STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245448	A. Building B. Wing	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park River Estates Care Center	9899 Avocet Street Northwest Coon Rapids, MN 55433

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. 49654 Based on interview and document review the facility failed to clarify with the resident and/or the resident's representative their current advance directive when there was conflicting documentation in the record for 1 of 24 residents (R328) reviewed for advance directives. This has the potential to affect all residents. Findings include: R328 diagnosis upon admission included Parkinson's Disease (a brain disorder that causes unintended or uncontrollable movements), adult failure to thrive (a condition where an older adult loses appetite, weight, and interest in activities), and chronic kidney disease (a condition that impairs kidney function and causes kidney damage). As well, R328 had a BIMS (Brief interview of mental status) of 15 indicating intact cognition. Hospital H&P (history and physical) dated 3/1/24, indicated code status as full code and noted as alert and oriented. Hospital discharge summary dated 3/4/24, indicated admission H&P valid: Yes, and treatment options as DNR (Do not resuscitate). However, document lacked any evidence of a discussion of changing code status. Progress note dated 3/4/24 at 10:57 p.m., 3/5/24 at 6:48 a.m., 3/6/24 at 4:56 p.m., 3/7/24 at 2:44 p.m., and 3/7/24 at 8:56 p.m., indicated resident was alert and oriented. Admission note on 3/5/24 at 11:32 a.m., licensed social worker (LSW) listed documents reviewed and provided to the resident at or prior to admission included advance directives/cardiopulmonary resuscitation. R328 denied receiving or reviewing this document. During interview on 3/12/24 at 10:36 a.m., R328 stated if she was cognitive enough to do things and knew what was going on, she wanted to be cared for. Further, if her heart stopped, and she was not breathing staff should let her die in peace. However, if she was alive enough to know what's happening, she'd want to live. R328 stated no one in the facility had talked to her about what she wanted in the event of an emergency. (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During interview on 3/12/24 at 10:52 a.m., licensed practical nurse (LPN)-1 stated resident code status was located on their nameplate with a red or green heart. LPN-1 opened R328's chart to tab marked Advanced Directives to clarify order and stated no document was present. During interview on 3/12/24 at 11:05 a.m., trained medication aide (TMA-1) stated orders for code status was in the chart under advanced directive tab. However, if nothing were in the chart she would assume resident was a full code. During interview on 3/12/24 at 12:19 p.m., assistant director of nursing (ADON) stated typically a resident came with a code status, and it was up to the admitting nurse to scan it into the chart. ADON went on to say if there wasn't a code status selected, or if orders were conflicting staff would temporarily mark full code and clarify orders with physician within one shift. ADON stated the staff should be checking with the resident as well to be sure any documentation was accurate but usually that was a conversation social services had on admission. During interview on 3/12/24 at 12:41 p.m., licensed social worker (LSW)-1 stated they would review physician's orders for life sustaining treatment (POLST) during the admission interview. The providers also reviewed with the residents. LSW documented in resident's medical record a recap of the code status conversation for the physician to review. Furthermore, if the resident did not have advance directives in place, LSW-1 notified provider to address this concern. LSW-1 stated she did not see a message sent to the provider regarding code status, nor a note regarding a discussion of code status in R328's chart. During interview on 3/12/24 at 2:51 p.m., director of nursing (DON) stated residents may already have a code status in place upon admission and code information was sent over with any referral paperwork. DON stated LSW reviewed POLST paperwork with residents upon admission, as well as the providers. DON reported code status was found in electronic medical record (EMR) under scanned documents or in the paper chart under advance directives. DON stated R328 did not have any advance directives available in either the EMR or paper copies . DON stated her expectation was advance directives were entered in and scanned to chart at admission. She stated I'm not finding it for R328. It was a problem because in an emergency staff wouldn't know how the resident wanted staff to respond. Facility Policy Advance directives Park River Estates care center with revised date of 3/24 stated upon admission the resident or resident's representative is given a written copy of the Minnesota Health Care Directive; upon admission a resident is asked if he/she has any written Advance Directives. If so, copies of these documents are requested, fi9led and distributed according to state and federal law; facility staff review the Advance Directives to determine the validity under state and federal law. Social Services reviews and updates the care plan as to Advance Directives/OPLST as needed but at least quarterly in conjunction with the resident's plan of care.

