

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  245412	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/25/2025
NAME OF PROVIDER OR SUPPLIER  Cokato Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  182 Sunset Avenue Cokato, MN 55321	

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)
<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49657</p> <p>Based on interview, and document review the facility failed to ensure advanced directives for emergency treatment were accurately reflected in all areas of the medical record to ensure the residents wishes would be implemented correctly in an emergent situation for 1 of 1 (R45) residents reviewed for inconsistent advanced directives.</p> <p>Findings include:</p> <p>R45's quarterly Minimum Data Set (MDS) dated [DATE], indicated R45 was admitted on [DATE], was cognitively intact, and had the following diagnoses: Hyperlipidemia (high fat levels in the blood), and Schizophrenia.</p> <p>R45's untitled code status form dated [DATE], indicated R45's resuscitation wishes were Do Not Resuscitate. The Document was signed by R45, their family member, and the physician.</p> <p>R45's physician orders reviewed and saved on [DATE] at 6:01 p.m., indicated R45 was FULL CODE.</p> <p>On [DATE] at 6:02 p.m., trained medical assistant (TMA)-B stated they would refer to the resident's hard chart when the needed to know their code status. TMA-B went to charting room and visually pointed out R45's code status was DNR on their hard chart, which would have been correct.</p> <p>On [DATE] at 6:05 p.m., registered nurse (RN)-A stated when needed to confirm a resident's code status they would use the hard chart or the face sheet. RN-A confirmed R45 was a DNR. RN-A stated the provider would typically go over the code status with a resident and then it would be entered into the charting system.</p> <p>On [DATE] at 6:09 p.m., the director of nursing (DON) stated their expectation for checking code statuses was employees will check the resident's hard chart in the report room, where the code statuses are on the side of the book, in their medical administration record (MAR), or on the matrix banner. Typically, social services will go over code statuses with residents, and then a record keeper will enter the order once it is signed. DON stated RN's will typically review the code status order prior to it being entered into the electronic medical record (EMR) but stated it was not always happening. The DON reviewed R45's chart and EMR and stated R45 was a DNR, the DON then reviewed the physician orders and confirmed R45's was listed as a FULL CODE and not a DNR as per R45's wishes. The DON confirmed all areas in the chart should match to fulfill the resident wishes.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility's Cardiopulmonary Resuscitation (CPR) policy last reviewed ,d+[DATE], indicated they provided basic life support, including CPR-Cardiopulmonary Resuscitation, when a resident required such emergency care, subject to physician order and resident choice indicated in the resident's advance directives.</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 44645</p> <p>Based on interview and document review, the facility failed to notify the attending physician of a change in condition for 1 of 1 residents (R46) reviewed for new onset of tardive dyskinesia symptoms (repetitive, involuntary movements) often caused by antipsychotic medications.</p> <p>Findings include:</p> <p>R46's quarterly Minimum Data Set (MDS) dated [DATE], indicated R46 admitted to the facility on [DATE], had severe cognitive impairment, and diagnoses included Alzheimer's disease, delusional disorders, and anxiety disorder.</p> <p>R46's care plan revised 4/23/25, identified psychotropic drug use, and approaches included Abnormal Involuntary Movement Scale (AIMS) assessment per pharmacy recommendation, and physician notified of changes in condition.</p> <p>R46's Order History report, printed 4/24/25, indicated R46 was prescribed increasing doses of quetiapine (antipsychotic medication) for delusional disorder as follows:</p> <ul style="list-style-type: none"> <li>- admission order quetiapine 12.5mg at bedtime</li> <li>- increased quetiapine to 25mg at bedtime on 11/19/24</li> <li>- increased quetiapine to 25mg twice a day (BID) on 12/12/24</li> <li>- increased quetiapine to 50mg BID on 1/3/25</li> </ul> <p>R46's initial AIMS assessment, dated 11/22/24, indicated a score of 0 with no observed involuntary movements.</p> <p>R46's follow-up AIMS assessment, dated 3/27/25, indicated a score of 4 with an increase in symptoms, and to continue current plan of care. However, the assessment did not indicate the physician had been notified of the increase in tardive dyskinesia symptoms.</p> <p>R46's clinical record lacked evidence the physician was notified of R46's change in condition.