STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E451	A. Building B. Wing	07/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dawson Place	208 W Prout Street Hill City, KS 67642

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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37450 The facility had a census of 33 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to provide effective pain management for Resident (R) 15, who experienced pain. This deficient practice placed R15 at risk for ongoing pain and impaired quality of life. Findings included: - R15's Electronic Medical Record (EMR) included diagnoses of bilateral osteoarthritis (chronic arthritis without inflammation) of the knee, constipation (difficulty passing stools), chronic pain, edema (swelling resulting from an excessive accumulation of fluid in the body tissues), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), pain in the right and left knee, congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), and hypertension (HTN-elevated blood pressure). The Quarterly Minimum Data Set (MDS), dated [DATE], documented R15 had moderately impaired cognition and had verbal behavioral symptoms directed toward others which occurred one to three days of the seven-day observation period. R15 required partial/moderate assistance with toileting hygiene, upper body dressing, and transfers to the bed and chair. R15 required partial/moderate assistance with showering and lower body dressing. The MDS further documented R15 was frequently incontinent of urine and occasionally of bowel. R15 received scheduled and as-needed (PRN) pain medication and had pain frequently which interfered with day-to-day activities. R15 had shortness of breath with exertion and two or more falls with no injury. R15 also received an anticoagulant (class of medication to prevent blood from clotting), an antidepressant (class of medications used to treat mood disorders), a diuretic (medication to promote the formation and excretion of urine), an opioid (medication to treat pain) and a hypoglycemic (class of medication used to lower blood glucose levels). The Pain Care Area Assessment (CAA), dated 02/29/24, documented R15 had osteoarthritis of both knees and chronic pain. R15's knee pain limited his mobility, and his primary caregiver reported the pain had been getting worse at home. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R15's Care Plan, dated 03/14/24, stated R15 required limited to extensive assistance with all activities of daily living. R15 had a diagnosis of bilateral osteoarthritis, pain (especially knee pain), difficulty going from a lying to a sitting position, difficulty getting out of bed and chair, and used an electric recliner and rollator for ambulation with one staff assistance. The care plan further documented a new onset of incontinence since admission. The care plan lacked staff direction for non-medication pain relief measures to alleviate pain. The Physician Order dated 03/05/24, directed staff to administer Tylenol 8-hour oral tablet, extended-release, 650 milligrams (mg) four times a day for bilateral osteoarthritis of the knee and chronic pain. The Physician Order dated 02/20/24, directed staff to administer meloxicam 7.5 mg (an anti-inflammatory) by mouth every 24 hours PRN for pain related to bilateral osteoarthritis. R15's Medication Administration Record (MAR) revealed R15 received the PRN meloxicam and was utilized 02/20/24, 02/27/24, and 02/27/24. The Physician Order dated 02/23/24, directed staff to administrate oxycodone 2.5 mg (opioid) by mouth every four hours PRN for back pain related to chronic pain. R15's MAR revealed that oxycodone was utilized one time in February 2024. During the month of March 2024, R15's oxycodone was administered 13 times. During the month of April 2024, oxycodone was administered eight times. During the month of May 2024, R15's oxycodone was administered three times. During the month of June 2024, the oxycodone had been administered 12 times. From July 1 through July 7, 2024, R15'soxycodone was given five times. The PRN oxycodone is utilized during the nighttime hours. The Progress Note dated 05/18/24 at 11:53 PM, documented R15 had diagnoses that do cause him a great deal of discomfort and he had the tendency to become verbally aggressive and short-tempered when experiencing pain. R15 was noted to yell at staff during transfers and toileting if hurting. On 07/09/24 at 11:20 AM, observation revealed R15 exiting his bathroom using a wheeled walker. R15 moved slowly and stiffly, and he walked to his electric recliner. R15 stated both knees had been replaced when he was in his sixties, and the left knee had the most pain now. R15 said when he has pain, he cannot sleep and he asks for pain pills. R15 also reported having to get up through the night to use the bathroom, stating he could not use a urinal because he was not able to stand and hold the urinal without losing his balance, so he called for assistance as instructed by staff. On 07/09/24 at 02:35 PM, Certified Nurse Aide (CNA) MM, stated R15 complained of pain mostly in his left leg. He called for staff to help with moving the left leg. CNA MM reported that she tells the charge nurse when R15 is in pain. On 07/10/24 at 07:30 AM, Licensed Nurse (LN) G reported she was not aware of R15's increased use of oxycodone during the night and stated they had given R15's PRN pain medication only a few times during day shift hours. LN G was unsure what nonpharmacological interventions were in place or attempted for R15. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/10/24 at 09:29 AM, Administrative Nurse D verified R15 had pain which could affect his mood, mobility, and continence. Administrative Nurse D verified R15's frequent use of PRN pain medication but was unsure if R15's physician had been notified. Administrative Nurse D verified that R15's plan lacked nonpharmacological intervention for pain. The facility's Pain Management policy, dated 10/29/09, documents that pain management will be a part of each resident's initial and ongoing assessment. The resident's individual plan of care will address medication and non-medication-based intervention that will promote the residents' comfort and enhance their quality of life. Nursing will monitor for adverse effects and impact on activities of daily living of prescribed analgesics such as falls, constipation, drowsiness, etc., and implement interventions in the resident's care plan to address adverse effects and provide optimal safety for the resident. The facility failed to provide effective pain management related to the increased use of PRN oxycodone, and lack of non-medication interventions for R15 who experienced ongoing pain which impaired R15's quality of life.