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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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46943 Based on observation, interview and document review the facility failed to ensure initial and ongoing assessment of physical device equipment restricting independent movement for 1 of 1 resident (R35) reviewed for appropriate use of a reclining wheelchair. This has the potential to effect all residents that utilize reclining equipment. Findings include: R35's quarterly minimum data set (MDS) dated [DATE], identified severely impaired cognition and diagnoses of non-Alzheimer's dementia, Parkinson's disease, restlessness, agitation, and frequent falls. R35's care plan dated 3/22/24, identified the ability to transfer with one to two staff assist, need for extensive assist of one staff for bed mobility and the ability to ambulate with one staff using a rolling walker or handheld assist. The care plan indicated the need for a high-backed wheelchair (w/c) and dependency on staff to reach intended destination. The care plan identified the risk for falls related to poor safety awareness, gait and balance problems and impulsivity. R35's Post Incident/Fall Review dated 1/3/24 at 12:50 p.m., indicated R35 was found sitting on the footrest of the broda (reclining) w/c and appeared to have slid out of the chair. R35's Post incident/Fall review dated 1/3/24 at 6:12 p.m., indicated R35 had a staff witnessed fall from the broda w/c and indicated R35 had scooted down to the footrest to attempt to stand up. The fall review identified R35 had gotten his feet on the floor and was crouching but could not stand all the way up then fell backwards onto the footrest. The root cause was identified as being due to the broda chair restraining and its footrests preventing the resident from being able to stand up on his own. R35's medical record lacked a physical device assessment and care plan identifying use of the broda chair as a potential physical restraint. R35's occupational therapy (OT) evaluation and plan of treatment dated 1/4/24, identified orders to address positioning to reduce fall risk from a facility rented broda w/c. The OT evaluation and plan of treatment identified staff education was completed on use and a sign was placed on the broda w/c instructing staff not to recline the chair all the way and instead use the tilt feature with slight recline. R35's treatment encounter notes dated 1/4/24, identified multiple observations by the therapist throughout the day of R35 in the rented broda w/c, being fully reclined back and to be attempting to lean forward to correct this posture. The treatment encounter notes identified the therapist provided education to multiple staff on proper use of the broda recline and tilt features however, noted they were not receptive stating if they did not recline the chair, R35 would fall. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R35's OT treatment encounter notes dated 1/9/24. Identified several staff indicated they had not seen the labels attached to the rented broda instructing not to recline the chair all the way although it was placed directly over the reclining lever. The note indicated the OT therapist then provided staff including assistant director of nursing, education to not use the chair footrests to increase ease and safety of transfers and to not recline the back of the w/c all the way back. R35's OT treatment encounter notes dated 1/10/24, identified arrival of a newly purchased broda w/c that tilted back even further than the rented w/c and staff education on the use of its tilt features was completed. R35's OT treatment encounter notes dated 2/1/24 identified staff verbalized understanding of using the tilt features of the broda w/c rather than reclining it all the way. R35's OT discharge summary dated 2/1/24 indicated some staff continued to fully recline R35 back in w/c even though not recommended and chair was labeled to only use the tilt feature. During observation on 3/11/24 at 1:52 p.m., R35 was in a facility common space near a nursing station fully reclined in a broda chair with feet on footrest and appeared to be sleeping with eyes closed. During observation on 3/12/24 at 4:10 p.m., R35 was in a facility common area fully reclined with feet on footrest and was watching television. When interviewed on 3/12/24 at 4:22 p.m., nursing assistant (NA)-C stated R35 has had falls from his broda from trying to stand up on his own. NA-C stated R35 was currently positioned correctly with the broda chair fully reclined and feet on footrests. R35 was usually less restless and more comfortable when in a fully reclined position. NA-C stated they were not