</p> <p>On 4/25/25 at 12:25 p.m., consulting pharmacist (PharmD) stated the purpose of an AIMS assessment was to monitor for tardive dyskinesia symptoms related to antipsychotics, and score changes should be communicated to the provider. PharmD stated it was important to notify the provider so the risks versus benefits could be reviewed, and the provider would need to have rationale documented for continuing the antipsychotic medication.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/25/25 at 1:53 p.m., director of nursing (DON) stated the purpose of an AIMS assessment was to monitor for adverse side effects from antipsychotic medications, and nurses were expected to notify the provider. DON stated it was important to notify the prescribing physician for the safety of the resident. DON verified R46's clinical record lacked evidence the nurse had not notified the physician that R46's AIMS score increased from 0 to 4. DON stated nurses were expected to document in the clinical record to support the physician had been notified.</p> <p>A policy was requested, but not provided by the facility.</p>		

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49657</p> <p>Based on interview, and document review, the facility failed to ensure a level II preadmission screening and resident review (PASARR) was completed for 1 of 2 residents (R5) reviewed for PASARR's.</p> <p>Findings Include:</p> <p>R5's quarterly Minimum Data Set (MDS) dated [DATE] indicated R5 was admitted to the facility on [DATE], and had the following diagnoses: Schizophrenia, arthritis, and diabetes.</p> <p>R5's Level 1 PASARR dated 4/30/24, indicated the screening was completed on 4/30/24 and prior to admission, R5 required a level II PASARR screening to be completed. No level II PASARR was found or provided.</p> <p>On 4/23/25 at 8:39 a.m., the social services director (SS)-A stated R5 had come from another facility, and they had used the other facilities completed PASARR for R5's admission. However, they were unaware a Level II PASARR was required until the survey team arrived onsite. SS-A confirmed they were typically responsible for completing the PASARR, and stated they had missed it and confirmed it was never completed.</p> <p>On 4/24/25 at 1:23 p.m., the administrator stated they expected the PASARR screenings to be completed by social services, themselves, or another delegated staff upon admission to the facility, and was important to complete to ensure each resident receives the cares and services they need.</p> <p>A policy related to PASARR was requested and none were provided.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49654</p> <p>Based on observation, interview and record review, the facility failed to ensure a comprehensive care plan was developed and maintained to ensure proper interventions were in place to prevent falls/lessen the likelihood of injury for 1 of 2 residents (R8) reviewed for falls.</p> <p>Findings include:</p> <p>R8's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated severe cognitive impairment without hallucinations or delusions present, and no behaviors. Section J: Health indications indicated R8 had two or more falls without injury and two or more falls with minor injury since admission. Section O: Special Treatments and Programs indicated R8 was not currently receiving physical or occupational therapies.</p> <p>R8's Face sheet printed 4/25/25, indicated R8 admitted to the facility on [DATE]. Furthermore, it also identified the following relevant diagnoses: osteoarthritis (degeneration of joints that causes pain and stiffness), weakness, and mixed incontinence.</p> <p>R8's care plan reviewed on 4/22/25, indicated R8 received assistance with mobility and was at risk for falls due to physical limitations, incontinence, and poor safety awareness.</p> <p>R8's progress notes indicated 23 documented falls between 10/8/24 and 4/16/25.</p> <p>During observation on 4/21/25 at 03:30 p.m., R8 was in room, seated in wheelchair with feet propped on bed, crossed at ankle. Door was open approximately 3-4 inches and had to be pushed open to fully view resident. Call light was on bed between pillow and wall, out of resident's reach.</p> <p>During observation on 4/21/25 at 5:52 p.m., R8's door was open approximately 3-4 inches. Left back wheelchair wheel was observed, however, could not visualize resident fully.</p> <p>During observation on 4/22/25 at 12:34 p.m. room door was opened and R8 was fully visible. Wheelchair brakes were unlocked, and resident was observed to be leaning forward sitting on edge of seat reaching for objects in room chair. Call light was on the bed pillow outside of resident's. Staff alerted.</p> <p>During interview on 4/24/25 at 3:37 p.m., certified nursing assistant (CNA)-C stated she was familiar with R8 and knew she was a high fall risk. CNA-C went on to say she knew R8 had fall interventions, however, was unaware of what they were or where to find them.</p> <p>During interview 4/24/25 at 3:42 p.m., CNA-D stated she frequently worked with R8 and was familiar with her needs. CNA-D stated she could recognize a high fall risk resident by whether or not they wore grippy socks. CNA-D went on to state she was aware R8 had multiple falls but was unable to identify any fall interventions or need for grippy socks.