STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175231	A. Building B. Wing	07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Ellsworth Village	1156 Highway 14 Ellsworth, KS 67439

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37450 The facility had a census of 38 residents. The sample included 12 residents. Based on observation, record review, and, interview, the facility failed to revise the care plan with effective intervention to prevent re-traumatization for Resident (R)2 related to a diagnosis of post-traumatic stress disorder (PTSD-mental disorder characterized by an acute emotional response to a traumatic event or situation involving severe environmental stress). This placed the resident at risk for impaired care due to uncommunicated care needs. Findings included: - R2's Electronic Medical Record (EMR) documented diagnoses of PTSD, epilepsy (brain disorder characterized by repeated seizures), heart failure, weakness, morbid obesity (excessive body fat), and localized edema (swelling). R2's Quarterly Minimum Data Set (MDS), dated [DATE], documented R2 had intact cognition. R2 used a walker and required substantial/maximal assistance with toileting and upper and lower body dressing. R2 required partial/moderate assistance with personal hygiene. R2 was independent with bed mobility and transfers. The MDS further documented a PTSD diagnosis. R2 received scheduled pain medication, an antianxiety (class of medications that calm and relax people), an antidepressant (class of medications used to treat mood disorders), and a diuretic (medication to promote the formation and excretion of urine). The Psychosocial Well-Being Care Area Assessment (CAA), dated 08/01/23, documented R2 had lost a close family member and had feelings of sadness, tearfulness, and loss. R2 stated he had accepted the loss but still had times of sadness. R2's Care Plan, initiated 04/28/21, documented R2 used antianxiety medications related to adjustment issues, his mother's death, and PTSD. The care plan directed staff to monitor anxiety, document side effects and effectiveness of antianxiety, and discuss with R2's health care provider and family if there is an ongoing need for the use of medications. The care plan lacked information regarding triggers and interventions related to R2's PTSD to prevent re-traumatization. (continued on next page)

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Trauma Assessment, dated 04/30/24, documented the purpose of the assessment was to identify residents who were survivors of trauma, to understand how trauma currently affected functioning, and to determine what triggers may cause re-traumatization. The assessment inquired if the resident had experienced some form of trauma or a stressful event, and R2's assessment recorded an answer of no, despite the diagnosis of PTSD The assessment further inquired how trauma currently affected the person, the trauma symptoms and triggers, support and coping strategies, and care planning. The latter portion of the assessment lacked descriptions and was incomplete. The Progress Note, dated 08/17/23 at 10:07 AM, documented R2 was in attendance at the care conference. The note further documented the review of R2's diet, weight, and activity involvement; there were no medication changes. The note recorded that a talk therapy appointment was set up for each month and the facility would transport R2 to sessions. The Progress Note, dated 05/07/24 at 10:19 AM, documented R2 verbalized feelings related to his emotional state and shared his grief with his caregivers. R2 expressed satisfaction with friendships and an improved mood state. R2 reported fewer episodes of anxiety behavior but had a continued need for 24-hour care in a nursing facility. On 06/27/24 at 02:05 PM, observation revealed R2 in his room, listening to music. R2 reported music helped his mood. On 07/02/24 at 09:57 AM Certified Nurse Aide (CNA) N reported knowledge of R2's PTSD diagnosis but was not aware of the cause or what may trigger the resident. CNA N reported she could tell when something was not right with R2's mood and said she tried to have an upbeat attitude which seemed to be effective. On 07/02/24 at 10:13 AM, Licensed Nurse (LN) J reported R2 was not having behaviors and was generally happy. LN J was not sure what may trigger PTSD for the resident. On 07/02/24 at 11:26 AM CNA P reported she thought R2's PTSD might have come from something experienced in his childhood and said R2 had not exhibited behaviors. On 07/02/24 at 11:19 AM, Administrative Nurse E verified the care plan lacked triggers or coping strategies for staff. On 07/02/24 at 02:28 PM, Administrative Nurse D verified R2 had a PTSD diagnosis which stemmed from a history of COVID-19 and his family member's death. Administrative Nurse D verified the care plan lacked triggers and coping strategies that would benefit the resident. The facility did not provide a care plan policy. The facility failed to ensure the care plan to include triggers that may cause re-traumatization related to R2 's diagnosis of PTSD which placed the resident at risk for impaired care due to uncommunicated care needs.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37450 The facility had a census of 38 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to provide nursing care that met the standards of practice for Resident (R) 25 when nursing staff failed to monitor the resident's intake and administer tube feedings per the physician's orders and failed to monitor urine output and report decreased output to the physician. This deficient practice placed the resident at risk for medical complications. Findings included: - R25's Electronic Medical Record (EMR) documented diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), dysphagia (swallowing difficulty), gastrostomy status (G-tube: tube surgically placed through an artificial opening into the stomach), unspecified protein-calorie malnutrition, encephalopathy (broad term for any brain disease that alters brain function or structure), urogenital candidiasis (yeast infection), obstructive and reflux uropathy (blocked or reduce urine flow), urinary tract infection (UTI), and weakness. The Quarterly Minimum Data Set (MDS), dated [DATE], documented R25 had severe cognitive impairment, disorganized thinking, and an altered level of consciousness present which fluctuated. R25 had not exhibited behaviors. R25 had no functional range of motion impairment and used a walker and wheelchair for mobility. R25 was dependent on staff for eating, oral care, toileting, bathing, upper and lower body dressing, and mobility. The MDS further documented R25 had an indwelling catheter (tube placed in the bladder to drain urine into a collection bag) and was always incontinent of bowel. He had no pain or pain treatments. R25 had a feeding tube (G-tube) and a mechanically altered diet; he received 51 percent (%) or more of his total calories through tube feeding with a fluid intake of 501 cubic centimeters (cc)/day or more. The resident received an antipsychotic (class of medications used to treat major mental conditions that cause a break from reality), antidepressant (class of medications used to treat mood disorders), antibiotic (medication to treat infections), and antiplatelet (medication to prevent blood from clotting). The antipsychotics were received on a routine basis only with no gradual dose reduction (GDR) attempted and no physician-documented GDR as clinically contraindicated. R25 also received speech and occupational therapy. The Nutritional Status Care Area Assessment (CAA), dated 02/21/24, documented R25 had scored a six on the nutritional assessment which indicated he was malnourished. R25 had not been eating while he was hospitalized , so a G-tube was placed; all nutrition and medications were given through the tube. The Feeding Tube Care Area Assessment (CAA), dated 02/21/24, documented that while hospitalized , R25 was not eating; a G-tube was placed, and all nutrition and medications were given via tube. The Dehydration/Fluid Maintenance Care Area Assessment (CAA), dated 02/21/24, documented R25 receives all fluids through G-tube. R25 received water before and after feedings and one other time during the day. Labs were monitored as ordered. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R25's Care Plan, dated 05/20/24, documented R25 had an indwelling catheter related to neurogenic bladder (dysfunction of the urinary bladder caused by a lesion of the nervous system) and instructed staff to monitor and document for pain or discomfort due to catheter. The plan directed staff to document output and monitor, record, and report to the health care provider for signs and symptoms of urinary tract infections. R25's Care Plan, dated 05/20/24, documented R25 met the criteria for malnutrition related to weight loss. The plan directed staff to monitor R25's weight weekly. R25's Care Plan, dated 05/20/24, documented R25 had nutrition problems related to G-tube feedings and medication. The care plan documented R25 had an order for a puree (smooth creamy constancy) diet and extremely thick liquids. R25 required assistance with eating; staff were to monitor for choking. The plan documented R25 had an order for Two- cal HN 2.0 (liquid nutritional supplement), 237 milliliters (ml) five times a day with 120 ml of water before and after feedings. R25's EMR recorded the following weights: 06/13/24 150.0 pounds (lbs.) 06/20/24 149.0 lbs. 06/27/24 146.8 lbs. The Physician Order, dated 06/14/24, directed staff to administer Two-cal HN 2.0 oral liquid 237 ml via G-tube three times a day related to dysphagia; flush with 120 ml of water before and after feeding. Administer if the resident ate less than 50% of his meal. The Dietary Progress Note, dated 06/26/24 at 09:35 AM, documented R25 had a loss of two pounds (lbs.) since 05/30/24. He received a regular diet with a minced and moist texture and had an oral intake of 51 to 100% at most meals. The tube feeding was changed to Two-cal HN 237 ml three times a day as needed if R25's intake was less than 50% at meals. R25's diet was supplemented with Boost Breeze (nutrition drink) daily at noon and the note recommended to increase the Boost to twice a day. R25's EMR lacked documentation of oral meal intake for 15 of 45 meal opportunities from 06/14/24 through 06/30/24. R25's EMR, including the Medication Administration Record/Treatment Administration Record (MAR/TAR), lacked documentation that staff assessed R25 for the need to administer, or that staff administered R25's physician-ordered Two-cal HN via his G-tube for those 15 of 45 opportunities when meal intakes were not monitored and recorded. R25's EMR under the Tasks for June 2024 recorded a urinary output of less than 30 ml hourly (720 ml) in a 24-hour period indicating minimal kidney function for 15 days in June 2024. R25's EMR lacked evidence the nursing staff identified this irregularity and reported it to R25's physician. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/27/24 at 08:30 AM, observation revealed R25 sitting in the dining room with Certified Nurse Aide (CNA) M sitting next to him. CNA M fed the resident a ground and minced diet of eggs, ground sausage, and a thin liquid supplement. R25 ate without any signs of difficulty. CNA M reported that R25 was eating well, but the resident had been in a mood for several days and had not eaten well. On 07/02/24 at 08:02 AM, CNA O reported that R25 required assistance with eating. CNA O stated the dietary staff recorded the intake of the resident. On 07/02/24 at 08:03 AM, Dietary Staff (DS) BB stated the dietary department recorded R25's intake into the EMR and reported to the charge nurse what R25's intake was, especially if the resident did not eat well. On 07/02/24 at 08:30 AM, Licensed Nurse (LN) H reviewed the EMR and stated R25 should have received supplemental G-tube feeding if he ate less than 50%. LN H said R25 continued with physician-ordered flush twice a day. to get water flushes two times a day. On 07/02/24 at 12:20 PM Administrative Nurse D stated R25's meal intakes should have been monitored and recorded and supplemental tube feeding given if the resident ate less than 50%. Administrative Nurse D verified nursing staff had not recorded supplemental feeding and verified it was the nurse's responsibility to ensure the need for supplemental feeding if needed. Administrative Nurse D said R25's urine output should be recorded in the EMR and it was the nursing staff's responsibility to assess for adequate urine output to promote health maintenance. The facility's Intake and Output with Hydration Guidelines policy, dated 05/07/24, the purpose of the policy is to measure fluid intake and/or output when ordered by the medical provider, on residents who receive G-tube feedings or have urinary catheters, to ensure that residents receive sufficient fluid intake to maintain proper hydration and health and to provide staff with ideas for hydration implementation. The policy further documented the facility to maintain acceptable parameters of nutritional status, unless the resident's clinical condition demonstrates that this is not possible or resident preference indicates otherwise and is offered sufficient fluid intake to maintain proper hydration and health. The facility failed to provide nursing care that met the standards of practice for R25 when nursing staff failed to monitor the resident's intake and administer tube feedings per the physician's orders and failed to monitor urine output and report decreased output to the physician. This deficient practice placed the resident at risk for medical complications.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26768 The facility had a census of 38 residents. The sample included 12 residents with three residents reviewed for urinary catheter care. Based on observation, interview, and record review, the facility failed to provide urinary catheter (a tube inserted into the bladder to drain urine into a collection bag) care in a manner to prevent urinary tract infections (UTI-an infection in any part of the urinary system) for Resident (R) 22 and R91. This placed the two residents at risk for infections and catheter-related complications. Findings included: - R22's Electronic Medical Record (EMR) documented diagnoses of cerebral infarction (stroke), acute and chronic kidney failure (a condition in which the kidneys lose the ability to remove waste and balance fluids), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), hyperlipidemia (condition of elevated blood lipid levels), hypercholesterolemia (greater than normal amounts of cholesterol in the blood), anxiety disorders (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear) and urinary tract infection. The Annual Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of three, indicating severely impaired cognition. The MDS documented R22 had no behaviors. R22 required maximal to total assistance for mobility, dressing, and toileting and had a urinary catheter. The MDS documented R22 received insulin (a hormone used to regulate blood glucose levels), antipsychotics (a class of medications used to treat major mental conditions that cause a break from reality), and antidepressant medications (a class of medications used to treat mood disorders). R22 received psychiatric therapy and a gradual dose reduction (GDR) of the antipsychotic drug had been attempted. The Care Area Assessment (CAA), dated 05/10/24, stated R22 had a Foley (brand name) catheter due to retention, was prone to UTIs, and received a prophylactic (preventative in nature) antibiotic (a medicine that inhibits the growth of or destroys microorganisms). Staff provide catheter care every shift and the catheter is changed as ordered and as needed. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R22's Care Plan, dated 05/14/24, stated R22 had a Foley catheter related to urinary retention and surgery, initiated on 05/08/23 and revised on 02/21/24. The care plan directed staff to monitor, and document for pain or discomfort due to the catheter initiated 05/08/23. Use enhanced barrier precautions (EBP -infection control interventions designed to reduce transmission of resistant organisms which employs targeted gown and glove use during high contact care) with care. The plan instructed staff to wear disposable gowns when performing high-contact resident care activities, doff gown and gloves inside the resident room, and complete hand hygiene before leaving the room, initiated 03/29/24, and revised on 06/05/24. R22 has a Foley Catheter 16 French (Fr-size), initiated 05/08/23. The plan directed staff to document output initiated on 02/08/24 and perform catheter care by CNA (Certified Nurse Aide) every shift, initiated on 02/16/24, and revised on 03/29/24. R22 has the potential for UTI related to catheter use and a history of UTIs, initiated on 02/21/24. The plan directed staff to collect specimens for culture and sensitivity as ordered, initiated 02/21/24. R22's EMR documented UTIs with antibiotic medication ordered on 08/31/23, 12/30/23, 01/12/24, 02/14/24, and 04/01/24. The 02/14/24 and 04/01/24 urine cultures documented Carbapenem-resistant Enterobacteriaceae (CRE-resistant bacterial infection), a multi-drug resistant organism (MDRO common bacteria that have developed resistance to multiple types of antibiotics). The Progress Note, dated 06/05/24 at 11:40 AM, documented R22 was readmitted to the facility after hospitalization for UTI and received intravenous (IV-administered directly into the bloodstream via a vein) antibiotics. On 06/26/24 at 02:50 PM, observation revealed R22 in his wheelchair in the hall. CNA N assisted R22 to the common resident bathroom where she performed catheter care by emptying the drainage bag. CNA N donned gloves but no gown set the measuring container on a barrier on the floor, emptied the catheter drainage bag, and used an alcohol wipe on the port. CNA N changed gloves without washing her hands, placed the drainage bag back into a privacy bag under the wheelchair, and took the resident back out to the commons area. On 06/27/24 at 01:02 PM, observation revealed R22 in his wheelchair in the hall with the catheter drainage bag in a privacy bag under the wheelchair. Approximately two inches of catheter tubing dragged on the floor when he self-propelled into the nurse's office. There was a wet area observed on the front of R22's slacks and Licensed Nurse (LN) I placed a towel over the wet spot and wheeled the resident to another area to weigh him, per his request, while four inches of catheter tubing dragged on the floor during the transport. On 06/27/24 at 01:27 PM, observation revealed CNA O took R22 in his wheelchair to his room with the catheter tubing dragging on the hallway floor. On 07/02/24 at 09:32 AM, LN H stated staff were to provide catheter care every shift and said staff should use gowns and gloves. LN H stated staff should not provide care in the common bathroom without EBP. On 07/02/24 at 09:42 AM, Administrative Nurse D verified the catheter tubing should not be allowed to drag on the floor and that staff should not use the common bathroom for catheter care. She stated staff should have used EBP every time they provided any catheter care. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Enhance Barrier Precautions (EBP) Protocol, directed staff to determine if EBP was needed for residents with wounds or indwelling medical devices and all residents infected or colonized with select MDROs. Staff was to set up a personal protective equipment (PPE) station inside the resident's room, notify staff that EBP was needed during high contact care, post signs on resident doors, update the care plan, and educate staff, residents, and family. The facility's Catheter Care policy, dated 02/10/23, stated every effort would be made to keep a resident's catheter covered or out of sight, and catheter tubing should never be allowed to touch the floor. When emptying the catheter bag, place a moisture-resistant barrier beneath the measuring container and avoid placing the container on the floor. When finished draining, clean the drainage port with an alcohol wipe and replace it in the holder. Measure and record the volume, discard the urine in the toilet and wash and dry the container according to facility procedures. The facility failed to provide urinary catheter care in a manner to prevent urinary tract infections R22. This placed the resident at risk for further UTI and other catheter-related complications. - R91's Electronic Medical Record (EMR) documented diagnoses of cervical/neck spine fracture and urinary hesitancy (difficulty starting or maintaining a urine stream). R91 was admitted to the facility on [DATE] following hospitalization for a fall and treatment of a urinary tract infection. R91's Catheter Care Plan, dated 06/25/24, stated R91 had an indwelling urinary catheter related to a neurogenic bladder (dysfunction of the urinary bladder caused by a lesion of the nervous system) and directed staff to monitor for pain or discomfort due to the catheter, document intake, and output, and provide catheter care every shift. The care plan stated R91 required 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 the indwelling catheter, initiated on 06/26/24. Staff was to don a gown and gloves when performing high-contact care activities including dressing, bathing, transferring, providing hygiene such as shaving or brushing teeth, changing linens, repositioning, checking and changing, device care or use, and wound care initiated on 06/26/24. The plan directed staff to doff gown and gloves inside the resident's room and perform hand hygiene, initiated on 06/26/24. On 06/27/24 at 11:57 AM, observation revealed R91 stood in his bathroom and stated he had emptied his urinary leg bag just now in the bathroom. Certified Nurse Aide (CNA) Q assisted R91 to his recliner with a walker, gait belt, and minimal assistance. CNA Q gloved but did not don an isolation gown. She performed peri-care, removed gloves, and assisted R91 to stand and transfer to his wheelchair. On 07/01/24 at 08:35 AM, observation revealed R91 sat in his wheelchair at a dining table independently eating. R91's urinary catheter bag hung under his wheelchair without a privacy bag or cover and yellow urine was visible to other residents in the dining room. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/01/24 at 01:50 PM, observation revealed R91 in his room in a wheelchair. CNA M donned gloves, but no isolation gown, set a measuring container directly on the floor with no barrier, removed the catheter drainage bag from under the wheelchair, and set it on the floor. CNA M used an alcohol wipe on the port before and after draining the bag, dropped the alcohol wipe on the floor then picked it up and wiped the inside of the port holder on the bag with the contaminated wipe. CNA N attempted to place the drainage bag back into the privacy bag under the wheelchair, and at one point placed the urine collection bag on the floor while trying to attach the privacy bag under the wheelchair. CNA M removed his gloves and attached the privacy bag, handled the Foley bag, and then emptied the urine container into the toilet. He used hand gel before leaving the room. On 06/27/24 at 03:40 PM, Administrative Nurse D stated EBP should have been initiated for R91's catheter care the day he was admitted (06/25/24) and verified it had not been. On 07/01/24 at 01:57 PM, CNA M verified staff should not set the drainage bag on the bare floor. He was not aware the resident was on EBP for the catheter. On 07/01/24 at 02:00 PM, Administrative Nurse D verified the resident was on EBP and showed the bookmark size EBP sign attached to the doorframe. The resident had a small plastic three-drawer cart in the room with EBP supplies, but no sign to indicate that was what was in it. On 07/02/24 at 09:42 AM, Administrative Nurse D verified catheter tubing should not be allowed to drag on the floor and staff should not use the common bathroom for catheter care. Staff should have used EBP every time they provided any catheter care. The facility's Enhance Barrier Precautions (EBP) Protocol, directed staff to determine if EBP was needed for residents with wounds or indwelling medical devices and all residents infected or colonized with select MDROs. Staff was to set up a PPE station inside the resident's room, notify staff that EBP was needed during high contact care, post signs on resident doors, update the care plan, and educate staff, resident, and family. The facility's Catheter Care policy, dated 02/10/23, stated every effort would be made to keep a resident's catheter covered or out of sight, and catheter tubing should never be allowed to touch the floor. When emptying the catheter bag, place a moisture-resistant barrier beneath the measuring container and avoid placing the container on the floor. When finished draining, clean the drainage port with an alcohol wipe and replace it in the holder. Measure and record the volume, discard the urine in the toilet and wash and dry the container according to facility procedures. The facility failed to provide urinary catheter care in a manner to prevent urinary tract infections and to maintain dignity for R91. This placed R91 at risk for further UTI and other catheter-related complications.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37450 The facility had a census of 38 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to ensure Resident (R)2 received trauma-informed care to eliminate or mitigate triggers that may cause re-traumatization related to a diagnosis of post-traumatic stress disorder (PTSD-mental disorder characterized by an acute emotional response to a traumatic event or situation involving severe environmental stress). This placed the resident at risk for unmet behavioral health care needs. Findings included: - R2's Electronic Medical Record (EMR) documented diagnoses of PTSD, epilepsy (brain disorder characterized by repeated seizures), heart failure, weakness, morbid obesity (excessive body fat), and localized edema (swelling). R2's Quarterly Minimum Data Set (MDS), dated [DATE], documented R2 had intact cognition. R2 used a walker and required substantial/maximal assistance with toileting and upper and lower body dressing. R2 required partial/moderate assistance with personal hygiene. R2 was independent with bed mobility and transfers. The MDS further documented a PTSD diagnosis. R2 received scheduled pain medication, an antianxiety (class of medications that calm and relax people), an antidepressant (class of medications used to treat mood disorders), and a diuretic (medication to promote the formation and excretion of urine). The Psychosocial Well-Being Care Area Assessment (CAA), dated [DATE], documented R2 had lost a close family member and had feelings of sadness, tearfulness, and loss. R2 stated he had accepted the loss but still had times of sadness. R2's Care Plan, initiated [DATE], documented R2 used antianxiety medications related to adjustment issues, his mother's death, and PTSD. The care plan directed staff to monitor anxiety, document side effects and effectiveness of antianxiety, and discuss with R2's health care provider and family if there is an ongoing need for the use of medications. The Trauma Assessment, dated [DATE], documented the purpose of the assessment was to identify residents who were survivors of trauma, to understand how trauma currently affected functioning, and to determine what triggers may cause re-traumatization. The assessment inquired if the resident had experienced some form of trauma or a stressful event, and R2's assessment recorded an answer of no, despite the diagnosis of PTSD The assessment further inquired how trauma currently affected the person, the trauma symptoms and triggers, support and coping strategies, and care planning. The latter portion of the assessment lacked descriptions and was incomplete. The Progress Note, dated [DATE] at 10:07 AM, documented R2 was in attendance at the care conference. The note further documented the review of R2's diet, weight, and activity involvement; there were no medication changes. The note recorded that a talk therapy appointment was set up for each month and the facility would transport R2 to sessions. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Progress Note, dated [DATE] at 10:19 AM, documented R2 verbalized feelings related to his emotional state and shared his grief with his caregivers. R2 expressed satisfaction with friendships and an improved mood state. R2 reported fewer episodes of anxiety behavior but had a continued need for 24-hour care in a nursing facility. On [DATE] at 02:05 PM, observation revealed R2 in his room, listening to music. R2 reported music helped his mood. On [DATE] at 09:57 AM Certified Nurse Aide (CNA) N reported knowledge of R2's PTSD diagnosis but was not aware of the cause or what may trigger the resident. CNA N reported she could tell when something was not right with R2's mood and said she tried to have an upbeat attitude which seemed to be effective. On [DATE] at 10:13 AM, Licensed Nurse (LN) J reported R2 was not having behaviors and was generally happy. LN J was not sure what may trigger PTSD for the resident. On [DATE] at 11:26 AM CNA P reported she thought R2's PTSD might have come from something experienced in his childhood and said R2 had not exhibited behaviors. On [DATE] at 11:19 AM, Administrative Nurse E reported R2 had experienced a personal history of COVID-19 (highly contagious respiratory virus) and had to be hospitalized far from the facility, due to lack of hospital bed availability. When R2 returned to the facility, a close family member also contracted Covid-19 and died . Administrative Nurse E said R2 began having thoughts that bothered him and had been throwing things. She reported R2 started seeing a counselor which helped. Administrative Nurse E verified the care plan lacked triggers or coping strategies for staff. On [DATE] at 02:28 PM, Administrative Nurse D verified R2 had a PTSD diagnosis which stemmed from a history of COVID-19 and his family member's death. Administrative Nurse D verified the care plan lacked triggers and coping strategies that would benefit the resident. The facility's Trauma Informed Care policy, dated [DATE], documented the purpose of the policy was to provide trauma-informed care and avoid re-traumatization. Trauma-informed care means being intentional by anticipating and avoiding institutional processes and practices that are likely to re-traumatize a resident who has a history of trauma. Staff will ensure that residents who experience trauma receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for resident's experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization. The facility failed to ensure R2 received trauma-informed care to eliminate or mitigate triggers that may cause re-traumatization of the resident which placed the resident at risk for unmet care, emotional, and psychosocial needs.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26768 The facility had a census of 38 residents. The sample included 12 residents. Based on observation, interview, and record review the facility failed to follow up on the Consultant Pharmacist (CP) recommendations regarding antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) and psychotropic (alters mood or thought) medication use for Resident (R)22, R32, and R25 and failed to ensure the CP identified and reported the lack of a stop date for R25's as needed psychotropic medication. This placed the three residents at risk to continue receiving unnecessary psychoactive medications without an explanation of why the benefits outweighed the risks. Findings included: - R22's Electronic Medical Record (EMR) documented diagnoses of anxiety disorders (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), cerebral infarction (stroke), acute and chronic kidney failure (condition in which the kidneys lose the ability to remove waste and balance fluids), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), and congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid). The Annual Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of three, indicating severely impaired cognition. The MDS documented R22 had no behaviors. R22 required maximal to total assistance for mobility, dressing, and toileting. R22 received antipsychotic and antidepressant medications (a class of medications used to treat mood disorders). The Psychotropic Drug Use Care Area Assessment (CAA), dated 05/10/24, stated R22 received a small dose of Zyprexa (antipsychotic) for anxiety and Celexa (antidepressant). The CAA documented that R22's mood has been stable, and he was doing well. R22 was seen by the tele-psych nurse for medication changes and status. R22's Care Plan, dated 05/14/24, directed staff to allow the resident time to respond due to slower processing of cognition skills. In the presence of behaviors or anxiety, staff were to provide opportunities for positive interaction and attention. The plan directed staff to minimize the potential for the resident's disruptive behaviors by offering tasks that divert attention. The plan directed staff to consult with the pharmacy and healthcare provider to consider dosage reduction when clinically appropriate. The Physician Order, dated 05/06/24, directed staff to administer Zyprexa (olanzapine) 2.5 milligrams (mg), two times a day for anxiety. The Physician Order, dated 03/18/2024, directed staff to administer Celexa (citalopram- antidepressant drug) 40 mg, at bedtime, for depression. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Medication Administration Record (MAR)/ Treatment Administration Record (TAR) documented R22 had no behaviors related to depression which included crying, isolation, yelling, change in mood, sadness, suicidal thinking, increased sleeping, or other depressive behaviors. R22 had no signs of psychosis which included crying, hallucinations, delusions, isolation, change in mood, sadness, suicidal thinking, increased sleeping, or other depressive behaviors. The Psychiatric Practitioner Note, dated 05/06/24, stated after tapering Zyprexa on 04/04/24, staff reported increased anxiety, excessive sleeping, and agitation. The prescriber increased Celexa to 30 mg after which staff reported some decrease in anxiety. The note stated R22's agitation begins at approximately 03:00 PM, but if identified, staff can calm R22 down most of the time. The practitioner ordered staff to continue Zyprexa 2.5 mg twice daily for mood or anxiety and increase Celexa to 40 mg daily. The Psychiatric Practitioner Note, dated 06/21/24, stated that R22 had a significant past psychiatric history. Staff reported increased anxiety, some frustration, and anxiety with communication due to a stroke. Staff reported that R22's anxiety levels had improved since he became aware of his schedule in advance. R22 stated he was doing well and not really having too much anxiety. He reported sleeping well and denied nightmares. The practitioner documented diagnoses of mood disorder with depressive features, dementia (a progressive mental disorder characterized by failing memory, and confusion), and generalized anxiety disorder. The note documented to continue to taper Zyprexa during subsequent visits as Kansas only approved the use of antipsychotics for certain diagnoses. The practitioner ordered to continue Celexa 20 mg daily for anxiety or mood. The Consultant Pharmacist Review, dated 11/14/23, questioned the diagnosis of anxiety for the use of Zyprexa. The physician responded- yes and documented anxiety without documenting a rationale for the indication or continued use of the antipsychotic medication. The Consultant Pharmacist Review, dated 12/13/23, recommended a gradual dose reduction (GDR) for Zyprexa and Celexa. The physician responded that R22 was evaluated by the psychiatric practitioner and ordered no changes without psychiatric physician involvement. No risk versus benefit rationale was documented. The Consultant Pharmacist Review, dated 06/06/24, recommended a GDR of Celexa 40 mg. The physician responded this was a recent increase with the in-house psychiatric practitioner, a GDR would be contradictive at this time. No risk versus benefit rationale was documented. On 06/27/24 at 07:31 AM, Licensed Nurse (LN) I administered an injection to R22. R22 stated he ate a good breakfast but couldn't remember exactly what he ate. On 07/01/24 at 01:22 PM, Administrative Nurse D verified the facility failed to follow up on the pharmacist consultant's recommendations to obtain an appropriate indication for use or a written rationale for the continued use of the Zyprexa which included the required documentation. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Drug Regimen Review policy, dated 02/10/23, stated a drug regimen review was performed for each resident at least once a month by a licensed pharmacist. The licensed pharmacist completes the drug regimen review by assessing the medication list and the resident's medical chart to identify potentially significant medication issues and notifies the physician if any discrepancies are found or additional information is needed. The pharmacist would follow up until a response was received from the physician. The pharmacist would review to identify that medication doses and duration are appropriate, medication-related errors, and gradual dose reductions. The pharmacist would complete a Medication Regimen Review summary and ensure the director of nursing services and the physician receive a copy. These reports must be acted upon. The facility failed to follow up on the Pharmacist Consultant's recommendations regarding antipsychotic medication use for R22, placing the resident at risk for unnecessary psychotropic medications. - R32's Electronic Medical Record (EMR) documented a diagnosis of dementia (a progressive mental disorder characterized by failing memory, and confusion). The Quarterly Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of five, indicating severely impaired cognition. The MDS documented R32 was independent for mobility, toileting, walking, and dressing. The MDS documented R32 received antianxiety (a class of medications that calm and relax people) and antidepressant (a class of medications used to treat mood disorders) medications. R32's Care Plan, dated 04/15/24, stated R32 used anti-anxiety medications related to dementia with anxiety disorder and directed staff to monitor and document side effects and effectiveness. Monitor R32 frequently for safety. Offer diversionary activities such as one one-on-one discussions. Offer the use of a rocking chair to ease anxiety. The plan directed staff to consult with the pharmacy and healthcare provider to consider dosage reductions when clinically appropriate. The Physician Order, dated 10/11/23, directed staff to administer paroxetine (a type of antidepressant medication), 20 milligrams (mg) daily for anxiety. The Physician Order, dated 10/20/23, directed staff to administer clonazepam (antianxiety medication that works by increasing the levels of a calming chemical in your brain) 0.5 mg daily for dementia. The Pharmacist Consultant Review, dated 03/28/24, recommended a gradual dose reduction (GDR) of paroxetine 15 mg daily and clonazepam 0.5 mg daily which the pharmacist wrote had been administered since 10/11/23. The physician declined the recommendation and wrote clinically contraindicated without writing a rationale or risk versus benefit statement. The Physician Visit Note, dated 05/24/24, documented R32 had severe dementia but had adjusted to living in the facility and seemed to be happier. The note recorded there were no changes to R32's medications. On 07/01/24 at 12:55 PM, observation revealed R32 independently ambulated from his room to the commons area and sat for a music activity. He was very polite and calm. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/02/24 at 10:15 AM, Administrative Nurse D verified the facility had not obtained a physician-written risk versus benefit statement or rationale for continuing paroxetine and clonazepam as recommended by the pharmacist consultant. The facility's Drug Regimen Review policy, dated 02/10/23, stated a drug regimen review was performed for each resident at least once a month by a licensed pharmacist. The licensed pharmacist completes the drug regimen review by assessing the medication list and the resident's medical chart to identify potentially significant medication issues and notifies the physician if any discrepancies are found or additional information needed. The pharmacist would follow up until a response was received from the physician. The pharmacist would review to identify that medication doses and duration are appropriate, medication-related errors, and gradual dose reductions. The pharmacist would complete a Medication Regimen Review summary and ensure the director of nursing services and the physician receive a copy. These reports must be acted upon. The facility failed to follow up on the Pharmacist Consultant's recommendations regarding psychotropic medication use for R32, placing the resident at risk for unnecessary psychotropic medications. 37450 - R25 ' s Electronic Medical Record (EMR) documented diagnoses of dementia (a progressive mental disorder characterized by failing memory, and confusion), dysphagia (swallowing difficulty), gastrostomy status (G-tube: tube surgically placed through an artificial opening into the stomach), unspecified protein-calorie malnutrition, encephalopathy (a broad term for any brain disease that alters brain function or structure), urogenital candidiasis (yeast infection), obstructive and reflux uropathy (blocked or reduce urine flow), urinary tract infection (UTI), and weakness. The Quarterly Minimum Data Set (MDS), dated [DATE], documented R25 had severe cognitive impairment, disorganized thinking, and an altered level of consciousness present which fluctuated. R25 had not exhibited behaviors. R25 had no functional range of motion impairment and used a walker and wheelchair for mobility. R25 was dependent on staff for eating, oral care, toileting, bathing, upper and lower body dressing, and mobility. The MDS further documented R25 had an indwelling catheter (tube placed in the bladder to drain urine into a collection bag) and was always incontinent of bowel. He had no pain or pain treatments. R25 had a feeding tube (G-tube) and a mechanically altered diet; he received 51 percent (%) or more of his total calories through tube feeding with a fluid intake of 501 cubic centimeters (cc)/day or more. The resident received an antipsychotic (class of medications used to treat major mental conditions that cause a break from reality), antidepressant (class of medications used to treat mood disorders), antibiotic (medication to treat infections), and antiplatelet (medication to prevent blood from clotting). The antipsychotics were received on a routine basis only with no gradual dose reduction (GDR) attempted and no physician-documented GDR as clinically contraindicated. R25 also received speech and occupational therapy. The Psychotropic Drug Use Care Area Assessment (CAA), dated 02/21/24, documented R25 received an antidepressant for depression. It was hard to determine if the resident was depressed. He was not happy with his situation and would hit out at staff when they were giving care. The CAA further documented the monitoring of medication side effects and depression. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R25's Care Plan dated 05/20/24 documented R25 received medications with Black Boxed Warnings (BBW-highest safety-related warning that medications can have assigned by the Food and Drug Administration)or warnings of adverse consequences. The care plan directed staff to consult with the pharmacy and healthcare provider to consider dosage reduction when clinically appropriate. R25's Care Plan dated 05/20/24 documented R25 used psychotropic medications related to anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear) and directed staff to consult with the pharmacy and health care provider to consider dosage reduction when clinically appropriate; monitor for signs and symptoms of anxiety. The Physician Order dated 05/11/24 directed staff to administer Zyprexa (antipsychotic) 2.5 milligrams (mg) by mouth two times a day for anxiety and every six hours as needed for anxiety. The order lacked a 14-day stop date for the PRN dose. R25's EMR recorded Zyprexa 2.5 mg PRN dose was administered on 06/15/24 at 06:45 PM. The Progress Note dated 02/22/24 documented a note to the physician from the facility that R25 had more frequent yelling throughout the day and night; Tylenol PRN seemed ineffective and R25 denied pain. R25's family felt the behaviors were anxiety related, and R25 currently took Zyprexa 2.5 mg daily and Celexa (antidepressant) 20 mg daily. The physician responded by increasing R25's Zyprexa to 2.5 mg twice a day. The Consultant Pharmacist [CP] Progress Notes dated 03/28/24, 04/24/24, 05/28/24, and 06/25/24, lacked evidence the CP identified and reported related to the use of Zyprexa without an approved indication, or a documented physician rationale which included the nonpharmacological interventions which were tried and failed as well as a risk versus benefit for the use of an antipsychotic. The notes also lacked evidence the CP identified and reported the lack of the required 14-day stop date for the PRN Zyprexa. On 06/27/24 at 08:30 AM, observation revealed R25 sitting in the dining room with Certified Nurse Aide (CNA) M sitting next to him. CNA M fed the resident a ground and minced diet of eggs, ground sausage, and a thin liquid supplement. R25 ate without any signs of difficulty. CNA M reported R25 was eating well, but the resident had been in a mood for several days and had not eaten well. On 07/02/24 at 11:07 AM, CNA P reported R25 was not capable of verbalization most of the time. CNA P stated that R25 occasionally punched out at the staff, but not hard, and this usually happened during bathing. CNA P reported giving R25 time and space for about 10 minutes and this helped with behaviors. On 07/02/24 at 12:20 PM Administrative Nurse D verified R25's Zyprexa had an unapproved indication of anxiety. Administrative Nurse D verified the CP had not reported that the needed Zyprexa did not have a stop date (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Drug Regimen Review policy, dated 02/10/23, stated a drug regimen review was performed for each resident at least once a month by a licensed pharmacist. The licensed pharmacist completes the drug regimen review by assessing the medication list and the resident's medical chart to identify potentially significant medication issues and notifies the physician if any discrepancies are found or additional information needed. The pharmacist would follow up until a response was received from the physician. The pharmacist would review to identify that medication doses and duration are appropriate, medication-related errors, and gradual dose reductions. The pharmacist would complete a Medication Regimen Review summary and ensure the director of nursing services and the physician receive a copy. These reports must be acted upon. The facility failed to ensure the CP identified and reported that R25 lacked a 14-day stop for the use of PRN psychotropic medication and lacked an appropriate indication for Zyprexa. This placed the resident at risk for inappropriate use of medications.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37450 The facility had a census of 38 residents. The sample included 12 residents in which five residents were reviewed for unnecessary medications. Based on observation, record review, and interview, the facility failed to ensure Resident (R)25, R31, and R22 had an approved indication for the use of an antipsychotic-(class of medications used to treat major mental conditions that cause a break from reality), and failed to ensure R25's as needed (PRN) antipsychotic had a stop date. The facility further failed to ensure R32 had a risk versus benefit statement for the continued use of clonazepam (an antianxiety- class of medications that calm and relax people) and paroxetine (an antidepressant class of medications used to treat mood disorders) without a gradual dose reduction. This placed the residents at risk of receiving unnecessary psychotropic (alters mood or thought) medications. Findings included: - R25's Electronic Medical Record (EMR) documented diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), dysphagia (swallowing difficulty), gastrostomy status (G-tube: tube surgically placed through an artificial opening into the stomach), unspecified protein-calorie malnutrition, encephalopathy (broad term for any brain disease that alters brain function or structure), urogenital candidiasis (yeast infection), obstructive and reflux uropathy (blocked or reduce urine flow), urinary tract infection (UTI), and weakness. The Quarterly Minimum Data Set (MDS), dated [DATE], documented R25 had severe cognitive impairment, disorganized thinking, and an altered level of consciousness present which fluctuated. R25 had not exhibited behaviors. R25 had no functional range of motion impairment and used a walker and wheelchair for mobility. R25 was dependent on staff for eating, oral care, toileting, bathing, upper and lower body dressing, and mobility. The MDS further documented R25 had an indwelling catheter (tube placed in the bladder to drain urine into a collection bag) and was always incontinent of bowel. He had no pain or pain treatments. R25 had a feeding tube (G-tube) and a mechanically altered diet; he received 51 percent (%) or more of his total calories through tube feeding with a fluid intake of 501 cubic centimeters (cc)/day or more. The resident received an antipsychotic (class of medications used to treat major mental conditions that cause a break from reality), antidepressant (class of medications used to treat mood disorders), antibiotic (medication to treat infections), and antiplatelet (medication to prevent blood from clotting). The antipsychotics were received on a routine basis only with no gradual dose reduction (GDR) attempted and no physician-documented GDR as clinically contraindicated. R25 also received speech and occupational therapy. The Psychotropic Drug Use Care Area Assessment (CAA), dated 02/21/24, documented R25 received an antidepressant for depression. It was hard to determine if the resident was depressed. He was not happy with his situation and would hit out at staff when they were giving care. The CAA further documented the monitoring of medication side effects and depression. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R25's Care Plan dated 05/20/24 documented R25 received medications with Black Boxed Warnings (BBW-highest safety-related warning that medications can have assigned by the Food and Drug Administration) or warnings of adverse consequences. The care plan directed staff to consult with the pharmacy and healthcare provider to consider dosage reduction when clinically appropriate. R25's Care Plan dated 05/20/24 documented R25 used psychotropic medications related to anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear) and directed staff to consult with the pharmacy and health care provider to consider dosage reduction when clinically appropriate; monitor for signs and symptoms of anxiety. The Physician Order dated 05/11/24 directed staff to administer Zyprexa (antipsychotic) 2.5 milligrams (mg) by mouth two times a day for anxiety and every six hours as needed for anxiety. The order lacked a 14-day stop date for the PRN dose. R25's EMR recorded Zyprexa 2.5 mg PRN dose was administered on 06/15/24 at 06:45 PM. The Progress Note dated 02/22/24 documented a note to the physician from the facility that R25 had more frequent yelling throughout the day and night; Tylenol PRN seemed ineffective and R25 denied pain. R25's family felt the behaviors were anxiety related, and R25 currently took Zyprexa 2.5 mg daily and Celexa (antidepressant) 20 mg daily. The physician responded by increasing R25's Zyprexa to 2.5 mg twice a day. The Consultant Pharmacist [CP] Progress Notes dated 03/28/24, 04/24/24, 05/28/24, and 06/25/24, lacked evidence the CP identified and reported related to the use of Zyprexa without an approved indication, or a documented physician rationale which included the nonpharmacological interventions which were tried and failed as well as a risk versus benefit for the use of an antipsychotic. The notes also lacked evidence the CP identified and reported the lack of the required 14-day stop date for the PRN Zyprexa. On 06/27/24 at 08:30 AM, observation revealed R25 sitting in the dining room with Certified Nurse Aide (CNA) M sitting next to him. CNA M fed the resident a ground and minced diet of eggs, ground sausage, and a thin liquid supplement. R25 ate without any signs of difficulty. CNA M reported R25 was eating well, but the resident had been in a mood for several days and had not eaten well. On 07/02/24 at 11:07 AM, CNA P reported R25 was not capable of verbalization most of the time. CNA P stated R25 occasionally punched out at the staff, but not hard, and this usually happened during bathing. CNA P reported giving R25 time and space for about 10 minutes and this helped with behaviors. On 07/02/24 at 12:20 PM Administrative Nurse D verified R25's Zyprexa had an unapproved indication of anxiety and the PRN lacked a stop date as required. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's Psychotropic Medication policy, dated 12/06/23, documented the purpose of the policy to evaluate behavior interventions and alternatives before using psychotropic medications and to eliminate unnecessary psychotropic medications. The resident will be free from any chemical restraint imposed for the purpose of discipline or convenience and not be required to treat the resident's medical symptoms. If the physician prescribes an antipsychotic for the resident, a registered nurse must complete the Initial Antipsychotic Medication Assessment and the Abnormal Involuntary Movement Scale in PCC. While the use of PRN psychotropic medication is not encouraged, if a PRN physician order is received, ensure that the order has clear parameters, i.e., severe agitation that does not respond to other care plan interventions. It is important to initiate other care plan interventions prior to the use of PRN psychotropic medications. PRN orders for psychotropic drugs are limited to 14 days. If the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN orders. PRN orders for antipsychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of the medication. The facility failed to ensure R25 had an approved indication for the use of an antipsychotic and failed to ensure R25's PRN antipsychotic had a stop date. This placed the resident at risk of receiving unnecessary psychotropic medications. - R31's Electronic Medical Record documented diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), essential tremors, hypertension (HTN-elevated blood pressure), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear) disorder, and Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness) without dyskinesia (inability to execute voluntary movements). R31's Quarterly Minimum Data Set (MDS), dated [DATE], documented R31 had severe cognitive impairment, had an acute onset of mental status change, and inattention which fluctuated; R31 had not exhibited behaviors. R31 was independent with functional abilities and mobility. The MDS further documented R31 received an antipsychotic and an antianxiety medication. The antipsychotic was received on a routine basis, had no gradual dose reduction (GDR) attempt, and no physician documented GDR as clinically contraindicated. R31's Care Plan Care Plan, dated 04/14/24, documented R31 used psychotropic medication related to dementia with high anxiety. The care plan directed staff to consult with the pharmacy and healthcare provider to consider dosage reduction when clinically appropriate. The plan directed to attempt non-medication approaches such as watching television shows, giving ice cream, or providing a quiet place and one-on-one interactions in times of anxiety and agitation. The care plan documented R31 also took medication with a Black Boxed Warning (BBW- the highest safety-related warning that medications can have assigned by the Food and Drug Administration). The Physician Order dated 09/15/23, directed staff to administer Seroquel (antipsychotic) 12.5 milligrams (mg) by mouth one time a day for anxiety. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Pharmacist Consultant Review, dated 10/10/23, documented R31 had a diagnosis of dementia and received Seroquel for anxiety. Antipsychotics had Boxed Warnings for increased mortality in older adults with psychosis related to dementia. Please attempt a GDR of Seroquel with the end goal of discontinuation. The review also included a note from facility staff that R31 had noted the current dose was not helping with an increase in anxiety and agitation. The prescriber's response directed to start an antidepressant and continue Seroquel. The Pharmacist Consultant Review, dated 11/02/23, documented the order for Seroquel for anxiety and reviewed the diagnosis for the use of antipsychotic medication. The prescriber's response was to continue medication, R31 was tolerating well and had improved symptoms on the medication, The Pharmacist Consultant Review, dated 03/28/24, documented a GDR request for Seroquel, to provide clinical rationale supporting the continued use. The prescriber's response was R31 had severe dementia with agitation, was doing wonderful with treatment, and would attempt to decrease at a later date. The Progress Note, dated 06/02/24 at 10:28 AM, documented R31 had increased episodes of fixation and agitation. R31 had asked approximately 10 times that shift why the air conditioner was on; the nurse attempted explanation and redirection, but R31 continued to ask and attempted to put blankets on the vents in the television area. R31 was agitated with staff and education was provided. R31's EMR lacked evidence of a physician-documented rationale which included the nonpharmacological interventions that were attempted and failed for the continued use of Seroquel with no GDR attempts. On 06/26/24 at 02:52 PM, observation revealed R31 participating in the activity in the dining room. She wore a long sweater and carried a purse while she independently ambulated throughout the facility. On 07/02/24 at 11:23 AM, Certified Nurse Aide (CNA) P reported R31 was easily redirected when she got anxious. CNA P said it was helpful to spend one-on-one time with R31, direct her to her room, and try to resolve what might be making her anxious were also helpful to the resident. On 07/02/24 at 12:33 PM, Administrative Nurse D stated she was aware that the use of Seroquel was not approved for anxiety but R31's physician had not changed or updated the diagnosis or provided the required documentation. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's Psychotropic Medication policy, dated 12/06/23, documented the purpose of the policy to evaluate behavior interventions and alternatives before using psychotropic medications and to eliminate unnecessary psychotropic medications. The resident will be free from any chemical restraint imposed for the purpose of discipline or convenience and not be required to treat the resident's medical symptoms. If the physician prescribes an antipsychotic for the resident, a registered nurse must complete the Initial Antipsychotic Medication Assessment and the Abnormal Involuntary Movement Scale in PCC. While the use of PRN psychotropic medication is not encouraged, if a PRN physician order is received, ensure that the order has clear parameters, i.e., severe agitation that does not respond to other care plan interventions. It is important to initiate other care plan interventions prior to the use of PRN psychotropic medications. PRN orders for psychotropic drugs are limited to 14 days. If the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN orders. PRN orders for antipsychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of the medication. The facility failed to ensure R31 had an approved indication for the use of an antipsychotic. This placed the resident at risk of receiving unnecessary psychotropic medications. 26768 - R22's Electronic Medical Record (EMR) documented diagnoses of anxiety disorders (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), cerebral infarction (stroke), acute and chronic kidney failure (condition in which the kidneys lose the ability to remove waste and balance fluids), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), and congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid). The Annual Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of three, indicating severely impaired cognition. The MDS documented R22 had no behaviors. R22 required maximal to total assistance for mobility, dressing, and toileting. R22 received antipsychotic and antidepressant medications (a class of medications used to treat mood disorders). The Psychotropic Drug Use Care Area Assessment (CAA), dated 05/10/24, stated R22 received a small dose of Zyprexa (antipsychotic) for anxiety and Celexa (antidepressant). The CAA documented R22's mood has been stable, and he was doing well. R22 was seen by the tele-psych nurse for medication changes and status. R22's Care Plan, dated 05/14/24, directed staff to allow the resident time to respond due to slower processing of cognition skills. In the presence of behaviors or anxiety, staff were to provide opportunities for positive interaction and attention. The plan directed staff to minimize the potential for the resident's disruptive behaviors by offering tasks that divert attention. The plan directed staff to consult with the pharmacy and healthcare provider to consider dosage reduction when clinically appropriate. The Physician Order, dated 05/06/24, directed staff to administer Zyprexa (olanzapine) 2.5 milligrams (mg), two times a day for anxiety. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Physician Order, dated 03/18/2024, directed staff to administer Celexa (citalopram- antidepressant drug) 40 mg, at bedtime, for depression. The Medication Administration Record (MAR)/ Treatment Administration Record (TAR) documented R22 had no behaviors related to depression which included crying, isolation, yelling, change in mood, sadness, suicidal thinking, increased sleeping, or other depressive behaviors. R22 had no signs of psychosis which included crying, hallucinations, delusions, isolation, change in mood, sadness, suicidal thinking, increased sleeping, or other depressive behaviors. The Psychiatric Practitioner Note, dated 05/06/24, stated after tapering Zyprexa on 04/04/24, staff reported increased anxiety, excessive sleeping, and agitation. The prescriber increased Celexa to 30 mg after which staff reported some decrease in anxiety. The note stated R22's agitation begins at approximately 03:00 PM, but if identified, staff can calm R22 down most of the time. The practitioner ordered staff to continue Zyprexa 2.5 mg twice daily for mood or anxiety and increase Celexa to 40 mg daily. The Psychiatric Practitioner Note, dated 06/21/24, stated R22 had a significant past psychiatric history. Staff reported increased anxiety, some frustration, and anxiety with communication due to a stroke. Staff reported R22's anxiety levels had improved since he became aware of his schedule in advance. R22 stated he was doing well and not really having too much anxiety. He reported sleeping well and denied nightmares. The practitioner documented diagnoses of mood disorder with depressive features, dementia (a progressive mental disorder characterized by failing memory, and confusion), and generalized anxiety disorder. The note documented to continue to taper Zyprexa during subsequent visits as Kansas only approved the use of antipsychotics for certain diagnoses. The practitioner ordered to continue Celexa 20 mg daily for anxiety or mood. The Consultant Pharmacist Review, dated 11/14/23, questioned the diagnosis of anxiety for the use of Zyprexa. The physician responded- yes and documented anxiety without documenting a rationale for the indication or continued use of the antipsychotic medication. The Consultant Pharmacist Review, dated 12/13/23, recommended a gradual dose reduction (GDR) for Zyprexa and Celexa. The physician responded that R22 was evaluated by the psychiatric practitioner and ordered no changes without psychiatric physician involvement. No risk versus benefit rationale was documented. The Consultant Pharmacist Review, dated 06/06/24, recommended a GDR of Celexa 40 mg. The physician responded this was a recent increase with the in-house psychiatric practitioner, a GDR would be contradictive at this time. No risk versus benefit rationale was documented. On 06/27/24 at 07:31 AM, Licensed Nurse (LN) I administered an injection to R22. R22 stated he ate a good breakfast but couldn't remember exactly what he ate. On 07/01/24 at 01:22 PM, Administrative Nurse D stated R22 was admitted with the diagnosis of anxiety for Zyprexa. She verified anxiety was an inappropriate indication for the use of Zyprexa and stated the physician had not changed it when the Pharmacist Consultant had requested. Administrative Nurse D verified the facility failed to follow up on the pharmacist consultant's recommendations to obtain an appropriate indication for use or a written rationale for the continued use of Zyprexa which included the required documentation. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's Psychotropic Medications policy, dated 12/06/23, stated before the administration of non-emergency psychotropic medication the staff must document observations of mood, symptoms, or behaviors that cause the resident distress and or endanger the resident or others and the response to interventions used. The care plan would be updated with non-pharmacological interventions to be used. The policy stated if staff determined that initiating a medication was warranted, staff would contact the physician and describe the behavior, attempted interventions, and recommendations. Staff were to obtain the corresponding diagnosis and medical symptom for the medication from the physician. The policy mood and behavior documentation must continue to monitor the effectiveness of the psychotropic medication. Gradual dose reductions must be done according to federal regulations. The facility should attempt gradual dose reduction of psychotropic drugs during at least two separate quarters during the first year unless clinically contraindicated. Continued use may be contraindicated if it was in accordance with relevant current standard of practice and the physician has documented the clinical rationale for why any attempted dose reeducation would be likely to impair the resident's function or cause psychiatric instability or the resident's targeted symptoms returned or worsened after the most recent attempt at a gradual dose reduction at the facility and the physician has documented the clinical rationale for why any additional attempted dose reduction would be likely to impair the resident's function or cause psychiatric instability. The facility failed to ensure an appropriate indication or the required physician documentation for the continued use of antipsychotic medication for R32. This placed the resident at risk for unnecessary psychotropic medications and potential adverse effects. - R32's Electronic Medical Record (EMR) documented a diagnosis of dementia (a progressive mental disorder characterized by failing memory, and confusion). The Quarterly Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of five, indicating severely impaired cognition. The MDS documented R32 was independent for mobility, toileting, walking, and dressing. The MDS documented R32 received antianxiety (a class of medications that calm and relax people) and antidepressant (a class of medications used to treat mood disorders) medications. R32's Care Plan, dated 04/15/24, stated R32 used anti-anxiety medications related to dementia with anxiety disorder and directed staff to monitor and document side effects and effectiveness. Monitor R32 frequently for safety. Offer diversionary activities such as one one-on-one discussions. Offer the use of a rocking chair to ease anxiety. The plan directed staff to consult with the pharmacy and healthcare provider to consider dosage reductions when clinically appropriate. The Physician Order, dated 10/11/23, directed staff to administer paroxetine (a type of antidepressant medication), 20 milligrams (mg) daily for anxiety. The Physician Order, dated 10/20/23, directed staff to administer clonazepam (antianxiety medication that works by increasing the levels of a calming chemical in your brain) 0.5 mg daily for dementia. The Pharmacist Consultant Review, dated 03/28/24, recommended a gradual dose reduction (GDR) of paroxetine 15 mg daily and clonazepam 0.5 mg daily which the pharmacist wrote had been administered since 10/11/23. The physician declined the recommendation and wrote clinically contraindicated without writing a rationale or risk versus benefit statement. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Physician Visit Note, dated 05/24/24, documented R32 had severe dementia but had adjusted to living in the facility and seemed to be happier. The note recorded there were no changes to R32's medications. On 07/01/24 at 12:55 PM, observation revealed R32 independently ambulated from his room to the commons area and sat for a music activity. He was very polite and calm. On 07/02/24 at 10:15 AM, Administrative Nurse D verified the physician had not written a risk versus benefit statement or rationale for continuing paroxetine and clonazepam. The facility's Psychotropic Medications policy, dated 12/06/23, stated before the administration of non-emergency psychotropic medication the staff must document observations of mood, symptoms, or behaviors that cause the resident distress and or endanger the resident or others and the response to interventions used. The care plan would be updated with non-pharmacological interventions to be used. The policy stated if staff determined that initiating a medication was warranted, staff would contact the physician and describe the behavior, attempted interventions, and recommendations. Staff were to obtain the corresponding diagnosis and medical symptom for the medication from the physician. The policy mood and behavior documentation must continue to monitor the effectiveness of the psychotropic medication. Gradual dose reductions must be done according to federal regulations. The facility should attempt gradual dose reduction of psychotropic drugs during at least two separate quarters during the first year unless clinically contraindicated. Continued use may be contraindicated if it was in accordance with relevant current standard of practice and the physician has documented the clinical rationale for why any attempted dose reeducation would be likely to impair the resident's function or cause psychiatric instability or the resident's targeted symptoms returned or worsened after the most recent attempt at a gradual dose reduction at the facility and the physician has documented the clinical rationale for why any additional attempted dose reduction would be likely to impair the resident's function or cause psychiatric instability. The facility failed to obtain a written risk versus benefit statement or rationale for the continued use of the psychotropic medications for R32, without attempted GDR, placing the resident at risk for unnecessary psychotropic medications and potential adverse effects.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37450 The facility had a census of 38 residents. Based on observation, record review, and interview, the facility failed to store, prepare, and serve food under sanitary conditions for 38 residents who reside in the facility and receive meals from the facility kitchen, placing the residents at risk for foodborne illness. Findings included: -On [DATE] at 09:19 AM, during initial inspection of the kitchen observation revealed the walk-in refrigerator and freezer had numerous boxes directly stored on the floor. Dietary Staff (DS) BB reported the facility had received supplies the day prior, staff had not unloaded boxes, and the boxes should not have been stored on the floor. The walk-in refrigerator also contained a bag of carrots, opened with use by date of [DATE]. The white refrigerator in the main kitchen had an open, unsealed bag of chicken patties without a label or contents or use-by date on it. Two cups, one plastic, and one Styrofoam, were stored in the bulk bin of thickener, and the ice machine drainage spout was sitting flush on the drainage grate. On [DATE] at 10:57 AM, observation revealed dietary staff preparing for the noon meal. During the process of plating the meal for serving DS CC donned gloves and started preparing plates for residents in the dining room. DS CC picked up the diet menu card from being pulled from being stored in the service window once, which was placed there by DS DD. DS DD was providing residents with drinks as they entered the dining room. DS CC with wisps or several inches of hair that was not contained in the hair net started to plate the food. She used gloved hands to place chopped lettuce and tomatoes as a garnish for the meal. Throughout the serving process DS CC wiped her hands on her clothing and touched her face, and other surfaces in the kitchen without changing gloves. DS BB, assisting DS CC, wore gloves used to assist with plating and serving food, left the kitchen and when returned continued wearing the same gloves. The kitchen utilized two fans, one fan blew directly on the clean area of the dishwashing machine area, and the other fan directly blew on the food service window. Both fans had grey fuzzy material on the screen and blades. The sanitation test strips in the facility kitchen had expired dates of ,d+[DATE], [DATE], and [DATE]. The drawer, cabinet fronts, equipment, and table legs were sticky to the touch. On [DATE] at 02:10 PM, DS BB stated gloves should have been changed between tasks and serving. DS BB said the fans should be cleaned and she had notified the maintenance department about the ice machine drainage spout. DS BB reported she had not been aware that sanitation test strips had an expiration date and had ordered new ones to come when the next supplies were delivered. The facility's General Sanitation Food and Nutrition policy, dated [DATE], documented that the Director of Food and Nutrition Services director maintains a supply of appropriate test strips and thermometers. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility's Food Supple Storage policy, dated [DATE], documented the Use By/Use or [NAME] By, phrasing will inform customers that these products should be consumed on or before the listed date on the product. The date label is for perishable products with potential safety implications or material degradation of critical performance, such as nutrition. The facility's Hand Washing and Glove Use Food Nutrition Services policy, dated [DATE], documented that employees do not touch any food with bare hands. Proper utensils such as tissue, spatula, tongs, and single-use gloves should be used for food handling to reduce the risk of cross-contamination. The facility's Ice Machine Use and Maintenance policy, dated [DATE], lacked information regarding drainage air gap space. The facility failed to store, prepare, and serve food under sanitary conditions for 38 residents who reside in the facility and receive meals from the facility kitchen, placing the residents at risk for foodborne illness.