncompliant with prescribed antibiotics and the condition worsened in terms of mental status, lethargy, and fatigue. R36 was brought to the emergency department and a workup revealed diabetic ketoacidosis. R36 had been admitted to the intensive care unit for an insulin drip.<br><br>The Physician Order dated 09/03/24 upon admission to the facility, directed staff to administer Insulin Glargine (long-acting insulin used to treat diabetes) 55 units subcutaneously (beneath the skin) daily and Insulin Aspart (a fast-acting insulin that lowers blood sugar in people with diabetes) 18 units with meals related to type 2 diabetes mellitus with hyperglycemia. The orders further directed staff to monitor blood glucose four times a day on Wednesdays and Saturdays related to type 2 diabetes mellitus with ketoacidosis without coma and to call the physician if the blood sugar reading was less than 50 millimeters (mm) or mercury (Hg) and greater than 400 mm/Hg.<br><br>The Registered Dietician (RD) Progress Note dated 10/06/24, documented a review of R36s' chart related to weight and/or low blood sugar. The RD documented low fasting blood sugar a few times a week and wondered about adjusting bedtime insulin, referred to the medical doctor for direction, to offer high protein, and low carb snacks from the kitchen at bedtime.<br><br>On 12/17/24 at 07:44 AM, R36 sat in the dining room eating breakfast independently. Her walker was next to her, and she conversed with other residents at the table.<br><br>On 12/18/24 at 11:34 AM, Administrative Nurse D verified R36 received insulin for the diagnosis of diabetes mellitus and that the care plan lacked guidance for the treatment of diabetic conditions and care.<br><br>The facility's undated Resident Directed Care Plan policy documented the facility was to provide an individualized, interdisciplinary plan of care for all residents that was appropriate to the resident's needs, strengths, limitations, and goals based on initial, recurrent, and continual needs of the resident. The resident care plan would be implemented: through the integration of assessment findings, consideration of the prescribed treatment plan, and the development of reasonable and measurable goals for the resident. The plan of care would be documented through the use of computerized care planning.<br><br>The facility failed to develop a person-centered care plan for R36's diabetes mellitus and use of insulin placing the resident at risk for diabetic complications due to uncommunicated care needs. |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for 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 55 residents. The sample included 15 residents. Based on observation, record review, and interview, the facility failed to follow up with the physician for direction when one resident, Resident (R) 10 became ill with a productive cough and coarse lung sounds. This placed R10 at risk for physical decline and complications due to delayed physician involvement.<br><br>Findings included:<br><br>- The Electronic Medical Record (EMR) for R10 documented diagnoses of chronic obstructive pulmonary disease (COPD - a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), Sjogren's syndrome (an immune system illness that mainly causes dry eyes and dry mouth), and epilepsy (epilepsy (brain disorder characterized by repeated seizures).<br><br>The Admission Minimum Data Set (MDS) dated [DATE] documented R10 had intact cognition and was independent with activities of daily living (ADLs). R10 had shortness of breath with exertion and received oxygen therapy.<br><br>The Significant Change MDS dated [DATE] documented R10 had intact cognition and was independent with ADLs. R10 had shortness of breath, received oxygen therapy, and was on hospice (specialized care that mainly aims to provide comfort and dignity to the patients, by providing physical comfort and emotional, social, and spiritual support for people nearing the end of life).<br><br>R10's Care Plan dated 09/27/24 and initiated 06/03/24 documented R10 required minimal staff assistance with ADLs and received oxygen therapy. The care plan directed staff to cue and assist R10 with oxygen management and assistance with reapplying oxygen when she removed it to ambulate or during locomotion in her wheelchair. The care plan directed staff to notify the physician and resident representative of any changes in condition or cognition.<br><br>The Nurse's Note dated 06/17/24 at 10:35 AM, documented R10 had a productive cough with thick green sputum (a mixture of saliva and mucus coughed up) that cleared with a cough. The note documented the physician was notified and they were awaiting a callback.<br><br>Review of the EMR lacked documentation the staff followed up with the physician when they did not receive direction from the physician for R10's cough.<br><br>The Nurse's Note dated 06/24/24 at 02:38 AM, documented R10 had a harsh cough with coarse lung sounds throughout, and the physician was notified on 06/17/24 but staff could not find where the physician had responded. The note further documented staff had sent a fax to the physician again on 06/24/24 at 02:30 AM and requested a chest X-ray (a type of electromagnetic radiation that can pass through many solid substances, allowing hidden objects to be photographed) and other interventions the physician may deem appropriate.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The return fax from the physician dated 06/24/24 documented R10 needed an appointment and asked the facility how long R10 had symptoms. The fax recorded an appointment for 07/03/24.<br><br>The Physician's Order dated 07/03/24 directed staff to administer azithromycin (an antibiotic medication that treats bacterial infections), 500 milligrams (mg) once, then decrease to 250 mg for four days for the diagnosis of bronchitis (an infection of the airways).<br><br>On 12/16/24 at 09:25 AM, R10 was in her room independently ambulating with her walker. She wore oxygen.<br><br>On 12/18/24 at 09:30 AM, Licensed Nurse (LN) G stated she had sent the original fax to the physician on 06/17/24 but then was off. She said she sent the second fax on 06/24/24. LN G further stated the physician was very hard to get responses from and staff would normally continue to contact the physician until they received a response.<br><br>On 12/18/24 at 12:15 PM, Administrative Nurse D stated staff should have continued to reach out to the physician for direction until they received a response. Administrative Nurse D stated the physician was very hard to get quick responses from.<br><br>The facility's Guidelines for Notifying Physicians of Clinical Problems policy, dated 02/24, documented medical care problems were communicated to the medical staff in a timely, efficient, and effective manner for all significant changes in resident status to be assessed and documented in the medical record. The charge nurse or supervisor was to contact the attending physician at any time they felt a clinical situation required immediate discussion and management.<br><br>The facility failed to follow up with the physician after they had not received a response regarding R10's productive cough. This placed the resident at risk for further physical decline and complications due to delayed physician involvement. |

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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** 41713<br><br>The facility identified a census of 55 residents. The sample included 15 residents with two residents reviewed for accidents. Based on observation, record review, and interview, the facility failed to ensure Resident (R) 42's low air loss mattress (a mattress designed to prevent and treat pressure wounds) was functioning which resulted in an avoidable fall. The facility failed to ensure R50 was assessed for the safe use of a recliner or the need for updated toileting interventions after sustaining falls to prevent further falls. This placed R42 and R50 at risk for preventable falls and possible injuries.<br><br>Findings included:<br><br>- R42's Electronic Medical Record (EMR) documented diagnoses of Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremors, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness), dementia (a progressive mental disorder characterized by failing memory and confusion), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), spinal stenosis (degenerative condition of the spine that could cause weakness and loss of use of extremities), and repeated falls.<br><br>R42's Significant Change Minimum Data Set (MDS) dated [DATE] documented he had both long and short-term memory problems. R42 had severely impaired decision-making skills and showed signs and symptoms of delirium (sudden severe confusion, disorientation, and restlessness). R42 was dependent on staff for all daily functional abilities and activities of daily living (ADLs). R42 had a history of falls and had one fall without injury since the prior assessment. R42 was on hospice services.<br><br>R42's Falls Care Area Assessment (CAA) dated 11/08/24 documented R42 has had an actual fall, had impaired gait and mobility, and the level of assistance required with transfers. The care plan would be initiated and reviewed to coordinate care with hospice.<br><br>R42's Care Plan revised on 10/30/24 directed staff R42 had been found on the floor next to his bed and staff would provide him with a fall mat. The care plan had an intervention initiated on 11/06/24 directing staff that R42 was on a low air-loss mattress.<br><br>R42's Assessment tab in the EMR contained a Fall Risk assessment dated [DATE] that documented R42 as a high risk for falls.<br><br>R42's Assessment tab in the EMR contained a Fall Risk assessment dated [DATE] that documented R42 as a high risk for falls.<br><br>R42's Orders tab documented a physician's order to admit him to hospice.<br><br>R42's EMR documented a Nurse Note dated 10/29/24 at 03:45 PM, documented R42's hospice supplies included: a low air-loss mattress, oxygen concentrator (a machine that provides supplemental oxygen), and high-back wheelchair, which had all been delivered to the facility.<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 | R42's EMR documented a Nurse Note dated 10/30/24 at 09:38 AM, documented he was found face down on the carpet next to his bed. R42's air mattress was not plugged in at the time. R42 had been lethargic and bedridden lately. R42 was assessed, changed due to incontinence of urine, and assisted back to bed. R42 had a noted bruise on his right knee and the second toe on the right foot was bleeding. The physician, representative, and the director of nursing (DON) were notified. A fall mat was placed in the resident's room after the incident. Staff would continue to monitor R42 as needed.<br><br>On 12/18/24 at 10:49 AM, Certified Nurse Aide (CNA) N stated most residents who received hospice services had a low air-loss mattress. CNA N stated she did not mess with the air mattresses, but the aides and nurse were supposed to make sure the mattresses worked properly each shift.<br><br>On 12/18/24 at 12:13 PM, Licensed (LN) H stated when R42 rolled out of bed on 10/30/24 it had been discovered by the staff member that found R42, that his low air-loss mattress had not been turned on. LN H stated R42's bed did not have the bolsters added to it at the time of the fall either. LN H stated R42's bed was in low position at the time of his fall.<br><br>On 12/18/24 at 01:31 PM, Administrative Nurse D stated staff had not made sure that his low air loss mattress had been plugged in which resulted in him rolling out of bed onto the floor. Administrative Nurse D stated interventions had been placed after the incident to ensure this did not happen again.<br><br>The facility's undated High Fall Risk Protocol policy documented each resident would be provided services and care that ensured that the environment was as free from accident hazards as possible. It documented residents would receive adequate supervision, and assistive devices to reduce accidents. Every resident would be assessed for the casual risk factors for falling at the time of admission, upon return from a health care community, and after every fall. Fall reduction and safety considerations included instructions for devices and equipment would be available and followed and associates would be instructed on the appropriate use of equipment.<br><br>The facility failed to ensure R42's low air-loss mattress was functioning properly, which resulted in an avoidable fall. This placed R42 at risk for preventable falls and possible injuries.<br><br>32360<br><br>- The Electronic Medical Record (EMR) for R50 documented diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), and constipation (difficulty passing stools).<br><br>The Admission Minimum Data Set (MDS) dated [DATE]/24 documented R50 had severely impaired cognition. R50 required partial assistance from staff for transfers, bathing, dressing, personal hygiene, mobility, transfers, and ambulation. R50 was frequently incontinent of bladder, and bowel, and was not on a toileting plan. R50 had upper functional impairment on one side and had one fall without injury.<br><br>(continued on next page) |