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During interview on 4/24/25 at 4:57 p.m., Director of Nursing (DON) stated all high fall risk residents would have a care plan focus area for falls which would include staff interventions. DON stated all falls were reviewed and a root cause analyses was completed. Further DON stated falls were reviewed by the interdisciplinary team (IDT) with fall interventions updated as needed. DON stated she was aware R8 had more than 10 falls since admission but was unsure exactly how many. She went on to state for residents with a high risk for falls she would expect to see care plan fall interventions to include the bed in the lowest position, a ridged mattress, keep resident in line of vision of staff or common area, grippy socks and a toileting plan. DON confirmed R8's care plan had not been updated after each fall and had limited interventions listed. DON stated it was important to keep care plans updated to ensure resident safety and prevent major injuries.</p> <p>Facility policy titled Nursing Department Care Plan Documentation/Quarterly indicated all care plans would be updated quarterly and as needed and the updates will reflect close evaluation care plan problems, goals and approaches.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49657</p> <p>Based on record review and interviews the facility failed to ensure care conferences were conducted to include input of the resident or resident representatives for 5 of 11 (R10, R19, R20, R21, and R43) residents reviewed for care conferences.</p> <p>Findings include:</p> <p>R10's quarterly Minimum Data Set (MDS) dated [DATE] indicated R10 was severely cognitively impaired and had the following diagnoses: hypertension (HTN) (high blood pressure), arthritis, and Dementia.</p> <p>R10's Care Plan last revised 3/17/25 indicated, R10 had cognitive loss, impaired decision-making skills, and memory deficits.</p> <p>R 10's medical record lacked any documentation the resident, resident representative or family members had been contacted prior to having care conferences for R10 and the implementation of any changes to the care plan.</p> <p>R10's Care Plan Summary dated 3/26/25, indicated input from nursing, social services, and dietary. However, lacked any indication of involvement from resident, resident representative or family members.</p> <p>R19 annual MDS dated [DATE], indicated R19 was rarely or never understood, cognition was severely impaired and had the following diagnoses: Dementia, and a seizure disorder.</p> <p>R19's care plan last revised 3/6/25, indicated R19 has a diagnosis of dementia, tends to wander and have anxiety when they do not know where they are. R19's care plan also indicated they communicate through their teddy bear, which they feel is alive.</p> <p>R 19's medical record lacked any documentation the resident, resident representative or family members had been contacted prior to having care conferences for R19 and the implementation of any changes to the care plan.</p> <p>R19's Care Plan Summary dated 3/12/25, indicated input from nursing, social services, and dietary. However, lacked any indication of involvement from resident, resident representative or family members.</p> <p>R20 quarterly MDS dated [DATE], indicated R20 was severely cognitively impaired and had the following diagnoses: HTN, arthritis, Alzheimer's, hemiparesis or hemiplegia (inability to use one side of one's body), and anxiety.</p> <p>R20's Care plan last revised 3/14/25 indicated R20 has short- and long-term memory issues, impaired decision-making abilities, and required frequent orientation to daily task of living. Also, tended to wander and was unaware of where they were.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>R 20's medical record lacked any documentation the resident, resident representative or family members had been contacted prior to having care conferences for R20 and the implementation of any changes to the care plan.</p> <p>R20's Care Plan Summary dated 3/25/25, indicated input from nursing, social services, and dietary. However, lacked any indication of involvement from resident, resident representative or family members.</p> <p>R21's quarterly MDS dated [DATE], indicated R21 was severely cognitively impaired and had the following diagnoses: HTN, Alzheimer's, and dementia.</p> <p>R21's Care plan last revised 3/20/25 indicated R21 has a diagnoses of Alzheimer's and dementia, and short-term memory loss.</p> <p>R 21's medical record lacked any documentation the resident, resident representative or family members had been contacted prior to having care conferences for R21 and the implementation of any changes to the care plan.</p> <p>R21's Care Plan Summary dated 3/26/25, indicated input from nursing, social services, and dietary. However, lacked any indication of involvement from resident, resident representative or family members.