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 27168 The facility had a census of 33 residents. The sample included 12 residents. Based on record review and interview, the facility failed to conduct or implement nursing competencies required for residents' care needs, as identified through resident assessments and plans of care. This placed the residents at risk for decreased quality of care. Findings included: - On 07/10/24 at 11:15 AM, Certified Medication Aide (CMA) R stated the facility had not provided any competency skill checks with her. On 07/10/24 at 11:15 AM, Certified Nurse Aide (CNA) O stated the facility had not provided any competency skills checks with him. On 07/10/24 at 09:30 AM, Administrative Nurse D verified she had not performed any competency checks with the staff. The June 24, 2024 Facility Assessment included the resident population profile, resident acuity profile, staff training, licensing, and required continuing education. The assessment recorded the facility would provide ongoing education and staff training. The staff training and education program is designed to ensure knowledge competency for all staff. Education is provided through online training, monthly employee in-service, peer mentoring, and instructor-led sessions. The training and competency program are reviewed and revised each time the Facility Assessment is reviewed or revised. The facility failed to implement a competency evaluation program, placing the residents who resided in the facility at risk of receiving impaired quality of care.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. 27168 The facility had a census of 33 residents. The sample included 12 residents. Based on record review and interview, the facility failed to provide regular in-service education based on the outcome of performance reviews and failed to ensure all nurse aides received the required number of in-service training hours per year. This placed the residents at risk for impaired care. Findings included: - The facility's employment records documented 5 nurse aides were employed at the facility for at least one year. The facility's in-service records documented that three of those nurse aides had not completed the required 12 hours of in-service training in the past year. On 07/09/24 at 09:30 AM, Administrative Nurse D stated she had a system in place to monitor the completion of in-service hours, but it was not up to date and failed to provide the needed hours for the by nurse aide staff. On 07/09/24 at 04:00 PM, Administrative Staff A stated they were unaware there was no system in place to monitor the completion of in-service hours. Administrative Staff A said the facility was implementing a new program to track staff hours and verified that the facility did not currently complete performance reviews of nurse aide staff on a regular basis. The Facility Assessment, dated 06/24/24, documented the resident population profile, resident acuity profile, staff training, licensing, and required continuing education. The assessment recorded the facility would provide ongoing education and staff training sufficient to ensure the continued competencies of nurse aides but no less than 12 hours per year. The staff training and education program is designed to ensure knowledge competency for all staff. Education is provided through online training, monthly employee in-service, peer mentoring, and instructor-led sessions. The training and competency program are reviewed and revised each time the Facility Assessment is reviewed or revised. The facility failed to ensure nurse aides employed for at least one year received a performance evaluation and completed the required in-service education, placing the residents who resided in the facility at risk of impaired care.

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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** 27168 The facility had a census of 33 residents. The sample included 12 residents, with five reviewed for unnecessary medications. Based on observation, interview, and record review, the facility failed to ensure the Consultant Pharmacist identified and reported the lack of a 14-day stop date or specific duration with physician rationale for Resident (R) 14 and R33's as needed (PRN) psychotropic (alters mood or thoughts) medication. This placed the resident at risk for unnecessary medication with side effects. Findings include: - R14's Electronic Health Record (EHR) revealed diagnosis of protein-calorie malnutrition (inadequate intake of food and other essential nutrients that result in changes to the body composition and function), hypertension (HTN-elevated blood pressure, chronic kidney disease (mild to moderate damage and they are less able to filter waste and fluid from your body), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), and dementia (progressive mental disorder characterized by failing memory, confusion) with behavioral disturbance. R14's Quarterly Minimum Data Set (MDS), dated [DATE], recorded R14 had severely impaired cognition. The MDS recorded she required extensive assistance from two staff with bed mobility and transfers. The MDS did not document the resident received antianxiety medication. R14's Care Plan, dated 06/27/24 recorded that R14 received medications with a Black Box Warning (BBW-highest safety-related warning) and had nursing considerations that need to be monitored. The care plan recorded staff to monitor for respiratory depression and sedation. The Physician's Order, dated 02/09/22, directed the staff to administer lorazepam (antianxiety) 1.0 milligrams (mg) every two hours a day as needed for anxiety. The order lacked a stop date. R14's EHR lacked an end date for the lorazepam. Review of the Consultant Pharmacist monthly reviews for R14 revealed on 06/06/24, 05/07/24, 04/16/24, 03/11/24, 02/08/24, 01/11/24, 12/08/23, 11/13/23, 10/10/23, 09/12/23, 08/08/23, and 07/10/23 the reviews lacked a recommendation the lorazepam needed a 14 day stop date. On 07/09/24 at 07:40 AM, observation revealed that R14 sat in a Broda chair (special chair with tilt and recline capability) in the dining room. Certified Medication Aide (CMA) administered Keppra (anti-seizure medication) 500 mg, one half tab equal to 250 mg crushed in applesauce and the resident tolerated it well. On 07/09/24 at 09:30 AM, Administrative Nurse D verified the resident received lorazepam PRN and that the order lacked 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 Psychotropic Medication Monitoring policy, undated, documented the pharmacist would notify the physician Medical Director and Director of Nursing whenever a psychotropic medication is past due for review. Upon monthly review, the consultant pharmacist would make recommendations for dosage reductions/adjustments of antipsychotic medication for residents with dementia in accordance with the CMS regulations and guidelines. The consultant pharmacist would recommend to the physician, any specific dose reduction, additions/changes, and/or discontinuations, based on needs, labs, and current dose. The facility failed to ensure the Consultant Pharmacist identified and reported R14's lorazepam lacked a 14-day stop date. This placed the resident at risk for unnecessary antipsychotic medication with side effects. 