aware of therapy recommendations to not fully recline the broda chair. During observation on 3/12/24 at 5:05 p.m., R35 continued to be fully reclined in the broda chair with feet on the footrest. When interviewed on 3/12/24 at 5:26 p.m., registered nurse (RN)-A stated R35 was positioned correctly in the broda chair. RN-A stated R35 had attempted to climb out of the broda chair whether it was reclined or not and had fallen. Further, RN-A was not aware of therapy recommendations to not fully recline the chair. When interviewed on 3/13/24 at 2:06 p.m., the director of nursing (DON) stated when R35 started using the broda chair OT evaluated for safe use due to falls from it. The DON stated the fully reclined position of the broda chair, and the footrests could hinder R35 from being able to safely rise from it when making self-transfer attempts and confirmed the lever for the reclining mechanism was on the back of the chair and could not be reached by R35. The DON confirmed R35's poor cognitive status prevented him from knowing how to raise the footrest on his own. The DON confirmed R35 was able to transfer and ambulate with staff assist and often made self-transfer attempts. The DON stated a physical device assessment for evaluation of the reclined broda and footrest as a potential restraint had not been completed, a provider order had not been obtained and responsible party education on risk/benefit or consent for use had not been obtained. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy Physical Device assessment dated [DATE] and last revised March 2024, identified Device use in our facility will only be considered to treat a medical symptom/condition that endangers the physical safety of the resident or other residents and under the following conditions: 1. As a last resort measure, after less restrictive measures have been taken and proven unsuccessful; 2. With a physician's order; 3. With the consent of the resident party; 4. When the benefits of the device outweigh the identified risks.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46943 Based on interview and document review, the facility failed to ensure consulting pharmacist identified irregularities in the monthly drug regimen reviews for 4 of 5 residents (R4, R25, R35, and R69) reviewed for unnecessary medications. This has the potential to affect all residents taking psychotropic medications. Findings include: R4's quarterly Minimum Data Set (MDS) dated [DATE], identified R4 had moderately impaired cognition and diagnoses of non-traumatic brain dysfunction, Alzheimer's disease, anxiety disorder, depression, neuralgia and neuritis, insomnia, age-related osteoporosis, visual hallucinations, muscle weakness, and long-term use of anticoagulants as well as daily use of antipsychotic and antidepressant medications. R4's Order Summary Report dated 3/14/24, identified orders for Seroquel (an antipsychotic) for dementia with hallucination and agitation with a start date 10/19/23 and Bupropion (an antidepressant) for major depressive disorder with a start date of 10/21/23. R4's care plan dated 3/13/24, indicated the use of psychotropic medications including an antipsychotic and antidepressant with a goal to be free of drug related complications, including movement disorder and hypotension. The care plan also instructed staff to monitor, document and report and medication side effects including tardive dyskinesia and hypotension. R4's medical record lacked evidence of pharmacy consultant (Pharm D) recommendations for monitoring of hypotension and/or AIMS (abnormal involuntary movement scale) assessment in any of the monthly medication regimen reviews since initiation of the psychotropic medications. R4's medical record lacked evidence of monitoring for hypotension, done by taking orthostatic blood pressures and completing AIMS assessments on a frequency normally recommended by the Pharm D. R4's medical record lacked evidence of assessment for abnormal involuntary movements (AIMS). R25's quarterly Minimum Data Set (MDS) dated [DATE], identified R25 had moderate cognitive impairment and required assistance with all activities of daily living (ADL)'s. R25's diagnoses included chronic respiratory failure with hypoxia, heart failure, hypertension, malnutrition, asthma, respiratory failure, polyneuropathy, osteoarthritis, and chronic pain syndrome. R25's Order Summary Report dated 3/14/24, identified orders for Lorazepam (an antianxiety) as needed for anxiety with a start date 10/26/23 and Haloperidol (an antipsychotic) as needed for agitation with a start date of 10/26/23. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R25's care plan dated 3/13/24, indicated the use of psychotropic medications including an antipsychotic and anti-anxiety with a goal to be free of drug related complications, including movement disorder and hypotension. The care plan also instructed staff to monitor, document and report and medication side effects including tardive dyskinesia and hypotension. R25's medical record lacked evidence of Pharm D recommendations to obtain a new order from the provider at 14 days for a rationale of continued use for both the Lorazepam and Haloperidol. R25's medical record lacked evidence of communication with the provider to obtain new orders for both the Lorazepam and Haloperidol, normally recommended by the Pharm D. R35's quarterly minimum data set (MDS) dated [DATE], identified severely impaired cognition and diagnoses of non-Alzheimer's dementia, Parkinson's disease, delusional disorders, major depressive disorder, and frequent falls as well as daily use of antipsychotic and antidepressant medications. R35's Order Summary Report dated 3/13/24, identified orders for the psychotropic medications Seroquel (an antipsychotic) for hallucinations related to Parkinson's disease and delusional disorder with a start date of 7/18/23, and Trazadone (an antidepressant) for insomnia with a start date of 11/30/23. R35's care plan dated 3/8/24, indicated the use of psychotropic medications including antipsychotic and antidepressant with a goal to be free of hypotension (low blood pressure). The care plan also instructed staff to monitor, document and report any medication side effects including hypotension related to Parkinson's and altered cardiovascular status. R35's medical record lacked evidence of Pharm D recommendations for monitoring of hypotension in any of the monthly medication regimen reviews since initiation of the psychotropic medications. R35's medical record lacked evidence of monitoring for hypotension, done by taking orthostatic blood pressures on a frequency normally recommended by the Pharm D. R69's significant change minimum data set (MDS) dated [DATE], identified severely impaired cognition and diagnoses of non-Alzheimer's dementia, Parkinson's disease, and depression as well as daily use of antipsychotic and antidepressant medications. R69's Order Summary Report dated 3/13/24, identified orders for Pimavanserin (an antipsychotic) for hallucinations and psychosis related to Parkinson's with a start date of 12/1/23, Trazadone (an antidepressant) for insomnia with a start date of 11/21/23 and Citalopram (an antidepressant) for depression with a start date of 11/21/23. R69's care plan dated 3/13/24, indicated use of psychotropic medications with a goal to be free of hypotension. The care plan also instructed staff to monitor, document and report any medication side effects including hypotension related to Parkinson's. R69's medical record lacked evidence of Pharm D recommendations for monitoring of hypotension in any of the monthly medication regimen reviews since initiation of the psychotropic medications. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R69's medical record lacked evidence of monitoring for hypotension, done by taking orthostatic blood pressures on a frequency normally recommended by the Pharm D. When interviewed on 3/13/24 at 12:56 p.m., the Pharm D stated orthostatic blood pressures should be done for anyone taking psychotropic medications and usually recommended they be done at least monthly and consists of taking a blood pressure from a lying position, then in a sitting position and then in a standing position to see if there was a decrease in blood pressure from these position changes. The Pharm D stated if a resident was unable to stand the taking of the orthostatic blood pressures could be modified and taken in a lying position and then a sitting position. The pharm D stated he had missed recommending this monitoring to the facility. The Pharm D stated normally an AIMS assessment was completed as a baseline with the start of an antipsychotic. The Pharm D stated he had missed recommending the facility complete an AIMS with the initiation of R4 & R69's antipsychotic. The Pharm D stated for prn psychotropics, the facility needed to obtain a new order every 14 days with a rationale/re-evaluation of medication for continued use of antipsychotic medication. The Pharm D stated he had missed the request for continuation from the provider for the prn Lorazepam and Haloperidol. During interview on 3/13/24 at 1:52 p.m., the director of nursing (DON) stated the facility's process was to rely on the Pharm D recommendations and ensure they were passed on to the resident's providers. The DON confirmed R4, R35 and R69's medical record lacked any orthostatic blood pressures. The DON stated the importance of orthostatic blood