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|---|---|---|---|
| | 175124 | A. Building<br>B. Wing | 12/18/2024 |

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| Lakepoint El Dorado, LLC | 1313 S High Street<br>El Dorado, KS 67042 |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The Quarterly MDS dated [DATE] documented R50 had severely impaired cognition. R50 required set-up assistance from staff for transfers, eating, toileting, and personal hygiene. R50 was dependent upon staff for assistance with ambulation. R50 was occasionally incontinent of bladder and bowel and was not on a toileting plan. R50 had no functional impairment and had no falls.<br><br>R50's Care Plan dated 12/02/24 and initiated on 05/28/24 directed staff to keep her bed in a low position with the mat on the floor beside the bed/ remind R50 to ask for assistance with transfers and ambulation. The update dated 09/18/24 directed staff to apply Dycem (a non-slip mat used for stabilization and gripping to prevent slipping) to her recliner. The update, dated 09/20/24, documented R50 slid out of her recliner and did not receive any injury. The updated intervention dated 09/21/24 directed staff to provide R50 with non-skid socks.<br><br>The Lift Chair Safety assessment dated [DATE] documented R50 was able to operate the lift chair safely.<br><br>The Fall Risk Assessments dated 05/23/24, 08/16/24, 09/18/24, and 10/25/24 documented R50 was a high risk for falls.<br><br>The Fall Investigation dated 05/23/24 at 10:30 PM, documented R50 fell out of bed, scooted herself off the fall mat, and scooted across the floor to get to the bathroom. R50 had not activated her call light and staff reminded R50 to use her call light for assistance. R50 did not sustain any injuries from the fall.<br><br>The Fall Investigation dated 09/18/24 at 04:28 AM, documented R50 scooted across the floor out into the hallway. Staff asked R50 what she needed, and she stated she needed to go to the bathroom. R50 had activated her call light but did not wait for staff assistance and had not put the footrest of her recliner down and she fell to the floor.<br><br>The Fall Investigation dated 09/20/24 at 05:45 AM, documented R50 did not put the footrest down on her recliner and she slid out of it. R50 was confused and did not sustain any injuries.<br><br>The Fall Investigation dated 09/21/24, documented R50 was found on the floor in the hallway in front of her room, and stated she needed to go to the bathroom. R50 did not sustain any injury and staff provided her with non-skid socks.<br><br>On 12/18/24 at 09:00 AM, Certified Nurse Aide (CNA) M placed a gait belt around R50's waist, had R50 place her hands on the arms of her recliner, push up to stand up in front of her walker. R50 ambulated with CNA M to the bathroom.<br><br>On 12/18/24 at 09:10 AM, Certified Nurse Aide (CNA) M stated R50 had falls because she was impulsive and would not wait for staff assistance. CNA M further stated that R50 has a low bed but preferred to sleep in the recliner and stated the resident can tell staff if she needs toileted.<br><br>On 12/18/24 at 09:20 AM, Licensed Nurse (LN) G stated that R50 does not like to wait for staff assistance and has had falls. LN G said R50 did not like to sleep in her bed, so she stayed in the recliner. LN G said R50 was not on a toileting plan because she could call for assistance, and staff tried to remind her.<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 | On 12/18/24 at 11:30 AM, Administrative Nurse D stated R50 did not have a toileting plan and verified R50 should have since the fall investigations showed that the resident was trying to get to the bathroom. Administrative Nurse D said that normally she would have put R50 on a toileting plan if she had seen that R50 was trying to get to the bathrooms which was the reason R50 had fallen but said she must have missed that information. Administrative Nurse D further verified R50 did not have a bowel and bladder assessment to see if she required a toileting program and would get R50 on a plan.<br><br>The facility's undated Fall Follow-up Protocol policy documented that each elder residing at the facility would be provided services and care that ensured that the environment remained as free from accident hazards as was possible. Every elder would be assessed for the causal risk factors for falling at the time of admission, upon return from a health facility, and after every fall in the facility. After every fall the facility would develop interventions to prevent further falls.<br><br>The facility failed to implement interventions to prevent falls from R50's lift recliner and further failed to identify toileting needs as a causative factor for repeated falls and implement a plan to reduce toileting-related falls. This placed the resident at risk for further falls and injury. |

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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** 41713<br><br>The facility identified a census of 55 residents. The sample included 15 residents with Resident (R) 29 reviewed for dialysis (a procedure where impurities or wastes are removed from the blood), nutrition, and hydration. Based on observation, record review, and interview, the facility failed to ensure R29's physician-ordered fluid restriction was followed, monitored, and documented. This placed R29 at risk of fluid overload and related complications.<br><br>Findings included:<br><br>- R29's Electronic Medical Record (EMR) documented diagnoses of end-stage renal disease (ESRD - a terminal disease of the kidneys), dependence on renal dialysis, diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), and hypertension (HTN - elevated blood pressure).<br><br>R29's Admission Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. R29 had impairment to both lower extremities and required set up to partial assistance from staff for her activities of daily living (ADLs). R29 used a walker or wheelchair for mobility assistance. R29 received dialysis services.<br><br>R29's Nutritional Status Care Area Assessment (CAA) dated 10/14/24 documented R29 had a high body mass index (BMI). R29's risk factors included weight instability, impaired fluid balance, abnormal lab values, and impaired skin integrity. R29's care plan would be initiated and maintained to maximize dietary and hydration status and monitor dietary and fluid intake.<br><br>R29's Care Plan initiated on 10/15/24 directed staff that she was on a carbohydrate control, regular texture diet, thin liquids, and a 1200 cubic centimeters (cc) fluid restriction. R29's Care Plan lacked a care focus and staff direction for her dialysis care.<br><br>R29's Orders tab of the EMR documented a physician's order dated 10/02/24 for a fluid restriction of 1200 milliliters (ml) daily for her end-stage renal disease.<br><br>R29's Orders tab of the EMR documented a physician's order for dialysis on Monday, Wednesday, and Friday at 12:00 PM. Obtain her weight and vital signs before and after.<br><br>R29's 2024 Treatment Administration Record (TAR) for October, November, and December, lacked evidence of monitoring and documentation that reflected R29's daily fluid intake value.<br><br>Review of R29's Progress Notes in the EMR lacked staff documentation of R29 compliance with her fluid restriction.<br><br>On 12/17/24 at 11:45 AM, R29 sat in her wheelchair in her room near her bedside table. R29 had a large mug beside her on the table and a supply of soda pop in her room. R29 stated she knew that she had the fluid restriction but really did not follow it as she should. R29 stated she enjoyed her pop and was going to drink it even though she should not be due to being on dialysis.<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 12/18/24 at 10:49 AM, Certified Nurse Aide (CNA) N stated she could not say for certain or not if R29 was on a fluid restriction.<br><br>On 12/18/24 at 12:13 PM, Licensed Nurse (LN) H stated R29 did have a physician-ordered fluid restriction but R29 was very non-compliant with it. LN H stated R29 would buy soda and keep it in her room, so it was hard to really state or document how much fluid she was drinking. LN H stated that a resident on a fluid restriction should have documentation and monitoring of their fluid intake. LN H confirmed that R29's fluid intake amounts were not being documented anywhere. LN H stated staff should be documenting in the progress notes that R29 was non-compliant with her fluid restriction.<br><br>On 12/18/24 at 01:31 PM, Administrative Nurse D stated R29 was very non-compliant with following her fluid restriction. Administrative Nurse D stated nursing staff should be documenting R29's fluid intake but that was hard to do because R29 had her own supply of soda and drinks in her room that she bought. Administrative Nurse D stated that nursing staff should also be documenting R29's non-compliance with her fluid restriction, notify the provider, and notify the dialysis clinic.<br><br>The facility did not provide a policy regarding fluid restriction as requested.<br><br>The facility failed to ensure that R29's fluid intake related to her fluid restriction was followed, monitored, and documented. This placed R29 at risk of fluid overload and related complications. |