32358 - R33's Electronic Medical Record (EMR) documented R33 had a diagnosis of anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). R33's Quarterly Minimum Data Set (MDS), dated [DATE], documented R33 had a Brief Interview of Mental Status (BIMS) score of seven, which indicated severe cognitive impairment. The MDS documented R33 did not receive an antianxiety medication during the observation period. R33's Care Plan, revised 05/09/24, documented R33 received Ativan (medication used for anxiety) and instructed staff to monitor R33 for side effects from the medication. R33's Physician Order, dated 05/10/24, instructed staff to administer Ativan, 0.25 milligram (mg) as needed (PRN), without a stop date. The Consultant Pharmacist (CP) drug regimen reviews revealed the following: On 05/07/24, the CP found no irregularities. On 06/06/24, the CP found no irregularities. A review of R33's clinical record lacked evidence the CP identified and notified the facility regarding the lack of a stop date for R33's PRN Ativan. On 07/09/24 at 07:50 AM, observation revealed R33 sat quietly in a chair at the dining room table with other residents. On 07/10/24 at 10:00 AM, Administrative Nurse D verified the CP had not alerted the facility of the lack of a stop date for R33's PRN Ativan. The facility's Consultants Policy, revised 11/21/17, documented that CP would provide to the Director of Nursing (DON) and Administrator written, dated, and signed findings, recommendations, plans for implementations, and plans for continued assessments. The CP failed to identify and report to the facility that R33's PRN Ativan lacked a stop date. This placed the resident at risk for unnecessary medication side effects.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27168 The facility had a census of 33 residents. The sample included 12 residents, with six reviewed for unnecessary medications. Based on observations, interviews, and record review, the facility failed to ensure a 14-day stop date or specified duration with physician rationale for Resident (R)14's, R16's, and R33's ongoing as needed (PRN) antianxiety (class of medications that calm and relax people) medication. This placed R14, R16, and R33 at risk for unintended effects related to psychotropic (alters mood or thought) drug medications. Findings include: - R14's Electronic Health Record (EHR) revealed diagnosis of protein-calorie malnutrition (inadequate intake of food and other essential nutrients that result in changes to the body composition and function), hypertension (HTN-elevated blood pressure, chronic kidney disease (mild to moderate damage and they are less able to filter waste and fluid from your body), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), and dementia (progressive mental disorder characterized by failing memory, confusion) with behavioral disturbance. R14's Quarterly Minimum Data Set (MDS), dated [DATE], recorded R14 had severely impaired cognition. The MDS recorded she required extensive assistance from two staff with bed mobility and transfers. The MDS did not document the resident received antianxiety medication. R14's Care Plan, dated 06/27/24 recorded R14 received medications with a Black Box Warning (BBW-highest safety-related warning) and had nursing considerations that need to be monitored. The care plan recorded staff to monitor for respiratory depression and sedation. The Physician's Order, dated 02/09/22, directed the staff to administer lorazepam (antianxiety) 1.0 milligrams (mg) every two hours a day as needed for anxiety. The order lacked a stop date. R14s EHR lacked an end date for the lorazepam. On 07/09/24 at 07:40 AM, observation revealed R14 sat in a Broda chair (special chair with tilt and recline capability) in the dining room. Certified Medication Aide (CMA) NN administered Keppra (anti-seizure medication) 500 mg, one half tab equal to 250 mg crushed in applesauce. On 07/09/24 at 09:30 AM, Administrative Nurse D verified the resident received PRN lorazepam that lacked a stop date. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Psychotropic Medication Monitoring policy, undated, documented the facility would use and administer psychotropic medications appropriately with the interdisciplinary team to ensure the appropriate use, evaluation, and monitoring. The facility would make every effort to comply with State and Federal regulations related to the use of psychopharmacological medications in the facility to include regular review for continued need, appropriate dosage, side effects, risks, and/or benefits. The facility supports the appropriate use of psychopharmacological medications that are therapeutic and enabling for residents suffering from mental illness while recognizing that the use of psychopharmacologic medications for dementia-related behaviors is inappropriate in most cases but rather the use of non-pharmacological interventions based on individual resident needs, preferences and routines is the most appropriate and first-line treatment for dementia-related behaviors. Efforts to reduce dosage or discontinue psychopharmacological medications will be ongoing, and appropriate, for the clinical situation. Psychotropic medications included: anti-anxiety/hypnotic, antipsychotic, and antidepressant classes of drugs. The policy documented that orders for as-needed (PRN) psychotropic medications would be time-limited to fourteen days or less and only for specific clearly documented circumstances. The policy documented the pharmacist would monitor psychotropic drug use in the facility to ensure that medications are not used in excess or for excess duration. The pharmacist would notify the physician Medical Director and Director of Nursing whenever a psychotropic medication is past due for review. Upon monthly review, the consultant pharmacist would make recommendations for dosage reductions/adjustments of antipsychotic medication for residents with dementia in accordance with the CMS regulations and guidelines. The consultant pharmacist would recommend to the physician, any specific dose reduction, additions/changes, and/or discontinuations, based on needs, labs, and current dose. The facility failed to ensure R14's lorazepam had a 14-day stop date or specified duration placing R14 at risk for adverse side effects. 