pressures was a part of monitoring for adverse effects related to use of psychotropics and can help with fall prevention. The DON confirmed normally the facility would do an AIMS assessment with the initiation of any antipsychotic medication but had been missed for R4 and R69. The DON stated the importance of these was to monitor for involuntary movements which are a potential side effect of antipsychotic use. Further, the DON confirmed R25's medical record lacked any recommendations from the Pharm D and/or documentation that R25's prn Lorazepam and Haloperidol was reviewed for a rationale for continued use. The facility policy Psychotherapeutic Medications dated 4/5/22, identified resident's receiving psychotherapeutic medication will have documentation of a summary of the outcomes to the interventions including response to medications. The policy also identified prior to the administration of an antipsychotic medication consent from the resident and/or responsible party along with education on potential side effects must be obtained and a baseline AIMS assessment must be done upon initiation of an antipsychotic medication with re-assessment every 6 months. 48013

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46943 Based on interview and document review, the facility failed to ensure monitoring for potential cardiovascular and neurological adverse consequences, and obtaining informed consent with use of psychotropic medications for 4 of 5 residents (R4, R25, R35, and R69) reviewed for unnecessary medications. This has the potential to affect all resident on psychotropic medications. Findings include: R4's quarterly Minimum Data Set (MDS) dated [DATE], identified R4 had moderately impaired cognition and diagnoses of non-traumatic brain dysfunction, Alzheimer's disease, anxiety disorder, depression, neuralgia and neuritis, insomnia, age-related osteoporosis, visual hallucinations, muscle weakness, and long-term use of anticoagulants as well as daily use of antipsychotic and antidepressant medications. R4's Order Summary Report dated 3/14/24, identified orders for the psychotropic medications Seroquel (an antipsychotic) for dementia with hallucination and agitation with a start date 10/19/23 and Bupropion (an antidepressant) for major depressive disorder with a start date of 10/21/23. R4's care plan dated 3/13/24, indicated the use of psychotropic medications including an antipsychotic and antidepressant with a goal to be free of drug related complications, including movement disorder and hypotension. The care plan also instructed staff to monitor, document and report and medication side effects including tardive dyskinesia and hypotension. R4's medical record lacked evidence of pharmacy consultant (Pharm D) recommendations for monitoring of hypotension and/or AIMS (abnormal involuntary movement scale) assessment in any of the monthly medication regimen reviews since initiation of the psychotropic medications. R4's medical record lacked evidence of monitoring for hypotension, which is done by taking orthostatic blood pressures and completing AIMS assessments on a frequency normally recommended by the Pharm D. R4's medical record lacked evidence of assessment for abnormal involuntary movements (AIMS). R25's quarterly Minimum Data Set (MDS) dated [DATE], identified R25 had moderate cognitive impairment and required assistance with all activities of daily living (ADL)'s. R25's diagnoses included chronic respiratory failure with hypoxia, heart failure, hypertension, malnutrition, asthma, respiratory failure, polyneuropathy, osteoarthritis, and chronic pain syndrome. R25's Order Summary Report dated 3/14/24, identified orders for the psychotropic medications Lorazepam (an antianxiety) as needed for anxiety with a start date 10/26/23 and Haloperidol (an antipsychotic) as needed for agitation with a start date of 10/26/23. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R25's care plan dated 3/13/24, indicated the use of psychotropic medications including an antipsychotic and anti-anxiety with a goal to be free of drug related complications, including movement disorder and hypotension. The care plan also instructed staff to monitor, document and report and medication side effects including tardive dyskinesia and hypotension. R25's medical record lacked evidence of pharmacy consultant (Pharm D) recommendations to obtain a new order from the provider at 14 days for a rationale of continued use for both the Lorazepam and Haloperidol. R25's medical record lacked evidence of communication with the provider to obtain new orders for both the Lorazepam and Haloperidol that is normally recommended by the Pharm D. R35's quarterly minimum data set (MDS) dated [DATE], identified severely impaired cognition and diagnoses of non-Alzheimer's dementia, Parkinson's disease, delusional disorders, major depressive disorder, and frequent falls as well as daily use of antipsychotic and antidepressant medications. R35's Order Summary Report dated 3/13/24, identified orders for the psychotropic medications Seroquel (an antipsychotic) for hallucinations related to Parkinson's disease and delusional disorder with a start date of 7/18/23 and Trazadone (an antidepressant) for insomnia with a start date of 11/30/23. R35's care plan dated 3/8/24, indicated the use of psychotropic medications including and antipsychotic and antidepressant with a goal to be free of hypotension (low blood pressure). The care plan also instructed staff to monitor, document and report any medication side effects including hypotension related to Parkinson's and altered cardiovascular status. R35's medical record lacked evidence of pharmacy consultant (Pharm D) recommendations for monitoring of hypotension in any of the monthly medication regimen reviews since initiation of the psychotropic medications. R35's medical record lacked evidence of monitoring for hypotension, done by taking orthostatic blood pressures, on a frequency recommended by the Pharm D. R69's significant change minimum data set (MDS) dated [DATE], identified severely impaired cognition and diagnoses of non-Alzheimer's dementia, Parkinson's disease, and depression as well as daily use of antipsychotic and antidepressant medications. R69's Order Summary Report dated 3/13/24, identified orders for the psychotropic medications Pimavanserin (an antipsychotic) for hallucinations and psychosis related to Parkinson's with a start date of 12/1/23, Trazadone (an antidepressant) for insomnia with a start date of 11/21/23 and Citalopram (an antidepressant) for depression with a start date of 11/21/23. R69's care plan dated 3/13/24, indicated use of psychotropic medications with a goal to be free of hypotension. The care plan also instructed staff to monitor, document and report any medication side effects including hypotension related to Parkinson's. R69's medical record lacked evidence of Pharm D recommendations for monitoring of hypotension in any of the monthly medication regimen reviews since initiation of the psychotropic medications. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park River Estates Care Center	9899 Avocet Street Northwest Coon Rapids, MN 55433

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R69's medical record lacked evidence of monitoring for hypotension, done by taking orthostatic blood pressures, on a frequency recommended by the Pharm D. R69's medical record lack evidence of assessment for abnormal involuntary movements (AIMS). R 69's medical record lacked evidence of informed consent including discussion of risk and benefit of taking an antipsychotic medication. During interview on 3/13/24 at 12:56 p.m., the pharm D stated orthostatic blood pressures should be completed for anyone taking psychotropic medications and recommended they be done at least monthly and consists of taking a blood pressure from a lying position, then in a sitting position and then in a standing position to see if there is a decrease in blood pressure from these position changes. The Pharm D stated if a resident was unable to stand the taking of the orthostatic blood pressures could be modified and taken in a lying position and then a sitting position. The pharm D stated he had missed recommending this monitoring to the facility. The Pharm D stated normally an AIMS assessment was done as a baseline with the start of an antipsychotic. The Pharm D stated he had missed recommending the facility complete an AIMS with the initiation of R4 and R69's antipsychotic. The Pharm D stated for prn psychotropics, the facility needed to obtain a new order every 14 days with a rationale/re-evaluation of medication for continued use of antipsychotic medication. The Pharm D stated he had missed the request for continuation from the provider for the prn Lorazepam and Haloperidol. During interview on 3/13/24 at 1:52 p.m., the director of nursing (DON) stated the facility's normal process was to rely on the Pharm D recommendations and ensure they get passed on to the resident's providers. The DON confirmed R4, R35's and R69's medical record lacked any orthostatic blood pressures. The DON stated the importance of orthostatic blood pressures is a part of monitoring for adverse effects related to use of psychotropics and can help with fall prevention. The DON confirmed normally the facility would do an AIMS assessment with the initiation of any antipsychotic medication but had been missed for R4 and R69. The DON