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| F 0699<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care or services that was trauma informed and/or culturally competent.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41713<br><br>The facility identified a census of 55 residents. The sample included 15 residents with one resident reviewed for trauma-informed care (treatment or care directed to prevent re-experiencing or reducing the effects of traumatic events). Based on observation, record review, and interviews, the facility failed to identify trauma-based triggers related to Resident (R) 2's post-traumatic stress disorder (PTSD - mental disorder characterized by an acute emotional response to a traumatic event or situation involving severe environmental stress) and failed to implement individualized interventions to prevent re-traumatization. These deficient practices placed R2 at risk for decreased psychosocial well-being and ineffective treatment.<br><br>Findings included:<br><br>- R2's Electronic Medical Record (EMR) documented diagnosis of cerebrovascular accident (CVA - stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), hemiplegia and hemiparesis (weakness and paralysis on one side of the body), and PTSD.<br><br>R2's Diagnosis tab of the EMR documented a diagnosis of PTSD dated 09/29/22.<br><br>R2's Annual Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. R2 had impairment on one side of both upper and lower extremities. R2 had a diagnosis of PTSD.<br><br>R2's Communication Care Area Assessment (CAA) dated 09/25/24 documented R2's impaired hearing and cognitive loss. R2 also had risk factors for decreased socialization, mood decline, and behavioral issues.<br><br>R2's Trauma Care Plan initiated on 02/22/24 directed staff to identify and mitigate triggers. A trauma-informed care assessment had been completed. Staff were directed that no current triggers were identified. The plan of care lacked individualized trigger-specific interventions that identified ways to decrease exposure to triggers that could re-traumatize her.<br><br>R2's undated Life Stressor Checklist-Revised had multiple questions marked Yes but had not been affected by any of the triggered areas in the past year.<br><br>On 12/18/24 at 10:45 AM, R2 sat in her wheelchair in the activity room with other residents listening to school kids singing Christmas songs.<br><br>On 12/18/24 at 10:47 AM, Certified Nurse Aide (CNA) N stated she was not aware of R2 having a diagnosis of PTSD or what had been the cause of it so she did not know what might be triggers for it.<br><br>(continued on next page) |

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| F 0699<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 12/18/24 at 12:13 PM, Licensed Nurse (LN) H stated R2 did have a current diagnosis of PTSD but could not say what any of the causes of it were. LN H stated that R2's care plan documented she did not have any current triggers. LN H stated the only thing she was aware of was that R2 only wanted to be recognized by her first name on her door sign. LN H stated she did believe that staff should be aware of the trauma she had experienced to provide care appropriately.<br><br>On 12/18/24 at 01:31 PM, Administrative Nurse D stated that a trauma-informed assessment had been completed on R2 but did not have any current triggers. Administrative Nurse D stated that R2's care plan lacked information about her traumas or possible triggers and interventions in place for possible re-traumatization.<br><br>The facility's undated Trauma Informed Care policy documented the facility was committed to implementing trauma-informed approaches to the care provided and the organizational culture created for the residents. Residents who have a trauma history deserved access to care that was trauma-sensitive and behavioral health treatment, as appropriate, that was trauma-specific. A trauma-informed assessment would be completed within 48 hours of admission to determine if a resident had trauma-related symptoms. The interdisciplinary team would discuss the findings of the assessment to determine a resident's treatment plan. Key principles and interventions should include ways to avoid re-traumatization by identifying and managing trauma-related triggers. Staff training should include awareness and knowledge of the impact and consequences of traumatic experiences.<br><br>The facility failed to identify trauma-based triggers related to R2's history of trauma and implement individualized interventions to prevent re-traumatization. These deficient practices placed R2 at risk for decreased psychosocial well-being and ineffective treatment. |

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| F 0756<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 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** 37450<br><br>The facility had a census of 55 residents. The sample included 15 residents with five reviewed for drug regimen. Based on observation, record review, and interview, the facility failed to ensure the Consultant Pharmacist (CP) identified and reported Resident (R)1 and R18's blood pressure medication was administered outside the physician-ordered parameters and R20 and R31s' use of antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) with an unapproved diagnosis. This placed the residents at risk for inappropriate use of medication and related complications.<br><br>Findings included:<br><br>- R1's Electronic Medical Record (EMR) included diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), muscle weakness, major depressive disorder (major mood disorder that causes persistent feelings of sadness), history of falling, dysphagia (swallowing difficulty), chronic obstructive pulmonary disease (COPD - a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), unspecified dementia (a progressive mental disorder characterized by failing memory and confusion), persistent mood disorder, and a need for assistance with personal care.<br><br>R1's Quarterly Minimum Data Set (MDS) dated [DATE] documented R1 had moderately impaired cognition. R1 required substantial/maximal assistance with toileting hygiene, upper body dressing, and personal hygiene; R1 was dependent on staff bathing, chair-to-bed transfers, sit-to-lying, and standing. R1 was frequently incontinent of urine and always continent of bowel. R31 received a scheduled pain medication regimen, antipsychotic, antidepressant (a class of medications used to treat mood disorders), opioid (a class of controlled drugs used to treat pain), antiplatelet (medication that prevents forming blood clots), and anticonvulsant (a class of medication used to treat and prevent seizures).<br><br>R1's Care Plan dated 09/11/24 documented R1 was at risk for complications due to medications with Black Box Warning (BBW - the highest safety-related warning that medications can have assigned by the Food and Drug Administration) including divalproex (anticonvulsant), Lexapro (antidepressant), lisinopril (a medication used to treat high blood pressure), Voltaren gel (topical pain medication), lorazepam (medications used to calm and relax people), and hydrocodone-acetaminophen (medication used to treat pain). The plan directed staff to administer medications as ordered, assess and monitor changes in mental status, and notify the physician of changes in condition or the presence of side effects. The plan documented that staff would review BBW quarterly and as necessary.<br><br>The Physician Order dated 11/01/23 directed staff to administer lisinopril 10 milligrams (mg) daily related to essential hypertension (HTN - elevated blood pressure). The order further directed staff to hold the lisinopril if the systolic blood pressure (SBP - top number, the force your heart exerts on the walls of your arteries each time it beats) above was below 100 and the diastolic blood pressure (DBP - minimum level of blood pressure measured between contractions of the heart; the bottom number of a blood pressure reading) less than 60.<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 - Some | Upon review of R1's Medication Administration Record (MAR), lisinopril 10 mg was administered outside the physician-ordered parameters three times in October 2024, nine times in November 2024, and three times in December 2024.<br><br>R1's MAR for October 2024 documented the following days R1 received the medication when the DBP was under the ordered parameters:<br><br>10/01/24 - 139/57 mmHg<br><br>10/03/24 - 105/43 mmHg<br><br>10/04/24 - 105/58 mmHg<br><br>10/16/24 - 139/56 mmHg<br><br>R1's MAR for November 2024 documented the following days R11 received the medication when the DBP was under the ordered parameters:<br><br>11/13/24 - 120/53 mmHg<br><br>11/14/24 - 143/56 mmHg<br><br>11/16/24 - 126/51 mmHg<br><br>11/17/24 - 118/50 mmHg<br><br>11/20/24 - 130/58 mmHg<br><br>11/21/24 - 122/52 mmHg<br><br>11/22/24 - 129/52 mmHg<br><br>11/27/24 - 126/50 mmHg<br><br>11/30/24 - 141/50 mmHg<br><br>R1's MAR for December 2024 documented the following days R1 received the medication when the DBP was under the ordered parameters:<br><br>12/09/24 - 136/52 mmHg<br><br>12/13/24 - 102/57 mmHg<br><br>12/14/24 - 114/59 mmHg<br><br>Review of the monthly Medications Regimen Reviews (MRR) by the CP from October 2024 through December 2024 lacked evidence the CP identified and reported the lisinopril given outside of physician-ordered parameters.<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 - Some | On 12/17/24 at 07:49 AM, staff brought R1 to the dining room for breakfast. R1 was alert, dressed, and groomed appropriately for the day.<br><br>On 12/18/24 at 11:27 AM, Administrative Nurse D verified that R1's lisinopril should not be administered out of the physician-orders parameters. Administrative Nurse D verified the CP had not identified and reported it.<br><br>The facility's Consultant Pharmacist Services Provider Requirement policy, dated 01/03/19, the consultant pharmacist provides pharmaceutical care services, including but not limited to reviewing the medication regimen of each resident in the care center at least monthly incorporating federally mandated standards of care in addition to other applicable professional standards, and documenting the review and findings. Communicating potential or actual problems detected related to medication therapy orders to the responsible physician and the Director of Nursing. Reviewing MARs and physician orders monthly at the facility to ensure proper documentation of medication orders and administration of medication to residents.<br><br>The facility failed to ensure the CP identified and reported that R1's lisinopril was administered outside of physician-ordered parameters. This placed R1 at risk of unnecessary medication use and related complications.<br><br>- R20's Electronic Medical Record (EMR) included diagnoses of insomnia (inability to sleep), muscle weakness, mood disorder, unspecified dementia (a progressive mental disorder characterized by failing memory and confusion), cognitive-communication deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear) disorder, recurrent depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and cerebrovascular disease (a condition that impact the brain's blood vessels and blood flow).<br><br>The Quarterly Minimum Data Set (MDS) dated [DATE] documented R20 had severe cognitive impairment, had hallucinations (sensing things while awake that appear to be real, but the mind created), delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue), inattention, disorganized thinking, and rejection of care which occurred one to three days of the seven-day look-back period. R20 was dependent on functional abilities and mobility. R20 was always incontinent of bladder and bowel and had pain as evidenced by nonverbal sounds, vocal complaints, facial expressions, and protective body movements. The MDS further documented R20 received an antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality), an antianxiety (a class of medications that calm and relax people), and an opioid (a class of controlled drugs used to treat pain). The antipsychotic was received on a routine basis only and a physician documented gradual dose reduction (GDR) as clinically contraindicated on 05/06/24.<br><br>R20's Behavioral Symptoms Care Plan dated 05/16/24 documented R20 had verbal and physical behavioral symptoms directed at others due to a diagnosis of anxiety disorder, unspecified dementia with behaviors, and mood disorder. The plan directed staff to administer medications as ordered by the physician. The plan listed lorazepam (an antianxiety medication) and quetiapine (an antipsychotic).<br><br>(continued on next page) |

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| | 175124 | A. Building<br>B. Wing | 12/18/2024 |