37450 -R16's Electronic Medical Record (EMR) included diagnosis of congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), edema (swelling resulting from an excessive accumulation of fluid in the body tissues), mood disorder, dementia (progressive mental disorder characterized by failing memory, confusion), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), and respiratory failure with hypoxia (inadequate supply of oxygen), and adult failure to thrive. R16's Significant Change Minimum Data Set (MDS), dated [DATE], documented R16 had moderately impaired cognition, rejected care behaviors that occurred one to three days during a seven-day observation period, and other changes in behavior that worsened. R15 had a functional range of motion impairment of both lower extremities and required substantial/maximal assistance with functional abilities and mobility. R16 was always incontinent of urine and had pain which occasionally interfered with daily activities. The MDS further documented R16 had shortness of breath or trouble breathing with exertion and lying flat, and had a condition or chronic disease that may result in a life expectancy of less than six months. R16 received an antidepressant (class of medications used to treat mood disorders), diuretic (medication to promote the formation and excretion of urine), oxygen therapy, and hospice care (care of the terminally ill). (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R16's Care Plan, dated 06/11/24, documented R16 had been admitted to hospice services with diagnoses of heart disease, failure to thrive, low endurance, depression, anorexia (loss of appetite), and unavoidable weight loss. The care plan directed staff to monitor signs of pain or distress while providing care and notify hospice nursing staff if interventions for pain or distress are ineffective. The Physician Order dated 06/11/24, directed staff to administer Ativan 0.5 milligrams (mg) tablet by mouth every four hours as needed for anxiety. The order lacked the required stop date. The Progress Note dated 06/27/24 at 05:26 PM, documented a care plan meeting held in the morning, and a family member attended. No concerns were voiced and R16 expressed happiness with care; the goal was comfort and the family requested food not to be pushed to eat. On 07/08/24 at 12:10 PM observation revealed R16 in the dining room. R16's oxygen tubing and the nasal cannula were coiled and placed on the oxygen concentrator uncovered. On 07/09/24 at 09:23 AM, Administrative Nurse D stated the Ativan order came from hospice. Administrative Nurse D said she was unaware the order did not have a stop date. The facility's Psychotropic Medication Monitor updated policy, documented orders for as-needed psychotropic will be limited to fourteen (14) days or less and only for specific clearly documented circumstances. The facility failed to ensure R16 had the required stop date for the use of Ativan, a psychotropic medication which placed the resident at risk of receiving unnecessary psychotropic medications. 32358 - R33's Electronic Medical Record (EMR) documented R33 had a diagnosis of anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). R33's Quarterly Minimum Data Set (MDS), dated [DATE], documented R33 had a Brief Interview of Mental Status (BIMS) score of seven, which indicated severe cognitive impairment. The MDS documented R33 did not receive an antianxiety medication during the observation period. R33's Care Plan, revised 05/09/24, documented R33 received Ativan (medication used for anxiety) and instructed staff to monitor R33 for side effects from the medication. R33's Physician Order, dated 05/10/24, instructed staff to administer Ativan, 0.25 milligram (mg) as needed (PRN), without a stop date. On 07/09/24 at 07:50 AM, observation revealed R33 sat quietly in a chair at the dining room table with other residents. On 07/10/24 at 10:00 AM, Administrative Nurse D verified R33's physician's order for PRN Ativan failed to have a stop date, and stated she was unaware that hospice residents who had PRN Ativan required a stop date. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Psychotropic (alters mood or thought) Medication Monitoring Policy, undated, documented physician orders for PRN psychotropic medications would be time limited to 14 days or less and only for specific clearly documented circumstances. The facility failed to identify and report to the facility that R33's PRN Ativan lacked a stop date. This placed the resident at risk for unnecessary medications and related complications.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 32358 The facility had a census of 33 residents. The sample included 12 residents. Based on observation, record review, and interviews, the facility failed to employ a full-time certified dietary manager for the 32 residents who resided in the facility and received meals from the facility kitchen. This placed the residents at risk for inadequate nutrition. Findings included: - On 07/09/24 review of the noon meal consisted of baked honey-glazed ham, oven-browned potatoes, seasoned green beans, and Amish sugar cookies. On 07/09/24 at 10:20 AM, observation revealed Dietary Staff BB in the kitchen overseeing the preparation of the noon meal. On 07/09/24 at 10:20 AM, Dietary Staff BB verified she was not a certified dietary manager. Dietary Staff BB stated she had completed the classes but was not scheduled for the exam. On 07/10/24 at 09:07 AM, Administrative Staff A verified Dietary Staff BB had no dietary manager certification. The facility's Food and Nutrition Services, undated, documented the facility would employ a qualified, registered dietitian or other clinically qualified nutrition professional, either full-time or part-time or on a consultant basis, who meet the criteria set by the state of Kansas for such a position. if the facility does not employ a full-time qualified dietitian or other clinically qualified nutrition professional, the facility would designate a person to serve as the director of food and nutrition services who was for designations prior to November 2016 and meets the following requirements no later than 5 years after November 28, 2016, or no later than one year after November 28, 2016, for designations after November 28, 2016. a certified dietary manager a certified food service manager or an individual who has similar national certification for food service management and safety from a national certifying body or an individual who has an associate's or higher degree in food service or restaurant management, from an accredited institution of higher learning; and in states that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers and receiving frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional The facility failed to employ a full-time certified dietary manager for 32 residents who resided in the facility and received meals from the kitchen. This placed the residents at risk for inadequate nutrition.