</p> <p>R43's admission MDS dated [DATE], indicated R43 was severely cognitively impaired, and had the following diagnoses: Parkinson's, heart failure (failure of the heart to pump effectively), HTN, and a hip fracture.</p> <p>R43's care plan last revised 3/10/25, indicated severe cognitive impairment, and short-term memory deficits.</p> <p>R 43's medical record lacked any documentation the resident, resident representative or family members had been contacted prior to having care conferences for R43 and the implementation of any changes to the care plan.</p> <p>R43's Care Plan Summary dated 3/25/25, indicated input from nursing, social services, and dietary. However, lacked any indication of involvement from resident, resident representative or family members.</p> <p>On 4/21/25 at 4:11 p.m., during a phone interview, family member (FM)-G stated they had never been made aware or included in any care conferences or asked to provide any input regarding R21's treatment and services. Furthermore, FM-G stated they would have to like to be included in those discussions.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 4/24/25 during multiple interviews at 12:57 p.m. and 1:51:p.m., social services director (SS)-A stated she was responsible for care conferences. She sent out the care plan summary to the included facility staff to add their input. Once compiled, the staff reviewed it, and SS-A sent it to the family via postal mail for review. Family may or may not request a care conference after review. SS-A stated a cover letter was sent with the care conference summary. If the family did not respond or have questions, no meeting was conducted in the facility. SS-A confirmed she conducted one to one meetings with residents, but it was after the care plan was revised. Further, SS-A stated confused residents may be able to answer yes/no questions, they may not be the best advocate for themselves.</p> <p>On 4/24/25 at 3:44 p.m., the administrator stated their expectation was, care conferences were to be conducted to communicate the needs of the resident, and to update the family of any change in condition, new needs or any new concerns. The administrator stated in the past the facility had had issues with getting family to participate so they changed their process to sending out the summary after it was completed. The administrator stated they needed a process change to get families more involved in guiding care. The administrator stated the importance of care conferences being conducted with the input of the resident and/or their representative to be sure the residents' cares and needs were met.</p> <p>The facility Person-Centered Care Planning Policy and Procedure last reviewed 1/2025, indicated the care plans will be reviewed at a care planning meeting with the resident and/or representative and a summary shared with the resident/representative.</p>		

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<p>F 0741</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 44645</p> <p>Based on interview, and document review, the facility failed to ensure non-pharmacological interventions were attempted prior to the administration of psychotropic medications (mood altering medications) for 1 of 1 residents (R7) reviewed for as needed (PRN) psychotropic medications.</p> <p>Findings include:</p> <p>R7's quarterly Minimum Data Set (MDS), dated [DATE], indicated R7 had severe cognitive impairment, and exhibited verbal behavioral symptoms directed toward others one to three times during the assessment period. R7's diagnoses included dementia, delusional disorders, and depression.</p> <p>R7's care plan, revised 3/21/25, identified the potential for psychosocial distress, and approaches included reassurance, encourage activity of choice, 1:1 visits, and redirection.</p> <p>R7's Order History report, printed 4/25/25, indicated an order dated 3/24/25 for lorazepam 0.25mL (0.5mg) every 4 hours PRN for anxiety/agitation, with a stop date of 4/6/25.</p> <p>R7's PRN Psychotropic Medication Monitoring log for PRN Med: Lorazepam indicated approaches to try prior to medication administration included redirection, 1:1, ensure calm environment, rule out pain/discomfort, rule out hunger/thirst, and rule out toileting need. The last notation made by staff on the log was dated 10/12/23.</p> <p>R7's Target Behavior Monitoring logs indicated R7's target behaviors were delusions and anxiety/agitation, and staff were to document the number of episodes, management intervention(s), and results every shift.</p> <p>R7's Medication Administration Record (MAR) dated 3/1 to 3/31/25, indicated lorazepam 0.25mL (0.5mg) was administered to R7 on 3/25/25 at 12:38 a.m. for behavior issue.</p> <p>However, R7's Target Behavior Monitoring log for March 2025 lacked documentation of target behavior episode(s) and management intervention(s) for 3/25/25 NOC (overnight) shift. Additionally, R7's clinical record lacked evidence non-pharmacological interventions had been attempted prior to administration of the PRN psychotropic.</p> <p>R7's Medication Administration Record (MAR) dated 4/1 to 4/24/25, indicated lorazepam 0.25mL (0.5mg) was administered to R7 on 4/2/25 at 1:21 a.m. for behavior issue.</p> <p>However, R7's Target Behavior Monitoring log for April 2025 lacked documentation of target behavior episode(s) and management intervention(s) for 4/2/25 NOC (overnight) shift. Additionally, R7's clinical record lacked evidence non-pharmacological interventions had been attempted prior to administration of the PRN psychotropic.</p> <p>R7's Medication Administration Record (MAR) dated 4/1 to 4/24/25, indicated lorazepam 0.25mL (0.5mg) was administered to R7 on 4/5/25 at 12:26 a.m. for other reason.</p> <p>(continued on next page)</p>		