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| F 0756<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | R20's Antipsychotic Care Plan initiated on 12/14/20, documented R20 was at risk for complications related to her use of antipsychotic medications and listed lorazepam and quetiapine. The care plan directed staff to administer and evaluate effectiveness, monitor for side effects of antipsychotic medication, and notify the physician if there were any changes.<br><br>The Physician Order dated 11/01/23 directed staff to administer quetiapine 50 milligrams (mg) tablet at bedtime related to dementia in other diseases classified elsewhere with behavioral disturbance.<br><br>The Consultant Pharmacist (CP) Review dated 05/02/24 documented R20 received quetiapine 50 mg daily and had a diagnosis of dementia. Antipsychotics should be used with extreme caution in this population due to the increased risk of cardiac death. Antipsychotics are not in compliance with the new guidelines unless the behavior is also harmful to self and others. Please consider a gradual dose reduction to 25 mg daily or consider a trial discontinuation.<br><br>On 05/09/24 the physician responded to the CP review stating R20 worsened after the last dose decrease. The physician did not address the rationale for the diagnosis of dementia associated with the prescribed quetiapine.<br><br>Review of the monthly Medications Regimen Reviews (MRR) by the CP from June 2024 through December 2024 revealed no evidence the CP readdressed the lack of a CMS-approved indication for use or a physician-documented rationale for the continued use of quetiapine.<br><br>On 12/17/24 at 07:49 AM, staff brought R20 to the dining room in a wheelchair, dressed and groomed appropriately for the day. The dietary staff provided the resident with a divided plate and breakfast finger food which she ate independently.<br><br>On 12/18/24 at 12:00 PM, Administrative Nurse D stated she expected the CP to address the use of quetiapine with the unapproved diagnosis of dementia to R20's physician again.<br><br>The facility's Consultant Pharmacist Services Provider Requirement policy dated 01/03/19 documented that the consultant pharmacist provided pharmaceutical care services, including but not limited to reviewing the medication regimen of each resident in the care center at least monthly, incorporating federally mandated standards of care in addition to other applicable professional standards, and documenting the review and findings. Communicating potential or actual problems detected related to medication therapy orders to the responsible physician and the Director of Nursing. Reviewing MARs and physician orders monthly at the facility to ensure proper documentation of medication orders and administration of medication to residents.<br><br>The facility failed to ensure the CP identified and reported that R20's administration of quetiapine for the diagnosis of dementia placed the resident at risk of unapproved medication use.<br><br>32360<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 - Some | - The Electronic Medical Record (EMR) for R18 documented diagnoses of cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), hemiparesis/hemiplegia (weakness and paralysis on one side of the body), chronic obstructive pulmonary disease (COPD - a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), dementia (a progressive mental disorder characterized by failing memory and confusion), and hypertension (high blood pressure).<br><br>The Annual Minimum Data Set (MDS) dated [DATE] documented R18 had intact cognition and was dependent upon staff for toileting, transfers, and lower body dressing. R18 required substantial assistance for bathing, upper body dressing, transfers, and mobility. R18 did not ambulate. The MDS documented R18 received an anticoagulant (a class of medications used to prevent the blood from clotting), an antidepressant (a class of medications used to treat mood disorders), and a diuretic (a medication to promote the formation and excretion of urine).<br><br>The Quarterly MDS dated [DATE] documented R18 had intact cognition and was dependent upon staff for toileting, mobility, transfers, and lower body dressing. R18 required substantial assistance with showers and partial assistance with personal hygiene. R18 did not ambulate and had upper and lower functional impairment on one side. The MDS documented R18 received anticoagulant (a class of medications used to prevent the blood from clotting), antidepressant (a class of medications used to treat mood disorders), and diuretic (a medication to promote the formation and excretion of urine).<br><br>R18's Care Plan dated 10/30/24 and initiated on 03/03/24 documented R18 received medications with a Black Box Warning (BBW - highest safety-related warning that medications can have assigned by the Food and Drug Administration) and directed staff to administer medications as ordered, monitor for signs and symptoms of side effects, notify the physician of any changes in mood, behavior, or cognition, and monitor lab work as ordered.<br><br>The Physician's Order dated 11/01/23 directed staff to administer amlodipine (high blood pressure medication), 5 milligrams (mg), one tablet, by mouth, daily for hypertension. Hold the medication if R18's systolic blood pressure (SBP - the top number that measures the force the heart exerts on the walls of the arteries each time it beats) was 120 millimeters of mercury (mmHg) or less and hold the medication if the diastolic blood pressure (DBP - minimum level of blood pressure measured between contractions of the heart; the bottom number of a blood pressure reading) was 70 mmHg or less.<br><br>R18's Medication Administration Record: (MAR) for October 2024 documented the following days R18 received the amlodipine when the DBP was under the ordered parameters:<br><br>10/01/24 - 159/60 mmHg<br><br>10/03/24 - 140/63 mmHg<br><br>10/08/24 - 133/61 mmHg<br><br>10/10/24 - 156/65 mmHg<br><br>10/16/24 - 138/66 mmHg<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 - Some | 10/31/24 - 130/59 mmHg<br><br>R18's MAR for November 2024 documented the following days R18 received the amlodipine when the DBP was under the ordered parameters:<br><br>11/03/24 - 134/64 mmHg<br><br>11/13/24 - 150/60 mmHg<br><br>11/17/24 - 148/65 mmHg<br><br>11/18/24 - 121/69 mmHg<br><br>11/25/24 - 150/61 mmHg<br><br>11/29/24 - 119/62 mmHg<br><br>11/30/24 - 129/58 mmHg<br><br>R18's MAR for December 2024 documented the following days R18 received the amlodipine when the DBP was under the ordered parameters:<br><br>12/09/24 - 148/60 mmHg<br><br>12/14/24 - 132/62 mmHg<br><br>12/17/24 - 133/63 mmHg<br><br>The Physician's Order, dated 11/01/23, directed staff to administer hydralazine hci (a blood pressure medication), 25 mg, by mouth, twice per day for hypertension. Hold the medication if R18's systolic blood pressure was 120 mmHg or less and hold the medication if the diastolic blood pressure was 70 mmHg or less.<br><br>The Medication Administration Record (MAR) for October 2024 documented the following days R18 received the hydralazine when the DBP was under the ordered parameters:<br><br>10/01/24 - 159/60 mmHg<br><br>10/03/24 - 140/63 mmHg<br><br>10/08/24 - 133/61 mmHg<br><br>10/10/24 - 156/65 mmHg<br><br>10/16/24 - 138/66 mmHg<br><br>10/31/24 - 130/59 mmHg<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 - Some | R18's MAR for November 2024 documented the following days R18 received the hydralazine when the DBP was under the ordered parameters:<br><br>11/03/24 - 134/64 mmHg<br><br>11/13/24 - 150/60 mmHg<br><br>11/17/24 - 148/65 mmHg<br><br>11/18/24 - 121/69 mmHg<br><br>11/25/24 - 150/61 mmHg<br><br>11/29/24 - 119/62 mmHg<br><br>11/30/24 - 129/58 mmHg<br><br>R18's MAR for December 2024 documented the following days R18 received the hydralazine when the DBP was under the ordered parameters:<br><br>12/01/24 - 124/65 mmHg<br><br>12/09/24 - 148/60 mmHg<br><br>12/14/24 - 132/62 mmHg<br><br>12/17/24 - 133/63 mmHg<br><br>The 'Physician's Order dated 11/01/23 directed staff to administer hydrochlorothiazide (HCTZ-a blood pressure medication), 12.5 mg, by mouth in the morning. Hold the medication if R18's systolic blood pressure was 120 mmHg or less and hold the medication if the diastolic blood pressure was 70 mmHg or less.<br><br>R18's MAR for October 2024 documented the following days R18 received the HCTZ when the DBP was under the ordered parameters:<br><br>10/01/24 - 159/60 mmHg<br><br>10/03/24 - 140/63 mmHg<br><br>10/08/24 - 133/61 mmHg<br><br>10/10/24 - 156/65 mmHg<br><br>10/16/24 - 138/66 mmHg<br><br>10/31/24 - 130/59 mmHg<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 - Some | R18's MAR for November 2024 documented the following days R18 received the HCTZ when the DBP was under the ordered parameters:<br><br>11/03/24 - 134/64 mmHg<br><br>11/13/24 - 150/60 mmHg<br><br>11/17/24 - 148/65 mmHg<br><br>11/18/24 - 121/69 mmHg<br><br>11/25/24 - 150/61 mmHg<br><br>11/29/24 - 119/62 mmHg<br><br>11/30/24 - 129/58 mmHg<br><br>R18's MAR for December 2024 documented the following days R18 received the HCTZ when the DBP was under the ordered parameters:<br><br>12/01/24 - 124/65 mmHg<br><br>12/09/24 - 148/60 mmHg<br><br>12/14/24 - 132/62 mmHg<br><br>12/17/24 - 133/63 mmHg<br><br>The Physician's Order, dated 11/01/24, directed staff to administer Losartan (a blood pressure medication), 25 mg, by mouth, in the morning. Hold the medication if R18's systolic blood pressure was 120 mmHg or less and hold the medication if the diastolic blood pressure was 70 mmHg or less.