confirmed the education on risk/benefit and informed consent had been missed with the initiation of R69's antipsychotic. The DON stated the importance of these was to monitor for involuntary movements which are a potential side effect of antipsychotic use and to make sure the residents and/or representative's have been informed of the potential risks of taking psychotropic medications. The DON confirmed R25's medical record lacked any recommendations from the Pharm D and/or documentation that R25's prn Lorazepam and Haloperidol was reviewed for a rationale for continued use. The facility policy Psychotherapeutic Medications dated 4/5/22, identified resident's receiving psychotherapeutic medication will have documentation of a summary of the outcomes to the interventions including response to medications. The policy also identified prior to the administration of an antipsychotic medication consent from the resident and/or responsible party along with education on potential side effects must be obtained and a baseline AIMS assessment must be done upon initiation of an antipsychotic medication with re-assessment every 6 months. 48013

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48013 Based on interview and document review, the facility failed to ensure 4 of 5 residents (R29, R33, R35 and R69) reviewed for immunizations were offered and/or provided the pneumococcal vaccine series as recommended by the Centers for Disease Control (CDC) to help reduce the risk of associated infection(s). Findings include: A CDC Pneumococcal Vaccine Timing for Adults feature, dated 3/15/2023, identified various tables when each (or all) of the pneumococcal vaccinations should be obtained. This identified when an adult over [AGE] years old had received the complete series (i.e., PPSV23 and PCV13; see below) then the patient and provider may choose to administer Pneumococcal 20-valent Conjugate Vaccine (PCV20) for patients who had received Pneumococcal 13-valent Conjugate Vaccine (PCV13) at any age and Pneumococcal Polysaccharide Vaccine 23 (PPSV23) at or after [AGE] years old. R29's face sheet, dated 3/13/24, indicated she was [AGE] years old. The immunization record, dated 3/13/24, indicated she received a PPSV23 on 1/25/2013 followed by the PCV13 on 6/5/2015. The record lacked evidence of shared clinical decision making with the physician for PCV20 at least 5 years after the last pneumococcal dose. The record lacked evidence that R29 was offered or received PCV20. R33's face sheet, dated 3/13/24, indicated he was [AGE] years old. The immunization record, dated 3/13/24, indicated he received a PPSV23 on 11/14/2001 followed by the PCV13 on 6/7/2016. The record lacked evidence of shared clinical decision making with the physician for PCV20 at least 5 years after the last pneumococcal dose. The record lacked evidence that R33 was offered or received PCV20. R35's face sheet, dated 3/13/24, indicated he was [AGE] years old. The immunization record, dated 3/13/24, indicated he received a PPSV23 on 8/20/2013 followed by a PCV13 on 1/4/2017. The record lacked evidence of shared clinical decision making with the physician for PCV20 at least 5 years after the last pneumococcal dose. The record lacked evidence that R35 was offered or received PCV20. R69's face sheet, dated 3/13/24, indicated she was [AGE] years old. The immunization record, dated 3/13/24, indicated she received a PPSV23 on 3/10/2014 followed by a PCV13 on 6/1/2015. The record lacked evidence of shared clinical decision making with the physician for PCV20 at least 5 years after the last pneumococcal dose. The record lacked evidence that R69 was offered or received PCV20. During an interview with infection preventionist (IP), on 3/13/2024 at 2:56 p.m., the IP indicated immunizations are reviewed upon admission. IP stated IP used the Centers of Disease Control and Prevention (CDC) pneumococcal vaccine recommendations, dated 2/16/2022 for eligibility of pneumococcal immunizations. IP verified R29, R33, R35 and R69's pneumococcal immunizations as listed above and that they had not been offered or provided education on the PCV20. IP verified there had been no shared clinical decision making with the provider regarding pneumococcal immunizations for R29, R33 R35, and R69. IP stated it was important to ensure residents are offered all available vaccinations to prevent the risk of developing symptoms to lead to acute illness. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A facility policy titled Pneumococcal Vaccines (PPSC23, PCV20, PCV15) with a review date of 3/2023 was provided. Policy indicated: Adults [AGE] years and older should receive a single dose of PCV15 followed by a dose of PPSV23 or a single dose of PCV20.