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<p>F 0741</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>However, R7's Target Behavior Monitoring log for April 2025 indicated R7 had 0 target behavior episodes 4/5/25 NOC (overnight) shift. Additionally, R7's clinical record lacked evidence non-pharmacological interventions had been attempted prior to administration of the PRN psychotropic.</p> <p>On 4/25/25 at 12:25 p.m., consulting pharmacist (PharmD) stated non-pharmacological interventions prior to administration of PRN psychotropics should be care planned and non-pharmacological interventions should be attempted prior to the administration of PRN psychotropics unless a severe situation of psychosis with potential for harm.</p> <p>On 4/25/25 at 1:53 p.m., director of nursing (DON) verified R7's clinical record lacked evidence of non-pharmacological interventions prior to the administration of PRN psychotropic on 3/25/25, 4/2/25, and 4/5/25. DON stated staff were expected to administer PRN psychotropic medications as ordered for the identified target behaviors. DON stated staff were expected to attempt and document non-pharmacological interventions prior to administration of PRN psychotropics.</p> <p>A policy was requested, but not provided by the facility</p>		

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NAME OF PROVIDER OR SUPPLIER  Cokato Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  182 Sunset Avenue Cokato, MN 55321	
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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 44645</p> <p>Based on interview and document review, the facility failed to ensure consulting pharmacist (PharmD) identified the facility's lack of target behavior monitoring in the monthly medication regimen review (MRR) for 1 of 5 residents (R46) reviewed for unnecessary psychotropic medications.</p> <p>Findings include:</p> <p>R46's quarterly Minimum Data Set (MDS) dated [DATE], indicated R46 admitted to the facility on [DATE], had severe cognitive impairment, and diagnoses included Alzheimer's disease, delusional disorders, and anxiety disorder.</p> <p>R46's order summary, printed 4/25/25, indicated R46 had the following psychotropic medication orders:</p> <ul style="list-style-type: none"> <li>- paroxetine (antidepressant) 40 mg daily for panic disorder</li> <li>- quetiapine 50 mg BID for delusional disorders</li> </ul> <p>R46's November 2024 Target Behavior Monitoring log identified target behaviors anxiety, agitation, feeling down, depressed, and hopeless, and the log indicated target behaviors were monitored 8 of 45 shifts. Additionally, R46's clinical record lacked evidence of documented target behavior monitoring from 12/1/24 through 4/22/25.</p> <p>R46's progress note, dated 04/07/25 at 6:11 a.m., indicated medications were reviewed by PharmD, and no problems identified. However, the MRR failed to identify the facility's lack of target behavior monitoring for R46's psychotropic medication use.</p> <p>R46's progress note, dated 03/09/25 at 10:23 a.m., indicated medications were reviewed by PharmD, and a gradual dose reduction (GDR) was recommended as follows:</p> <ol style="list-style-type: none"> <li>1. Please evaluate and document ongoing need for paroxetine for anxiety and quetiapine for delusions. Document target behaviors and symptoms being controlled. Consider attempting dose reduction if appropriate.</li> </ol> <p>However, the MRR failed to identify the facility's lack of target behavior monitoring for R46's psychotropic medication use.</p> <p>R46's progress note, dated 02/02/25 at 09:10 a.m., indicated medications were reviewed by PharmD, and no problems identified. However, the MRR failed to identify the facility's lack of target behavior monitoring for R46's psychotropic medication use.</p> <p>R46's progress note, dated 1/6/25 at 9:47 a.m., indicated medications were reviewed by PharmD, and the following recommendations were made:</p> <p>(continued on next page)</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>1. Recommend monitoring orthostatic blood pressure monthly while on Seroquel. If unable to obtain orthostatic blood pressure, please document reason. Recommend entering order into matrix for monthly orthostatic blood pressures.</p> <p>2. Patient is noted to have multiple falls recently. Paxil and Seroquel may contribute. Seroquel dose has been increased twice in the last month. Determine if medications are contributing to falls and if benefits outweigh risks of medications.