<br><br>R18's MAR for October 2024 documented the following days R18 received the medication when the DBP was under the ordered parameters:<br><br>10/01/24 - 159/60 mmHg<br><br>10/03/24 - 140/63 mmHg<br><br>10/08/24 - 133/61 mmHg<br><br>10/10/24 - 156/65 mmHg<br><br>10/16/24 - 138/66 mmHg<br><br>10/31/24 - 130/59 mmHg<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 - Some | R18's MAR for November 2024 documented the following days R18 received the medication when the DBP was under the ordered parameters:<br><br>11/03/24 - 134/64 mmHg<br><br>11/13/24 - 150/60 mmHg<br><br>11/17/24 - 148/65 mmHg<br><br>11/18/24 - 121/69 mmHg<br><br>11/25/24 - 150/61 mmHg<br><br>11/29/24 - 119/62 mmHg<br><br>11/30/24 - 129/58 mmHg<br><br>R18's MAR for December 2024 documented the following days R18 received the medication when the DBP was under the ordered parameters:<br><br>12/01/24 - 124/65 mmHg<br><br>12/09/24 - 148/60 mmHg<br><br>12/14/24 - 132/62 mmHg<br><br>12/17/24 - 133/63 mmHg<br><br>Review of the monthly Medications Regimen Reviews (MRR) by the CP from October 2024 through December 2024 lacked evidence the CP identified and reported the amlodipine, HCTZ, Losartan, and hydralazine were given outside of physician-ordered parameters.<br><br>On 12/17/24 at 08:03 AM, Certified Medication Aide (CMA) R administered all of R18's morning medications to her. CMA R revealed she had already taken R18's blood pressure, and it was 133/63 mmHg. CMA R said she was unsure of what R18's parameters were, and she agreed to look up the parameters. Upon review, CMA R said she realized she had mistakenly administered R18's blood pressure medications when the DBP was out of parameters.<br><br>On 12/17/24 at 08:15 AM, Administrative Nurse D stated she had not been notified by the CP of the medications given when the blood pressure was out of parameters.<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 - Some | The facility's Consultant Pharmacist Services Provider Requirement policy dated 01/03/19 documented that the consultant pharmacist provided pharmaceutical care services, including but not limited to reviewing the medication regimen of each resident in the care center at least monthly, incorporating federally mandated standards of care, in addition to other applicable professional standards, and documenting the review and findings. Communicating potential or actual problems detected related to medication therapy orders to the responsible physician and the Director of Nursing. Reviewing MARs and physician orders monthly at the facility to ensure proper documentation of medication orders and administration of medication to residents.<br><br>The facility failed to ensure the CP identified and reported that R18's blood pressure medications were administered outside of physician-ordered parameters. This placed R18 at risk of unnecessary medication use and related complications.<br><br>41713<br><br>- R31's Electronic Medical Record (EMR) documented diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion) with behavioral disturbances, major depressive disorder (major mood disorder that causes persistent feelings of sadness), bipolar disorder (a major mental illness that causes people to have episodes of severe high and low moods), and hypertension (HTN - elevated blood pressure)<br><br>R31's Significant Change Minimum Data Set (MDS) dated [DATE] documented she had both short and long-term memory problems. R31 had severely impaired cognitive skills for daily decision-making. R31 had continuous behaviors of inattention and disorganized thinking. R31 had delusions (untrue persistent beliefs or perceptions held by a person although evidence shows it was untrue). R31 had impairment on both sides of her lower extremities. R31 required partial to substantial assistance from staff for her functional abilities and activities of daily living (ADLs). R31 received antipsychotics (a class of medications used to treat major mental conditions that cause a break from reality) and antidepressants (a class of medications used to treat mood disorders) mediations during the look-back period.<br><br>R31's Quarterly MDS dated [DATE] documented both short and long-term memory problems. R31 had severely impaired cognitive skills for daily decision-making. R31 had continuous behaviors of inattention and disorganized thinking. R31 had impairment on both sides of her lower extremities. R31 required substantial assistance to being dependent on staff for her functional abilities and ADLs. R31 received antipsychotics and antidepressant medications during the look-back period.<br><br>R31's Psychotropic Drug Use Care Area Assessment (CAA) dated 01/25/24 documented she used psychotropic (alters mood or thought) medications to manage her psychiatric condition. The licensed nurse should monitor for medication side effects each shift and notify the physician of any abnormal findings. A pharmacist consultant would review the medications monthly, and the provider would review the medications with each visit.<br><br>R31's Care Plan last revised on 10/24/24 directed staff to administer psychotropic medications as directed. The consultant pharmacist would do routine drug evaluations.<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 - Some | R31's Orders tab of the EMR documented a physician's order dated 10/28/23 for Seroquel (an antipsychotic medication) to give 10 milligrams (mg) two times daily related to her dementia. This order was discontinued on 12/08/23.<br><br>R31's Orders tab of the EMR documented an order dated 12/08/23 for Seroquel 50 mg to be given by mouth twice daily for dementia.<br><br>R31's clinical records lacked a physician's documented clinical rationale for the continued use of Seroquel or an approved indication for use. The facility was unable to provide this information upon request.<br><br>Review of the monthly Medications Regimen Reviews (MRR) by the CP from November 2023 to the present revealed no recommendation for a CMS approved indication for use for the antipsychotic medication Seroquel.<br><br>On 12/17/24 at 12:26 PM, R31 rested in her bed. R31's bed was in a low position and her call light was within reach.<br><br>On 12/18/24 at 12:13 PM, Licensed Nurse (LN) I stated R31 did have dementia and had been taking Seroquel. LN I stated she knew that psychotropic medications should not be used for dementia and was not sure if the physician had attempted to change the diagnosis or the need for the use of Seroquel.<br><br>On 12/18/24 at 01:31 PM, Administrative Nurse D stated the facility had been working on the psychotropic medication use and working on getting the physicians to avoid or quit prescribing antipsychotic medication altogether. Administrative Nurse D stated that R2 did not have an appropriate indication for the use of Seroquel.<br><br>The Consultant Pharmacist Services Provider Requirements policy updated 01/03/19 documented the consultant pharmacist reviewed the Medication Administration Record (MARS) and the physician orders monthly to ensure proper documentation of the medication orders and administration of medication to residents. The appropriate review was documented in the resident's clinical record.<br><br>The Drug Regimen Review policy documented the consultant pharmacist would perform a drug regimen review on each resident living in the facility at the time of admission and at least monthly but no longer than every six months. All medications would be reviewed for adequate and appropriate indications for each ordered medication; the need for gradual dose reduction based on the manufacturer's recommendations and regulatory requirements.<br><br>The facility failed to ensure the CP identified and reported that R31 had a non-CMS approved indication for use of antipsychotic medication. This placed the resident at risk for unnecessary medications and related complications. |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident's drug regimen must be free from unnecessary drugs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32360<br><br>The facility had a census of 55 residents. The sample included 15 residents, with five reviewed for unnecessary medications. Based on observation, record review, and interview, the facility failed to hold blood pressure medications per the physician-ordered parameters for two residents, Resident (R) 18 and R1. This placed the resident at risk for physical decline and other related complications.<br><br>Findings included:<br><br>- The Electronic Medical Record (EMR) for R18 documented diagnoses of cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), hemiparesis/hemiplegia (weakness and paralysis on one side of the body), chronic obstructive pulmonary disease (COPD - a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), dementia (a progressive mental disorder characterized by failing memory and confusion), and hypertension (high blood pressure).<br><br>The Annual Minimum Data Set (MDS) dated [DATE] documented R18 had intact cognition and was dependent upon staff for toileting, transfers, and lower body dressing. R18 required substantial assistance for bathing, upper body dressing, transfers, and mobility. R18 did not ambulate. The MDS documented R18 received an anticoagulant (a class of medications used to prevent the blood from clotting), an antidepressant (a class of medications used to treat mood disorders), and a diuretic (a medication to promote the formation and excretion of urine).<br><br>The Quarterly MDS dated [DATE] documented R18 had intact cognition and was dependent upon staff for toileting, mobility, transfers, and lower body dressing. R18 required substantial assistance with showers and partial assistance with personal hygiene. R18 did not ambulate and had upper and lower functional impairment on one side. The MDS documented R18 received anticoagulant (a class of medications used to prevent the blood from clotting), antidepressant (a class of medications used to treat mood disorders), and diuretic (a medication to promote the formation and excretion of urine). The MDS documented R18 received an anticoagulant (a class of medications used to prevent the blood from clotting), an antidepressant (a class of medications used to treat mood disorders), and a diuretic (a medication to promote the formation and excretion of urine).<br><br>R18's Care Plan dated 10/30/24 and initiated on 03/03/24 documented R18 received medications with a Black Box Warning (BBW - highest safety-related warning that medications can have assigned by the Food and Drug Administration) and directed staff to administer medications as ordered. Staff were to monitor for signs and symptoms of side effects, notify the physician of any changes in mood, behavior, or cognition, and monitor lab work as ordered.<br><br>(continued on next page) |