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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. 32358 The facility had a census of 33 residents. The facility had one kitchen. Based on observation, record review, and interview, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety, in one of one kitchen. This placed the residents who received their meals from the facility's kitchen at risk for foodborne illness. Findings included: - On 07/08/24 at 07:28 AM, observation in the kitchen revealed the following: In the walk-in refrigerator, an unlabeled, undated container with 10 green peppers had a white substance on it. Dietary Staff (DS) CC verified the finding and discarded the green peppers. DS CC stated they were molded, and the fresh vegetables were not staying fresh like they should. In the area by the walk-in refrigerator, two loaves of whole grain bread with an expiration date of 07/06/24. DS DD verified the finding and discarded the loaves of bread. On 07/09/24 at 10:20 AM, observation in the kitchen revealed the upper white metal cabinets above the three-sink had numerous size brownish-black substances around the two cabinet handles. On 07/9/24 at 10:50 AM, Dietary Manager (DM) BB verified the issue with the cabinets and stated all staff were responsible for cleaning the kitchen, with tasks to complete daily. DM BB stated all staff should check the food items' expiration dates daily. The facility's Food Storage Policy, revised 06/14/16, documented that food service or other designated staff would always maintain clean food storage areas. The policy documented foods should be rotated as delivered and used the first in, first out method. Items would be dated on receipt to facilitate this procedure. The facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for the residents who received their meals from the facility's kitchen. This placed the residents at risk for foodborne illness.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27168 The facility had a census of 33 residents. The sample included 12 residents with two reviewed for hospice (a type of health care that focuses on the terminally ill patient's pain and symptoms and attending to their emotional and spiritual needs at the end of life) services. Based on observation, record review, and interview, the facility failed to ensure a coordinated plan of care, which coordinated care and services provided by the facility with the care and services provided by hospice, was developed and available for Resident (R)14 and R 16. This placed R14 and R16 at risk for inappropriate end-of-life care. Findings included: - R14's Electronic Health Record (EHR) revealed diagnosis of protein-calorie malnutrition (inadequate intake of food and other essential nutrients that result in changes to the body composition and function), hypertension (HTN-elevated blood pressure, chronic kidney disease (mild to moderate damage and they are less able to filter waste and fluid from your body), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), and dementia (progressive mental disorder characterized by failing memory, confusion) with behavioral disturbance. R14's Quarterly Minimum Data Set (MDS), dated [DATE], recorded R14 had severely impaired cognition. The MDS recorded she required extensive assistance from two staff with bed mobility and transfers. The MDS documented the resident received hospice services. R14's Care Plan, dated 04/10/24, recorded R14 required extensive assistance with most activities of daily living (ADL) care. R14's Care Plan documented the resident received hospice services due to severe protein-calorie malnutrition and directed staff to administer pain medication as ordered and notify the hospice nurse if there is breakthrough pain. The plan lacked instruction on the services provided by hospice including hospice staff visits, supplies and medical equipment provided by hospice, and medications covered by hospice. A review of R14's medical records revealed the resident was admitted to hospice care on 11/26/22 but lacked evidence of coordination of care between hospice and the facility. The facility had received a hospice plan of care dated 03/08/24 and an end date of 05/08/24. The review revealed there was no communication book or external document. On 07/09/24 at 07:45 AM, R14 sat in a Broda chair (special chair with tilt and recline capability) at the dining room table. Certified Nurse Aide (CNA) MM assisted the resident to eat her breakfast On 07/10/24 at 09:45 PM, Administrative Nurse D stated she expected the facility to have a hospice care plan for R14 to be able to coordinate care with hospice services. Administrative Nurse D verified the facility lacked a hospice care plan that coordinated with the facility care plan. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Hospice Policy and Procedure policy, dated 05/24/24, documented the nursing facility and the hospice are responsible for performing each of their respective functions that have been agreed upon and included in the Plan of Care. Hospice retains overall professional management responsibility for directing the implementation of the Plan of Care related to terminal illness and related conditions. When a resident is admitted to Hospice Care the Plan of Care reflects the participation and responsibility of the hospice staff, the nursing facility staff, and the resident or representative. The Plan of Care will include directives for ongoing pain management and the hospice and nursing facility staff will communicate with each other regarding indications of need for care plan adjustment. The facility failed to coordinate care between the facility and the hospice provider for R14, who received hospice services. This deficient practice placed her at risk for inappropriate end-of-life care. 37450 - R16's Electronic Medical Record (EMR) included diagnosis of congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), edema (swelling resulting from an excessive accumulation of fluid in the body tissues), mood disorder, dementia (progressive mental disorder characterized by failing memory, confusion), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), and