</p> <p>3. Recent lipid panel showed elevated triglycerides, LDL, and total cholesterol. Consider adding lipid lowering medication such as atorvastatin.</p> <p>However, the MRR failed to identify the facility's lack of target behavior monitoring for R46's psychotropic medication use.</p> <p>R46's progress note, dated 1/6/25 at 9:47 a.m., indicated medications were reviewed by PharmD, and to review report for recommendations. However, the MRR failed to identify the facility's lack of target behavior monitoring for R46's psychotropic medication use.</p> <p>On 4/25/25 at 12:25 p.m., consulting pharmacist (PharmD) stated every psychotropic medication needed identified target behaviors. Staff are expected to monitor the identified target behaviors, and the monitoring should be documented so the provider can identify if behaviors have increased.</p> <p>On 4/25/25 at 1:53 p.m., director of nursing (DON) verified R46's clinical record lacked evidence of target behavior monitoring from 12/1/24 through 4/22/25. DON stated nurses were expected to initiate target behavior monitoring when the provider ordered a psychotropic medication. DON stated target behavior monitoring was necessary, so providers know if a psychotropic medication has been effective/ineffective and if target behaviors have increased/decreased. DON stated the target behavior monitoring is important so providers can determine if a psychotropic medication is appropriate.</p> <p>The facility's Pharmacy Consultant Expectations Policy, revised 2/24, indicated to meet the needs of each resident accurately and safely, by collaborating with the licensed pharmacist, serving as consultant, to guide the facility with a system consistent with clinical best practice, quality resident care, and regulatory compliance for pharmacy services in the facility. Additionally, the consulting pharmacist would conduct monthly medication regimen review (MRR) for each resident to address irregularities.</p>		

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<p>F 0868</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>49657</p> <p>Have the Quality Assessment and Assurance group have the required members and meet at least quarterly</p> <p>Based on document review, and interview the facility failed to ensure Quality Assurance Performance Improvement (QAPI) meetings were held on a quarterly basis. This practice had the potential to affect all 53 residents residing in the facility.</p> <p>Findings include:</p> <p>Review of the QAPI meeting minutes agendas identified QAPI meetings were held on 4/16/24, 8/27/24, and 1/7/25 outside of the required time frame of every 3 months or quarterly.</p> <p>On 4/25/25 at 2:06 p.m., the director of nursing confirmed they were the lead for the QAPI meetings, and the facility had not been meeting quarterly and stated they should have completed one more meeting to have been in compliance.</p> <p>The facility's Quality Assurance and Performance Improvement Plan effective date 1/2025, indicated the QAPI committee was responsible for meeting, at a minimum, on a quarterly basis; more frequently, if necessary.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>49657</p> <p>Based on observation, and interview the facility failed to conduct appropriate hand hygiene during medication administration for 1 of 3 staff members observed during medication administration. This had the potential to affect at 53 residents in residence at the facility.</p> <p>Findings include:</p> <p>On 4/22/25 at 11:47 a.m., trained medication aide (TMA)-A was observed giving medications to a resident in the main sitting area of the facility. TMA-A then returned to the medication room, where writer was waiting to observe the medication administration. TMA-A agreed to be observed, TMA-A then began preparing medications for a second resident, however, did not perform hand hygiene prior to starting the second medication administration. TMA-A proceeded to administer medications to the second resident, and then returned to the medication cart. TMA-A then began a third resident's medications, and did not perform proper hand hygiene, in between residents. TMA-A then administered the medications to the third resident, came back to the cart, stated they were finished. TMA-A failed to complete hand hygiene after completing all medication administrations.</p> <p>On 4/22/25 at approximately 12:00 p.m., TMA-A requested assistance with another staff member, licensed practical nurse (LPN)-B, who was present in the room during the observation. TMA-A then stated they should have preformed hand hygiene before and after each resident and in between residents when passing medications. TMA-A confirmed they did not perform hand hygiene appropriately and stated hand hygiene was important to prevent spread of infection.</p> <p>On 4/22/25 at approximately 12:20 p.m., the director of nursing (DON) stated they expected staff members conducting medication administration to perform hand hygiene before and after all medication administrations, and in between residents. The DON stated the importance of completing appropriate hand hygiene to prevent the spread of infection within the facility.</p> <p>The facility's Hand Washing/Hygiene Policy last revised 2/24, indicated hand washing will be completed between resident care and whenever direct physical contact of resident occurs.</p>		