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| | 175124 | A. Building<br>B. Wing | 12/18/2024 |

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|---|---|
| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The Physician's Order dated 11/01/23 directed staff to administer amlodipine (high blood pressure medication), 5 milligrams (mg), one tablet, by mouth, daily for hypertension. Hold the medication if R18's systolic blood pressure (SBP - the top number that measures the force the heart exerts on the walls of the arteries each time it beats) was 120 millimeters of mercury (mmHg) or less and hold the medication if the diastolic blood pressure (DBP - minimum level of blood pressure measured between contractions of the heart; the bottom number of a blood pressure reading) was 70 mmHg or less.<br><br>R18's Medication Administration Record (MAR) for October 2024 documented the following days R18 received the amlodipine when the DBP was under the ordered parameters:<br><br>10/01/24 - 159/60 mmHg<br><br>10/03/24 - 140/63 mmHg<br><br>10/08/24 - 133/61 mmHg<br><br>10/10/24 - 156/65 mmHg<br><br>10/16/24 - 138/66 mmHg<br><br>10/31/24 - 130/59 mmHg<br><br>R18's MAR for November 2024 documented the following days R18 received the amlodipine when the DBP was under the ordered parameters:<br><br>11/03/24 - 134/64 mmHg<br><br>11/13/24 - 150/60 mmHg<br><br>11/17/24 - 148/65 mmHg<br><br>11/18/24 - 121/69 mmHg<br><br>11/25/24 - 150/61 mmHg<br><br>11/29/24 - 119/62 mmHg<br><br>11/30/24 - 129/58 mmHg<br><br>R18's MAR for December 2024 documented the following days R18 received the amlodipine when the DBP was under the ordered parameters:<br><br>12/09/24 - 148/60 mmHg<br><br>12/14/24 - 132/62 mmHg<br><br>12/17/24 - 133/63 mmHg<br><br>(continued on next page) |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The Physician's Order, dated 11/01/23, directed staff to administer hydralazine hci (a blood pressure medication), 25 mg, by mouth, twice per day for hypertension. Hold the medication if R18's systolic blood pressure was 120 mmHg or less and hold the medication if the diastolic blood pressure was 70 mmHg or less.<br><br>The Medication Administration Record (MAR) for October 2024 documented the following days R18 received the hydralazine when the DBP was under the ordered parameters:<br><br>10/01/24 - 159/60 mmHg<br><br>10/03/24 - 140/63 mmHg<br><br>10/08/24 - 133/61 mmHg<br><br>10/10/24 - 156/65 mmHg<br><br>10/16/24 - 138/66 mmHg<br><br>10/31/24 - 130/59 mmHg<br><br>R18's MAR for November 2024 documented the following days R18 received the hydralazine when the DBP was under the ordered parameters:<br><br>11/03/24 - 134/64 mmHg<br><br>11/13/24 - 150/60 mmHg<br><br>11/17/24 - 148/65 mmHg<br><br>11/18/24 - 121/69 mmHg<br><br>11/25/24 - 150/61 mmHg<br><br>11/29/24 - 119/62 mmHg<br><br>11/30/24 - 129/58 mmHg<br><br>R18's MAR for December 2024 documented the following days R18 received the hydralazine when the DBP was under the ordered parameters:<br><br>12/01/24 - 124/65 mmHg<br><br>12/09/24 - 148/60 mmHg<br><br>12/14/24 - 132/62 mmHg<br><br>12/17/24 - 133/63 mmHg<br><br>(continued on next page) |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The 'Physician's Order dated 11/01/23 directed staff to administer hydrochlorothiazide (HCTZ - a blood pressure medication), 12.5 mg, by mouth in the morning. Hold the medication if R18's systolic blood pressure was 120 mmHg or less and hold the medication if the diastolic blood pressure was 70 mmHg or less.<br><br>R18's MAR for October 2024 documented the following days R18 received the HCRTZ when the DBP was under the ordered parameters:<br><br>10/01/24 - 159/60 mmHg<br><br>10/03/24 - 140/63 mmHg<br><br>10/08/24 - 133/61 mmHg<br><br>10/10/24 - 156/65 mmHg<br><br>10/16/24 - 138/66 mmHg<br><br>10/31/24 - 130/59 mmHg<br><br>R18's MAR for November 2024 documented the following days R18 received the HCTZ when the DBP was under the ordered parameters:<br><br>11/03/24 - 134/64 mmHg<br><br>11/13/24 - 150/60 mmHg<br><br>11/17/24 - 148/65 mmHg<br><br>11/18/24 - 121/69 mmHg<br><br>11/25/24 - 150/61 mmHg<br><br>11/29/24 - 119/62 mmHg<br><br>11/30/24 - 129/58 mmHg<br><br>R18's MAR for December 2024 documented the following days R18 received the HCTZ when the DBP was under the ordered parameters:<br><br>12/01/24 - 124/65 mmHg<br><br>12/09/24 - 148/60 mmHg<br><br>12/14/24 - 132/62 mmHg<br><br>12/17/24 - 133/63 mmHg<br><br>(continued on next page) |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The Physician's Order dated 11/01/24 directed staff to administer Losartan (a blood pressure medication), 25 mg, by mouth, in the morning. Hold the medication if R18's systolic blood pressure was 120 mmHg or less and hold the medication if the diastolic blood pressure was 70 mmHg or less.<br><br>R18's MAR for October 2024 documented the following days R18 received the medication when the DBP was under the ordered parameters:<br><br>10/01/24 - 159/60 mmHg<br><br>10/03/24 - 140/63 mmHg<br><br>10/08/24 - 133/61 mmHg<br><br>10/10/24 - 156/65 mmHg<br><br>10/16/24 - 138/66 mmHg<br><br>10/31/24 - 130/59 mmHg<br><br>R18's MAR for November 2024 documented the following days R18 received the medication when the DBP was under the ordered parameters:<br><br>11/03/24 - 134/64 mmHg<br><br>11/13/24 - 150/60 mmHg<br><br>11/17/24 - 148/65 mmHg<br><br>11/18/24 - 121/69 mmHg<br><br>11/25/24 - 150/61 mmHg<br><br>11/29/24 - 119/62 mmHg<br><br>11/30/24 - 129/58 mmHg<br><br>R18's MAR for December 2024 documented the following days R18 received the medication when the DBP was under the ordered parameters:<br><br>12/01/24 - 124/65 mmHg<br><br>12/09/24 - 148/60 mmHg<br><br>12/14/24 - 132/62 mmHg<br><br>12/17/24 - 133/63 mmHg<br><br>(continued on next page) |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 12/17/24 at 08:03 AM, Certified Medication Aide (CMA) R administered all of R18's morning medications to her. CMA R revealed she had already taken R18's blood pressure, and it was 133/63 mmHg. CMA R said she was unsure of what R18's parameters were and she agreed to look up the parameters. Upon review, CMA R said she realized she had mistakenly administered R18's blood pressure medications when the DBP was out of parameters.<br><br>On 12/17/24 at 08:15 AM, Administrative Nurse D stated CMA R should have checked the blood pressure parameters and held the medications.<br><br>On 12/18/4 at 09:30 AM, Licensed Nurse (LN) G stated the CMAs are supposed to tell the nurse if the resident's blood pressure is outside of the parameters and that the medication was held.<br><br>The facility did not provide a policy for administering blood pressure medications or blood pressure parameters.<br><br>The facility failed to hold blood pressure medications for R18 when her blood pressure was out of the physician-ordered parameters. This placed the resident at risk for physical decline and other related complications.<br><br>37450<br><br>- R1's Electronic Medical Record (EMR) included diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), muscle weakness, major depressive disorder (major mood disorder that causes persistent feelings of sadness), history of falling, dysphagia (swallowing difficulty), chronic obstructive pulmonary disease (COPD - a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), unspecified dementia (a progressive mental disorder characterized by failing memory and confusion), persistent mood disorder, and a need for assistance with personal care.<br><br>R1's Quarterly Minimum Data Set (MDS) dated [DATE] documented R1 had moderately impaired cognition. R1 required substantial/maximal assistance with toileting hygiene, upper body dressing, and personal hygiene; R1 was dependent for bathing, chair-to-bed transfers, sit-to-lying, and standing. R1 was frequently incontinent of urine and always continent of bowel. R31 received a scheduled pain medication regimen, antipsychotic, antidepressant (a class of medications used to treat mood disorders), opioid (a class of controlled drugs used to treat pain), antiplatelet (medication that prevents forming blood clots), and anticonvulsant (a class of medication used to treat and prevent seizures).<br><br>R1's Care Plan dated 09/11/24 documented R1 was at risk for complications due to medications with Black Box Warning (BBW - highest safety-related warning that medications can have assigned by the Food and Drug Administration) including divalproex (an anticonvulsant), Lexapro (antidepressant), lisinopril (a medication used to treat high blood pressure), Voltaren gel (topical pain medication), lorazepam (medications used to calm and relax people), and hydrocodone-acetaminophen (medication used to treat pain). The plan directed staff to administer medications as ordered, assess and monitor changes in mental status, and notify the physician of changes in condition or the presence of side effects. The care plan documented staff would review BBW quarterly and as necessary.<br><br>(continued on next page) |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The Physician Order dated 11/01/23, directed staff to administer lisinopril 10 milligrams (mg) daily related to essential hypertension (HTN - elevated blood pressure). The order further directed staff to hold the lisinopril if the systolic blood pressure (SBP - top number, the force your heart exerts on the walls of your arteries each time it beats) above was below 100 and the diastolic blood pressure (DBP - minimum level of blood pressure measured between contractions of the heart; the bottom number of a blood pressure reading) less than 60.<br><br>Upon review of R1's Medication Administration Record (MAR) lisinopril 10 mg was administered outside the physician-ordered parameters three times in October 2024, nine times in November 2024, and three times in December 2024.<br><br>R1's MAR for October 2024 documented the following days R1 received the medication when the DBP was under the ordered parameters:<br><br>10/01/24 - 139/57 mmHg<br><br>10/03/24 - 105/43 mmHg<br><br>10/04/24 - 105/58 mmHg<br><br>10/16/24 - 139/56 mmHg<br><br>R1's MAR for November 2024 documented the following days R1 received the medication when the DBP was under the ordered parameters:<br><br>11/13/24 - 120/53 mmHg<br><br>11/14/24 - 143/56 mmHg<br><br>11/16/24 - 126/51 mmHg<br><br>11/17/24 - 118/50 mmHg<br><br>11/20/24 - 130/58 mmHg<br><br>11/21/24 - 122/52 mmHg<br><br>11/22/24 - 129/52 mmHg<br><br>11/27/24 - 126/50 mmHg<br><br>11/30/24 - 141/50 mmHg<br><br>R1's MAR for December 2024 documented the following days R1 received the medication when the DBP was under the ordered parameters:<br><br>12/09/24 - 136/52 mmHg<br><br>(continued on next page) |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 12/13/24 - 102/57 mmHg<br><br>12/14/24 - 114/59 mmHg<br><br>On 12/17/24 at 07:49 AM, staff brought R1 to the dining room for breakfast. R1 was alert, dressed, and groomed appropriately for the day.<br><br>On 12/18/24 at 11:27 AM, Administrative Nurse D verified that R1's lisinopril should not be administered out of the physician-orders parameters.<br><br>The facility did not provide a policy for administering blood pressure medications or blood pressure parameters.<br><br>The facility failed to hold R1's blood pressure medication lisinopril when the blood pressure was out of physician-ordered parameters. This placed the resident at risk of receiving unnecessary medications. |