respiratory failure with hypoxia (inadequate supply of oxygen), and adult failure to thrive. R16's Significant Change Minimum Data Set (MDS), dated [DATE], documented R16 had moderately impaired cognition, rejected care behaviors that occurred one to three days during a seven-day observation period, and other changes in behavior that worsened. R15 had a functional range of motion impairment of both lower extremities and required substantial/maximal assistance with functional abilities and mobility. R16 was always incontinent of urine and had pain which occasionally interfered with daily activities. The MDS further documented R16 had shortness of breath or trouble breathing with exertion and lying flat, and had a condition or chronic disease that may result in a life expectancy of less than six months. R16 received an antidepressant (class of medications used to treat mood disorders), diuretic (medication to promote the formation and excretion of urine), oxygen therapy, and hospice care (care of the terminally ill). R16's Care Plan, dated 06/11/24, documented R16 had been admitted to hospice services with diagnoses of heart disease, failure to thrive, low endurance, anorexia (loss of appetite), and unavoidable weight loss. The care plan directed staff to monitor signs of pain or distress while providing care and notify hospice nursing staff if interventions for pain or distress are ineffective. The plan lacked instruction on the services provided by hospice including hospice staff visits, supplies and medical equipment provided by hospice, and medications covered by hospice. A review of R16's medical records revealed the resident was admitted to hospice care on 06/11/24 but lacked evidence of coordination of care between hospice and the facility for a certified period of 06/11/24 to 09/08/24. Further review revealed no communication book. The Progress Note dated 06/27/24 at 05:26 PM, documented a care plan meeting was held in the morning, and family members attended. No concerns were voiced and R16 expressed happiness with care. The goal was comfort and the family requested food not to be pushed to eat. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/09/24 at 12:15 PM observation revealed R16 sat in the dining room, in a wheelchair being assisted with eating lunch. On 07/09/24 at 03:52 PM, Certified Nurse Aide (CNA) N reported R16 was on hospice services. CNA N stated hospice usually provided incontinent briefs, pads, and wipes, but if she had questions about care she would consult the charge nurse or Director of Nursing. On 07/10/24 at 09:45 PM, Administrative Nurse D stated she expected the facility to have a hospice care plan for R16 to be able to coordinate care with hospice services. Administrative Nurse D verified the facility lacked a hospice care plan that coordinated with the facility care plan. The Hospice Policy and Procedure policy, dated 05/24/24, documented the nursing facility and the hospice are responsible for performing each of their respective functions that have been agreed upon and included in the Plan of Care. Hospice retains overall professional management responsibility for directing the implementation of the Plan of Care related to terminal illness and related conditions. When a resident is admitted to Hospice Care the Plan of Care reflects the participation and responsibility of the hospice staff, the nursing facility staff, and the resident or representative. The Plan of Care will include directives for ongoing pain management and the hospice and nursing facility staff will communicate with each other regarding indications of need for care plan adjustment. The facility failed to coordinate care between the facility and the hospice provider for R16, who received hospice services. This deficient practice placed her at risk for inappropriate end-of-life care.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 37450 The facility had a census of 33 residents. Based on observation, record review, and interview, the facility failed to implement Enhanced Barrier Precautions (EBP-an infection control practice that uses personal protective equipment (PPE) to reduce the spread of multi-drug resistant organisms (MDROs) for Resident (R) 10 who had an indwelling urinary catheter (tube placed in the bladder to drain urine into a collection bag) and R3 who had an enteral (provision of nutrients through the gastrointestinal tract when the resident cannot ingest, chew or swallow food) feeding tube while providing direct care contact. The facility also failed to implement a water management program for Legionella disease (Legionella is a bacterium spread through mist, such as air-conditioning units in large buildings. Adults over the age of 50 and people with weak immune systems, chronic lung disease, or heavy tobacco use are most at risk of developing pneumonia caused by legionella). These deficient practices placed the facility's residents at risk of contracting or spreading infectious processes. Findings included: - On 07/08/24 at 03:52 PM observation revealed Licensed Nurse (LN) H administered R3's medication via feeding tube. LN H donned gloves, but not a gown. No signage or additional PPE related to ENP was noted in the resident's room. On 07/09/24 at 01:52 PM, observation revealed Certified Nurse Aide (CNA) N, donned gloves and proceeded to empty R10's indwelling catheter drainage bag. No signage or additional PPE related to EBP was noted in the resident's room. On 07/09/24 at 01:37 PM, Administrative Nurse D stated there were no residents on EBP. Administrative Nurse D stated she was not aware of what defined EBP and that staff was to utilize standard precaution (an infection control technique of avoiding contact with patients' bodily fluid by wearing nonporous articles, such as gloves) for all residents. On 07/09/24 at 03:01 PM, Administrative Nurse E reported she had a meeting about a month or so ago with nursing and housekeeping regarding EBP and was not aware staff were not following the protocol. Administrative nurse E said she was unsure of who was responsible for initiating EBP for residents who required it. On 07/10/24 at 09:25 AM, Administrative Staff A reported the maintenance department lacked information and verified the lack of procedures related to the waterborne pathogens system management. On 07/10/24 at 09:35 AM, Administrative Nurse D stated the Infection Preventionist was responsible for implementing EBP. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility's Infection Prevention and Control Program policy, dated 04/01/20, documented the facility maintains an organized, effective facility-wide program designed to symptomatically identify and reduce the risk of acquiring and transmitting infections among residents, visitors, and healthcare workers. This program involves the collaboration of all staff and services within the facility and is designed to meet the needs and safety of our residents. Authority of the Infection Prevention and Control program has been delegated by the Director of Nursing (DON) to the facility's Infection Preventionist. In collaboration with the DON and the Medical Director, the Infection Preventionist has the authority to institute emergency medical and/or administrative actions when there is danger or threat to residents and/or staff regarding infection prevention/control matters. The facility has infection prevention policies and procedures, which outline strategies designed to reduce the risk of transmission of infectious agents among healthcare workers, residents, and visitors. Policies and procedures are based on relevant guidelines. The facility's Legionella Risk Management Policy dated 07/18/18, documented the purpose of the policy is to ensure, that as far as possible, all users of this facility are protected from the incident of Legionnaire's disease. The Maintenance Supervisor is responsible for all relevant details regarding roles and responsibilities and testing regimes contained in this policy and procedure. It is the policy of this facility to ensure that appropriate precautions for the control of legionella bacteria are identified through a Legionella risk assessment process and appropriate control measures implemented to ensure, so far as is reasonably practicable, the health, safety, and welfare of residents, visitors, staff members, and volunteers. The facility failed to implement EBP for R10 who had an indwelling urinary catheter and R3 who had an enteral feeding tube and failed to implement a water management program for Legionella disease which placed the facility's residents at risk of contracting or spreading infectious processes.

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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 33 residents. Based on interview and record review, the facility failed to consistently utilize an antibiotic stewardship program that included tracking, monitoring, and attempts to decrease the use of unnecessary antibiotic (a class of medications used to treat infections) treatments which placed Resident (R) 17 at risk of adverse outcomes associated with the inappropriate use of antibiotics and development of antibiotic-resistant organisms. Findings included: - R17's Electronic Medical Record (EMR) included diagnoses of major depressive disorder (major mood disorder that causes persistent feelings of sadness), Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremors, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness), schizoaffective (mental disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought) disorder bipolar type (major mental illness that caused people to have episodes of severe high and low moods), personal history of urinary tract infection (UTI-an infection in any part of the urinary system), and diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin). R17's Quarterly Minimum Data Set (MDS), dated [DATE], documented R17 had intact cognition and had not exhibited behaviors. R17 had a functional range of motion of the lower extremities and required partial to moderate assistance with functional abilities and substantial to maximal assistance with mobility. R17 utilized an external urinary catheter, had a toileting program, and was frequently incontinent of urine. The MDS further documented R17 received scheduled and as-needed pain medication, an antidepressant (class of medications used to treat mood disorders), an anticoagulant (class of medications to prevent blood from clotting), and an antibiotic. The Urinary Incontinence Care Area Assessment (CAA), dated 01/17/24, documented R17 had an overactive bladder, a history of UTI with scheduled prophylactic (preventative in nature) antibiotic, used a sit-to-stand lift for transfers, wore incontinent products, declined a toileting schedule and was incontinent. R17's Care Plan, dated 03/02/23, documented R17 had an activity of daily living self-care performance related to impaired balance, Parkinson's disease, and mood disorder. The care plan directed staff to provide extensive assistance with all activities of daily living. The care further directed R17 required extensive assistance with toileting tasks and with peri-care by staff to ensure proper wiping; R17 wore pull-ups and staff were directed to apply the external catheter at night. The Physician Order dated 02/01/23, directed staff to administer cephalexin (antibiotic) oral tablet 250 milligrams (mg) at bedtime. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Pharmacy Consultant Note dated 09/12/23, documented a periodic review is needed for prophylactic antibiotics due to the risk of resistant organisms. Pushing non-sugar fluid and good peri-care and catheter care show evidence for the prevention of UTI infections. Suggestion to switch cephalexin to methenamine Hippurate (medication used to prevent UTI) 1 gram twice a day for UTI prophylaxis and requested a note of benefit versus risk. The physician's response was no changes. However, the physician did not document a risk versus benefit statement. R17's clinical record lacked evidence of a physician-documented rationale for the ongoing use of antibiotics for prophylaxis. On 07/08/24 at 03:52 PM, R17 reported continued use of the external catheter at night and stated she took an antibiotic daily to prevent UTIs. On 07/09/24 at 02:39 PM during the review of the infection control survey task along with reviewing R17's antibiotic use, Administrative Nurse E and Administrative Nurse F who shared duties of Infection Preventionist (IP) role, explained the antibiotic stewardship began with the floor nurses when observation of changes in a resident's condition were identified. The nurse filled out a form that documented signs, symptoms, vital statistics, and other concerns associated with the condition change. The form was sent to the physician for review and orders if needed. The form was also processed through medical records for documentation in the medical record. Once an antibiotic order was prescribed, the antibiotic information was logged for specific requirements to further assess the appropriateness of the treatment. The IPs reported when the antibiotic order did not meet the criteria, they notified the physician to discontinue the medication and/or consider another course of treatment. If the prescriber did not respond or provide a risk versus benefit statement, the antibiotic would continue as ordered. The IPs verified this process lacked documentation of communication with prescribers. The IPs reported the continued use of antibiotic therapy without meeting the criteria for an infectious process and further verified R17's ongoing prophylactic use of an antibiotic without recent confirmation of signs or symptoms of infections or supportive lab evidence. The IPs said the information was brought to the monthly risk/quality assurance meeting but lacked further action from the facility or prescribers. The facility's Antibiotic Stewardship Program policy, dated 01/04/21, documented the facility will implement an Antibiotic Stewardship Program (ASP) which will promote the appropriate use of antibiotics while optimizing the treatment of infections, at the same time reducing the possible adverse events associated with antibiotic use, potential to limit antibiotic resistance in the care setting, improving treatment efficacy and resident safety. Activities include these basic elements: leadership, accountability, drug expertise, action to implement recommended policies or practices, tracking measures, reporting data, education for clinicians, nursing staff, residents and families. The mission of the ASP is to provide the best antimicrobial therapy (right dose, right drug, and right duration) to residents that results in the best outcome with the least amount of toxicity and resistance. The facility failed to ensure an effective antibiotic stewardship program which included a system to assess the appropriateness of antibiotic usage in the facility, which placed the resident at risk of unnecessary antibiotic treatments.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. 37450 The facility had a census of 33 residents. Based on the interview and record reviews the facility failed to offer pneumococcal (type of bacterial infection) PCV20 immunizations for Residents (R) 3, R4, and R19 per the guidance from the Centers for Disease Control and Prevention (CDC) This placed the residents at risk for pneumococcal infection. Findings included: - R3's Electronic Health Record (EHR) documented i R3 received one Pneumovax dose on 10/09/18. The facility lacked documentation R3 was offered or refused any further pneumococcal vaccinations. R4's EHR documented R4 received one Pneumovax dose on 04/12/22. The facility lacked documentation R4 was offered or refused any further pneumococcal vaccinations. R19's EHR documentation indicated R19 received one Pneumovax dose on 04/12/22. The facility lacked documentation R19 was offered or refused any further pneumococcal vaccinations. During an interview on 07/09/24 at 03:01 PM, Administrative Nurse E and F verified the three residents had not received or been offered a second pneumonia immunization since admission to the facility, and the facility had not screened the residents for eligibility for a second pneumovax. During an interview on 07/10/24 at 09:40 AM, Administrative Nurse D stated she was unsure what the pneumococcal vaccination requirements were, but she expected the Infection Preventionist (IP) to know and provide residents with the required immunizations. The facility's Immunization and Pneumococcal Immunizations policy, revised 01/27/10, documented all residents will be provided appropriate information in order for a resident to execute his or her right to make an informed choice about receiving influenza and/or pneumococcal vaccine. Offer a pneumococcal immunization unless the immunization is medically contraindicated, or the resident has already been immunized. The facility failed to offer R3, R4, and R19 the updated pneumococcal immunization per current guidelines. This placed the residents at risk of acquiring pneumonia.

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F 0908 Level of Harm - Potential for minimal harm Residents Affected - Many	Keep all essential equipment working safely. 32358 The facility had a census of 33 residents. The sample included 12 residents. Based on observation, record review, and interview the facility failed to ensure one of two kitchen ovens was in safe and operable condition. Findings included: - On 07/09/24 at 10:20 AM, observation revealed in the kitchen one oven was not working. On 07/09/24 at 10:20 AM, Dietary Manager (DM) BB verified one oven was not working and stated it had a gas leak so a company came in and capped it off approximately 1.5 years ago. DM BB stated it was on the list to be replaced. On 07/10/24 at 09:07 AM, Administrative Staff A stated she was unaware one of the kitchen ovens was not working. She stated she knew the dietary manager had put in for a grant to update the kitchen but ended up not qualifying for the grant. Administrative Staff A was unaware of a kitchen repair list. Administrative Staff A stated she would notify the facility board. Upon request, the facility did not provide a preventative maintenance policy. The facility failed to maintain all mechanical, electrical, and resident care equipment in safe operating condition.