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<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement a program that monitors antibiotic use.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44645</b></p> <p>Based on interview and document review, the facility failed to ensure prescribed antibiotics met criteria for antibiotic use. Further, the facility failed to assess for continued need of the antibiotics to help reduce unnecessary antibiotic use and reduce potential drug resistance were completed for 1 of 1 residents (R31) reviewed for antibiotic use. This had the potential to affect any of the 53 residents who resided in the facility who might use antibiotics.</p> <p>Findings include:</p> <p>R31's quarterly Minimum Data Set (MDS) dated [DATE], indicated R31 was cognitively intact, had an indwelling urinary catheter, and diagnoses included Parkinson's disease, dementia, and obstructive uropathy (urine flow is obstructed).</p> <p>R31's order history report, dated 4/25/25, indicated an antibiotic was ordered by the provider for cefpodoxime 200mg twice a day (BID) for a diagnosis of urinary tract infection (UTI), with a start date of 3/29/25 and end date of 4/2/25.</p> <p>R31's progress note, dated 3/26/25 at 3:32 p.m., indicated the licensed practical nurse (LPN)-A notified the provider that R31 completed an order for Macrobid (antibiotic) for a positive UTI, with no improvement in dark, cloudy, odorous urine and increased sleeping. The provider ordered a urinalysis (UA).</p> <p>R31's UA results report, verified 3/28/25, indicated the urine specimen contained many bacteria, 500 (large) leukocytes, &gt;180 (H) red blood cells, and negative nitrite. On 3/28/25, at the bottom of the UA report, the provider wrote an antibiotic order for cefpodoxime 200 mg by mouth (PO) every (q) 12 hours two times a day (BID). Additionally, the order directed the facility to update the culture and sensitivity ASAP as it may warrant a change in antibiotic. However, the report did not identify it had been reviewed by a nurse.</p> <p>R31's physician order, dated 3/28/25 at 4:46 p.m., indicated Start Vantin (cefepodoxime) 200 mg PO q12hrs for 5 days, and I highly recommend they fax and call with culture and sensitivity results. The order was acknowledged in writing by registered nurse (RN)-C.</p> <p>R31's urine culture (UC) results report, verified 3/29/25, indicated Growth (A) [abnormal] &gt;100,000 CFU/mL mixed bacterial growth and Mixed bacterial growth indicates the specimen is likely contaminated at collection with urogenital and/or fecal flora. On 4/1/25, the provider wrote update with sensitivities, at the bottom of the UC report. However, the report did not identify it had been reviewed by a nurse.</p> <p>R31's clinical record lacked evidence the provider had been notified a sensitivities report had not been received. Additionally, R31's clinical record lacked evidence reviewed based on antibiotic stewardship guidelines and criteria.</p> <p>(continued on next page)</p>		

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<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/25/25 at 11:02 a.m., director of nursing (DON) stated she was the facility infection preventionist (IP) and it was her role to oversee the resident infections and antibiotic use. DON stated the facility used McGeer criteria to help identify infections, and Loeb criteria was used to determine when antibiotics were indicated. DON stated R31 had completed taking an antibiotic for a urinary tract infection (UTI) on 3/25/25, but staff reported that R31 was still symptomatic, the provider was notified, and a UA/UC was ordered. DON verified the UC report indicated the sample was likely contaminated and the test had not been repeated. DON confirmed a 72-hour time-out had not been completed. DON stated a 72-hour time-out should have been completed for R31 to identify the provider had not been alerted when UC susceptibilities were not provided. DON stated the antibiotic stewardship guidelines should have been followed to ensure criteria was met and the resident was prescribed the correct antibiotic. DON stated it was important to follow the antibiotic stewardship guidelines to avoid antibiotic resistance.</p> <p>The facility's Antimicrobial Stewardship Policy, revised 2/24, indicated the key objectives include reducing inappropriate antimicrobial use, improving patient care outcomes and mitigating adverse consequences. Additionally, the duration of antimicrobial therapy will be defined and/or regularly reviewed based on evidence-based guidelines (ie. 72-hour antibiotic time out).</p>		