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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** 37450<br><br>The facility had a census of 55 residents. The sample included 15 residents of which five were reviewed for unnecessary medications. Based on observation, record review, and interview, the facility failed to ensure Resident (R) 20 and R31 had an approved diagnosis or a physician-documented rationale which included risk versus benefit for the use of quetiapine (antipsychotic - class of medications used to treat major mental conditions which cause a break from reality). This placed the residents at risk of receiving unnecessary psychotropic medication.<br><br>Findings included:<br><br>- R20's Electronic Medical Record (EMR) included diagnoses of insomnia (inability to sleep), muscle weakness, mood disorder, unspecified dementia (a progressive mental disorder characterized by failing memory and confusion), cognitive-communication deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear) disorder, recurrent depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and cerebrovascular disease (a condition that impact the brain's blood vessels and blood flow).<br><br>The Quarterly Minimum Data Set (MDS) dated [DATE] documented R20 had severe cognitive impairment, hallucinations (sensing things while awake that appear to be real, but the mind created), delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue), inattention, disorganized thinking, and rejection of care which occurred one to three days of the seven-day look-back period. R20 was dependent on functional abilities and mobility. R20 was always incontinent of bladder and bowel and had pain as evidenced by nonverbal sounds, vocal complaints, facial expressions, and protective body movements. The MDS documented R20 received an antipsychotic, an antianxiety (a class of medications that calm and relax people), and an opioid (a class of controlled drugs used to treat pain). The antipsychotic was received on a routine basis only and a physician documented gradual dose reduction (GDR) as clinically contraindicated on 05/06/24.<br><br>R20's Behavioral Symptoms Care Plan dated 05/16/24 documented R20 had verbal and physical behavioral symptoms directed at others due to a diagnosis of anxiety disorder, unspecified dementia with behaviors, and mood disorder. The plan directed staff to administer medications as ordered by the physician. The plan listed lorazepam (an antianxiety medication) and quetiapine (an antipsychotic).<br><br>R20's Antipsychotic Care Plan initiated on 12/14/20 documented R20 was at risk for complications related to her use of antipsychotic medications and listed lorazepam and quetiapine. The care plan directed staff to administer and evaluate effectiveness, monitor for side effects of antipsychotic medication, and notify the physician if there were any changes.<br><br>The Physician Order dated 11/01/23 directed staff to administer quetiapine 50 milligrams (mg) tablet at bedtime related to dementia in other diseases classified elsewhere with behavioral disturbance.<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 | R20's EMR lacked evidence of a physician-documented rationale which included the risks versus benefits for R20's quetiapine.<br><br>On 12/17/24 at 07:49 AM, staff brought R20 to the dining room in a wheelchair, dressed and groomed appropriately for the day. The dietary staff provided the resident with a divided plate and breakfast finger food which she ate independently.<br><br>On 12/18/24 at 12:00 PM, Administrative Nurse D stated R20 the use of quetiapine had an unapproved indication diagnosis of dementia.<br><br>The facility's undated Psychotropic Medication Monitoring policy documented the facility supports the appropriate use of psychopharmacologic medications that are therapeutic and enabling for residents suffering from mental illness while recognizing that the use of psychopharmacologic medications for dementia-related behaviors was inappropriate in most care but rather the use of non-pharmacological interventions based on the individual resident needs, preferences, and routine was the most appropriate and first-line of treatment for dementia-related behaviors. The facility will make every effort to comply with the state and federal regulations related to the use of psychopharmacological medications in the facility including regular review for continued need, appropriate dosage, side effects, and risk versus benefits.<br><br>The facility failed to ensure R20 had an approved indication for use or a physician-documented rationale including risk versus benefits for the use of quetiapine. This placed the resident at risk of receiving unnecessary psychotropic medications.<br><br>41713<br><br>- R31's Electronic Medical Record (EMR) documented diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion) with behavioral disturbances, major depressive disorder (major mood disorder that causes persistent feelings of sadness), bipolar disorder (a major mental illness that causes people to have episodes of severe high and low moods), and hypertension (HTN - elevated blood pressure)<br><br>R31's Significant Change Minimum Data Set (MDS) dated [DATE] documented she had both short and long-term memory problems. R31 had severely impaired cognitive skills for daily decision-making. R31 had continuous behaviors of inattention and disorganized thinking. R31 had delusions (untrue persistent beliefs or perceptions held by a person although evidence shows it was untrue). R31 had impairment on both sides of her lower extremities. R31 required partial to substantial assistance from staff for her functional abilities and activities of daily living (ADLs). R31 received antipsychotics (a class of medications used to treat major mental conditions which cause a break from reality) and antidepressants (a class of medications used to treat mood disorders) mediations during the look-back period.<br><br>R31's Quarterly MDS dated [DATE] documented she had both short and long-term memory problems. R31 had severely impaired cognitive skills for daily decision-making. R31 had continuous behaviors of inattention and disorganized thinking. R31 had impairment on both sides of her lower extremities. R31 required substantial assistance to being dependent on staff for her functional abilities and ADLs. R31 received antipsychotics and antidepressant medications during the look-back period.<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 | R31's Psychotropic Drug Use Care Area Assessment (CAA) dated 01/25/24 documented she used psychotropic (alters mood or thought) medications to manage her psychiatric condition. The licensed nurse should monitor for medication side effects each shift and notify the physician of any abnormal findings. A consultant pharmacist would review the medications monthly, and the provider would review the medications with each visit.<br><br>R31's Care Plan last revised on 10/24/24 directed staff to administer psychotropic medications as directed. The consultant pharmacist would do routine drug evaluations.<br><br>R31's Orders tab of the EMR documented a physician's order dated 10/28/23 for Seroquel (quetiapine) to give 10 milligrams (mg) two times daily related to her dementia. This order was discontinued on 12/08/23.<br><br>R31's Orders tab of the EMR documented an order dated 12/08/23 for Seroquel 50 mg to be given by mouth twice daily for dementia.<br><br>R31's clinical records lacked a physician's documented clinical rationale for the continued use of Seroquel or an approved indication for use. The facility was unable to provide this information upon request.<br><br>On 12/17/24 at 12:26 PM, R31 rested in her bed. R31's bed was in a low position and her call light was within reach.<br><br>On 12/18/24 at 12:13 PM, Licensed Nurse (LN) I stated R31 had dementia and had been taking Seroquel. LN I stated she knew that psychotropic medications should not be used for dementia and was not sure if the physician had attempted to change the diagnoses or the need for the use of Seroquel.<br><br>On 12/18/24 at 01:31 PM, Administrative Nurse D stated the facility had been working on the psychotropic medication use and working on getting the physicians to avoid or quit prescribing antipsychotic medication altogether. Administrative Nurse D stated that R2 did not have an appropriate indication for the use of Seroquel.<br><br>The facility's undated Psychotropic Medication Monitoring policy documented the facility would make every effort to comply with State and Federal regulations related to the use of psychopharmacological medications in the facility including a regular review for the continued need, the appropriate dosage, side effects, risks, and benefits.<br><br>The facility failed to ensure R31 had a CMS-approved indication or the required physician documentation, for use for antipsychotic medications. This placed R31 at risk for unnecessary medication administration and possible adverse side effects. |

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| | 175124 | A. Building<br>B. Wing | 12/18/2024 |