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 26768 The facility had a census of 38 residents. The sample included 12 residents. Based on record review and interview, the facility lacked evidence the required committee members, including the medical director, attended the Quality Assurance Performance Improvement (QAPI) meetings at least quarterly. This placed the residents who resided in the facility at risk for decreased quality of care. Findings included: - The facility's QAPI meeting attendance sheets documented the members including the QAPI facilitator, the administrator, the director of nursing, the infection control preventionist, the safety director, the social services designee, the activity director, an environmental services employee, the pharmacist consultant, and the medical director. A review of the sign-in sheets from July 2023 through June 2024 revealed only four members attended the November 2023 meeting. The attendance sheets revealed the medical director did not attend a QAPI meeting during the last quarter of 2023. On 07/02/24 at 01:52 PM, Administrative Staff B verified the medical director did not attend and that there was overall low attendance at the QAPI meeting in November 2023. The facility's 2024 QAPI Plan, dated 01/30/24, stated the Plan was designed to outline a comprehensive and data-driven QAPI program that focuses on improving the outcomes and experiences of the residents. The QAPI plan provides a strategic approach to the prevention, identification, reporting, investigation, analysis, and development of performance improvement activities. The facility failed to ensure the medical director attended QAPI meetings at least quarterly as required which placed residents at risk of unidentified quality care services.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 26768 The facility had a census of 38 residents. The sample included 12 residents. Based on observation, interview, and record review the facility failed to ensure 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) for infection control were used when staff provided care for Resident (R) 22 and R91's urinary catheters (tube inserted into the bladder to drain urine into a collection bag). This placed residents at risk for potential infections and cross contamination. Findings included: - On 06/26/24 at 02:50 PM, observation revealed R22 in his wheelchair in the hall. CNA N assisted R22 to the common resident bathroom where she performed catheter care by emptying the drainage bag. CNA N donned gloves but no gown set the measuring container on a barrier on the floor, emptied the catheter drainage bag, and used an alcohol wipe on the port. CNA N changed gloves without washing her hands, placed the drainage bag back into a privacy bag under the wheelchair, and took the resident back out to the commons area. On 07/01/24 at 01:50 PM, observation revealed R91 in his room in a wheelchair. CNA M donned gloves, but no isolation gown, set a measuring container directly on the floor with no barrier, removed the catheter drainage bag from under the wheelchair, and set it on the floor. CNA M used an alcohol wipe on the port before and after draining the bag, dropped the alcohol wipe on the floor then picked it up and wiped the inside of the port holder on the bag with the contaminated wipe. CNA N attempted to place the drainage bag back into the privacy bag under the wheelchair, and at one point placed the urine collection bag on the floor while trying to attach the privacy bag under the wheelchair. CNA M removed his gloves and attached the privacy bag, handled the Foley bag, and then emptied the urine container into the toilet. He used hand gel before leaving the room. On 06/27/24 at 03:40 PM, Administrative Nurse D stated EBP should have been initiated for R91's catheter care the day he was admitted (06/25/24) and verified it had not been. On 07/01/24 at 02:00 PM, Administrative Nurse D verified the resident was on EBP and showed the bookmark size EBP sign attached to the doorframe. The resident had a small plastic three-drawer cart in the room with EBP supplies, but no sign to indicate that was what was in it. On 07/02/24 at 09:32 AM, LN H stated staff were to provide catheter care every shift and said staff should use gowns and gloves. LN H stated staff should not provide care in the common bathroom without EBP. On 07/02/24 at 09:42 AM, Administrative Nurse D verified the staff should have used EBP every time they provided any catheter care. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175231	A. Building B. Wing	07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Ellsworth Village	1156 Highway 14 Ellsworth, KS 67439

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Enhance Barrier Precautions (EBP) Protocol, directed staff to determine if EBP was needed for residents with wounds or indwelling medical devices and all residents infected or colonized with select MDROs. Staff was to set up a PPE station inside the resident's room, notify staff that EBP was needed during high contact care, post signs on resident doors, update the care plan, and educate staff, resident, and family. The facility failed to ensure EBP for infection control was used when staff provided care for R22 and R91's urinary catheters. This placed residents at risk for potential infections and cross-contamination.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37450 The facility had a census of 38 residents. The sample included 12 residents with five reviewed for medications. Based on observation, interview, and record review, the facility failed to implement antibiotic (medication used to treat infections) stewardship protocols to avoid unnecessary and/or inappropriate antibiotic use to reduce the risk of adverse events, including antibiotic resistance, when the facility failed to monitor the effectiveness of and identified inappropriate extended administration of an antibiotic for Resident (R) 25. This placed the resident at risk for complications related to antibiotic use. Findings included: - R25 ' s Electronic Medical Record (EMR) documented diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), dysphagia (swallowing difficulty), gastrostomy status (G-tube: tube surgically placed through an artificial opening into the stomach), unspecified protein-calorie malnutrition, encephalopathy (broad term for any brain disease that alters brain function or structure), urogenital candidiasis (yeast infection), obstructive and reflux uropathy (blocked or reduce urine flow), urinary tract infection (UTI), and weakness. The Quarterly Minimum Data Set (MDS), dated [DATE], documented R25 had severe cognitive impairment, disorganized thinking, and an altered level of consciousness present which fluctuated. R25 had not exhibited behaviors. R25 had no functional range of motion impairment and used a walker and wheelchair for mobility. R25 was dependent on staff for eating, oral care, toileting, bathing, upper and lower body dressing, and mobility. The MDS further documented R25 had an indwelling catheter (tube placed in the bladder to drain urine into a collection bag) and was always incontinent of bowel. He had no pain or pain treatments. R25 had a feeding tube (G-tube) and a mechanically altered diet; he received 51 percent (%) or more of his total calories through tube feeding with a fluid intake of 501 cubic centimeters (cc)/day or more. The resident received an antipsychotic (class of medications used to treat major mental conditions that cause a break from reality), antidepressant (class of medications used to treat mood disorders), antibiotic (medication to treat infections), and antiplatelet (medication to prevent blood from clotting). The antipsychotics were received on a routine basis only with no gradual dose reduction (GDR) attempted and no physician-documented GDR as clinically contraindicated. R25 also received speech and occupational therapy. The Dehydration/Fluid Maintenance Care Area Assessment (CAA), dated 02/21/24, documented R25 receives all fluids through G-tube, R25 received water before and after feedings, and one other time during the day. Labs monitored as ordered. R25's Care Plan, dated 05/20/24, documented R25 received antibiotic therapy related to prophylactic (preventative in nature) for urinary tract infection and sepsis (a life-threatening systemic reaction that develops due to infections that cause inflammation throughout the entire body). The care plan directed staff to monitor the resident condition based on clinical practice guidelines or clinical standards of practice related to the use of Augmentin (an antibiotic). (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Physician Order, dated 05/12/24, directed staff to administer amoxicillin-potassium clavulanate oral tablet 875-125 milligrams (mg) by mouth in the morning daily for prophylactically UTI. The order lacked a stop date. R25's clinical record lacked evidence of physician-documented rationale for the extended use of Augmentin and a benefit statement that the benefit outweighed the risk of increased antibiotic resistance. On 07/01/24 at 09:44 AM, observation revealed Certified Nurse Aide (CNA) Q took R25 to his room via wheelchair. CNA Q explained she was going to drain and measure the catheter leg bag. CAN Q donned appropriate PPE for EBP, then she proceeded to drain the leg bag into a measuring device and cleansed the drainage spout before adjusting the drainage bag under R25 ' s pant leg. The urine was straw in color and measured 100 milliliters (ml). CNA Q reported the catheter is drained every shift and staff are to put the drained amount in the EMR. CNA Q stated she would report to the charge nurse if there was no urine in the drainage bag if the urine had a bad odor, or if the resident seemed to have pain in the bladder area. On 07/02/24 at 12:20 PM, Administrative Nurse D stated R25 had been on Augmentin since admission. Administrative Nurse D reported she had provided antibiotic stewardship information and inquired to discontinue the use of the antibiotic, but the physician declined. The facility's Antibiotic Stewardship policy, dated 12/07/23, documented the purpose of the policy was to decrease the incidence of multi-drug resistance organisms (MDROs), to promote appropriate use while optimizing the treatment of infections and reducing the possible adverse events associated with antibiotic use. The facility failed to implement antibiotic use protocols to avoid unnecessary and/or inappropriate antibiotic use to reduce the risk for adverse events, including antibiotic resistance when the facility failed to monitor effectiveness and identify the extended use of Augmentin for R25, which placed the resident at risk for complications related to antibiotic use.