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| Lakepoint El Dorado, LLC | 1313 S High Street<br>El Dorado, KS 67042 |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure medication error rates are not 5 percent or greater.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32360<br><br>The facility had a census of 55 residents. The sample included 15 residents and 25 medication administrations observed. Based on observation, record review, and interview, the facility failed to ensure a medication error rate less than 5 percent (%). This placed the residents in the facility who received medications at risk for physical decline and other related complications.<br><br>Findings included:<br><br>- The Electronic Medical Record (EMR) for R18 documented diagnoses of cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), hemiparesis/hemiplegia (weakness and paralysis on one side of the body), chronic obstructive pulmonary disease (COPD - a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), dementia (a progressive mental disorder characterized by failing memory and confusion), and hypertension (high blood pressure).<br><br>The Quarterly Minimum Data Set (MDS) dated [DATE] documented R18 had intact cognition and was dependent upon staff for toileting, mobility, transfers, and lower body dressing. R18 required substantial assistance with showers and partial assistance with personal hygiene. R18 did not ambulate and had upper and lower functional impairment on one side. The MDS documented R18 received an anticoagulant (a class of medications used to prevent the blood from clotting), an antidepressant (a class of medications used to treat mood disorders), and a diuretic (a medication to promote the formation and excretion of urine).<br><br>R18's Care Plan dated 10/30/24 and initiated on 03/03/24 documented R18 received medications with Black Box Warning (BBW - highest safety-related warning that medications can have assigned by the Food and Drug Administration) and directed staff to administer medications as ordered, monitor for signs and symptoms of side effects, notify the physician of any changes in mood, behavior, or cognition, and monitor lab work as ordered.<br><br>The Physician's Order dated 11/01/23 directed staff to administer amlodipine (high blood pressure medication), 5 milligrams (mg), one tablet, by mouth, daily for hypertension. Hold the medication if R18's systolic blood pressure (SBP - the top number that measures the force the heart exerts on the walls of the arteries each time it beats) was 120 millimeters of mercury (mmHg) or less and hold the medication if the diastolic blood pressure (DBP - minimum level of blood pressure measured between contractions of the heart; the bottom number of a blood pressure reading) was 70 mmHg or less.<br><br>The Physician's Order dated 11/01/23 directed staff to administer hydralazine hci (a blood pressure medication), 25 mg, by mouth, twice per day for hypertension. Hold the medication if R18's systolic blood pressure was 120 mmHg or less and hold the medication if the diastolic blood pressure was 70 mmHg or less.<br><br>(continued on next page) |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | The 'Physician's Order dated 11/01/23 directed staff to administer hydrochlorothiazide (HCTZ-a blood pressure medication), 12.5 mg, by mouth in the morning. Hold the medication if R18's systolic blood pressure was 120 mmHg or less and hold the medication if the diastolic blood pressure was 70 mmHg or less.<br><br>The Physician's Order dated 11/01/24 directed staff to administer Losartan (a blood pressure medication), 25 mg, by mouth, in the morning. Hold the medication if R18's systolic blood pressure was 120 mmHg or less and hold the medication if the diastolic blood pressure was 70 mmHg or less.<br><br>On 12/17/24 at 08:03 AM, Certified Medication Aide (CMA) R administered all of R18's morning medications to her including the amlodipine, Losartan, HCTZ and hydralazine. CMA R revealed she had already taken R18's blood pressure, and it was 133/63 mmHg. CMA R said she was unsure of what R18's parameters were, and she agreed to look up the parameters. Upon review, CMA R verified she had mistakenly administered R18's blood pressure medications when the DBP was out of parameters.<br><br>On 12/17/24 at 08:15 AM, Administrative Nurse D stated CMA R should have checked the blood pressure parameters and held the medications. Administrative Nurse D stated the physician and the family had been notified of the medication error.<br><br>The facility did not provide a policy for medication errors.<br><br>The facility failed to hold blood pressure medications for R18 when her blood pressure was out of the physician-ordered parameters which created an observed medication error rate of 16%. This placed residents who received medications at risk for physical decline and other related complications. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>37450<br><br>The facility had a census of 55 residents. The sample included 15 residents. Based on observation, record review, and interview, the facility failed to ensure the medications and biologicals were stored and monitored appropriately in one of two medication rooms. This placed the affected residents at risk of ineffective medication.<br><br>Findings included:<br><br>- On 12/18/24 at 08:29 AM, the East medication room had two refrigerators that lacked evidence the temperatures were assessed and recorded for nine out of 17 days in December 2024. Further observation revealed one of the refrigerators had 24 Activa yogurts with expiration dates of September 2024 through November 2024.<br><br>On 12/18/24 at 08:29 AM, Licensed Nurse (LN) J verified the lack of temperature documentation. LN J stated the refrigerator temperatures were taken by the medication aides, but any nursing staff could take the temperatures. LN J also verified the expiration date on the yogurts and disposed of them.<br><br>On 12/18/24 at 11:37 AM, Administrative Nurse D verified that the medication room refrigerator temperature should be recorded daily. Administrative Nurse D said the night shift nursing staff was responsible for taking and recording the temperatures daily.<br><br>The facility did not provide a policy related to the storage of medication and biologicals.<br><br>The facility failed to ensure medications and biologicals were stored and monitored appropriately which placed the affected residents at risk of ineffective medication. |

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| F 0849<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32360<br><br>The facility had a census of 55 residents. The sample included 15 residents, with two reviewed for hospice services. Based on observation, record review, and interview, the facility failed to ensure collaboration between the hospice provider and the facility for two residents, Resident (R) 10, who was admitted to hospice on 10/01/24, and R42, who went on hospice on 10/25/24. This placed the residents at risk of inadequate end-of-life care.<br><br>Findings included:<br><br>- The Electronic Medical Record (EMR) for R10 documented diagnoses of chronic obstructive pulmonary disease (COPD - a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), Sjogren's syndrome (an immune system illness that mainly causes dry eyes and dry mouth), and epilepsy (epilepsy (brain disorder characterized by repeated seizures).<br><br>The Admission Minimum Data Set (MDS) dated [DATE] documented R10 had intact cognition and was independent with activities of daily living (ADLs). R10 had shortness of breath with exertion and received oxygen therapy.<br><br>The Significant Change MDS dated [DATE] documented R10 had intact cognition and was independent with ADLs. R10 had shortness of breath, received oxygen therapy, and was on hospice.<br><br>R10's Care Plan dated 10/01/24 directed staff to adjust the provision of ADLs to compensate for R10's changing abilities; assess the resident's coping strategies and respect her wishes. The care plan directed staff to encourage R10 to express feelings, listen with non-judgmental acceptance, and encourage the support system of family and friends. The care plan further documented that hospice would provide an oxygen concentrator, 5-liter (L) wheelchair bottles, adult tubing, connectors, and nasal cannulas. The care plan further directed staff to work cooperatively with the hospice team to ensure the resident's spiritual, physical, and social needs were met. The care plan lacked a contact number for hospice, what supplies, and medications hospice would provide, when hospice staff would be in the building, and what cares they would provide.<br><br>On 12/16/24 at 09:25 AM, R10 walked in her room independently ambulating with her walker. She wore oxygen.<br><br>On 12/18/24 at 09:30 AM, Licensed Nurse (LN) G stated that R10 received hospice services and that the hospice staff would visit with R10 as often as needed. LN G said the hospice provided the facility with R10's medications and supplies. LN G further stated a hospice aide came to the facility to assist R10 with bathing weekly.<br><br>On 12/18/24 at 12:15 PM, Administrative Nurse D stated the care plan should be more specific related to the services provided by hospice, as well as the care the facility staff provided.<br><br>(continued on next page) |

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| F 0849<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The facility's End of Life, Palliative, and Hospice Care policy revised May 2024 documented that the facility would maintain a relationship with hospice to ensure continuity of the highest-quality palliative care.<br><br>The facility failed to ensure collaboration of care between R10's hospice provider and the facility. This placed R10 at risk of inadequate end-of-life care.<br><br>41713<br><br>- R42's Electronic Medical Record (EMR) documented diagnoses of Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremors, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness), dementia (a progressive mental disorder characterized by failing memory and confusion), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), spinal stenosis (degenerative condition of the spine that could cause weakness and loss of use of extremities), and repeated falls.<br><br>R42's Significant Change Minimum Data Set (MDS) dated [DATE] documented short- and long-term memory problems. R42 had severely impaired decision-making skills and showed signs and symptoms of delirium (sudden severe confusion, disorientation, and restlessness). R42 was dependent on staff for all daily functional abilities and activities of daily living (ADLs). R42 had a history of falls and had one fall without injury since the prior assessment. R42 was on hospice services.<br><br>R42's Cognitive Loss Care Area Assessment (CAA) dated 11/08/24 documented the area triggered secondary to orientation, memory, and recall deficits noted during the cognition interview. Contributing factors included dementia, a change in mental status, and short-term and long-term memory loss. Risk factors included self-care deficits, falls and injuries, incontinence, decreased socialization, skin breakdown, weight loss, and fluid imbalance. His care plan would be coordinated with hospice to provide comfort and dignity throughout the end-of-life process as it relates to his needed cares.<br><br>R42's Care Plan last revised on 11/25/24 directed staff that he was admitted to hospice services on 10/25/24. Staff were directed to notify the resident's physician and representative of any changes in the resident's condition. Staff were directed that R42 had a do-not-resuscitate (DNR) code status. R42's care plan lacked staff direction regarding how to collaborate with hospice, what supplies and medications the hospice service provided, or when hospice staff would visit.<br><br>R42's Orders tab of the EMR noted an order dated 10/25/24 to admit him to hospice.<br><br>R42's hospice binder contained the hospice-provided plan of care (POC) including medications, discipline orders, how often visits would be made, interdisciplinary care plan, and treatments.<br><br>On 12/17/24 at 12:13 PM, R42 lay on his low air-loss mattress in his room. R42's bed was in a low position and the fall mat was beside the bed. The hospice nurse was in R42's room for a visit.<br><br>On 12/18/24 at 10:49 AM, Certified Nurse Aide (CNA) N stated R42 was on hospice but could not say for certain if the hospice information was on his care plan. CNA N stated the nurse would usually report to the staff when a resident was on hospice. CNA S stated hospice information was in R42's hospice book in the nurse's office.<br><br>(continued on next page) |

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| F 0849<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 12/18/24 at 12:13 PM, Licensed Nurse (LN) H stated R42's hospice information was under his advanced directives care area. LN H stated that R42's hospice information was in his hospice book, but his care plan did not include all the hospice information including when hospice staff would make visits or what supplies the hospice provided.<br><br>On 12/18/24 at 01:31 PM, Administrative Nurse D stated R42's Care Plan says that he was on hospice and the aide's brains (report on each of the residents) they get at the beginning of each shift would say if a resident was on hospice. Administrative Nurse D stated each resident on hospice has a book provided by hospice in the nurse's office that has their plan of care and the list of medications when hospice staff would make their visits. Administrative Nurse D stated that R42's Care Plan did not include all that information.<br><br>The facility's End of Life, Palliative, and Hospice Care policy revised May 2024 documented that the facility would maintain a relationship with hospice to ensure continuity of the highest-quality palliative care.<br><br>The facility failed to ensure collaboration of care between R42's hospice provider and the facility. This placed R42 at risk of inadequate end-of-life care. |