STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265708	A. Building B. Wing	04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shirkey Nursing and Rehabilitation Center	804 Wollard Blvd Richmond, MO 64085

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32513 Based on interview and record review, the facility failed to ensure one resident and/or representative (Resident (R) 65) of five residents reviewed for unnecessary medications out of a total sample of 21 residents was informed of the risk and benefits of physician ordered psychotropic medications. This failure placed the resident and/or representative at risk of not knowing the risks and benefits of the use of the medications. Review of the Face Sheet, located in the Face Sheet tab of the electronic medical record (EMR), revealed R65 was admitted to the facility on [DATE] with diabetes, heart failure, and chronic obstructive pulmonary disease (COPD). Review of the significant change Minimum Data Set (MDS) located in the MDS tab of the EMR with an Assessment Reference Date (ARD) of 11/07/23 revealed, R65 had a Brief Interview of Mental Status (BIMS) of 14 out of 15 which indicated she was cognitively intact for daily decision-making. Review of a 10/24/23 Psychotropic Medication Change [Recorded as Late Entry on 11/07/23] located in the Progress Notes tab of the EMR revealed NEW ORDER for Seroquel [an antipsychotic medication] 12.5 mg at HS [hour of sleep] for increased behaviors, hallucinations and paranoia .Resident has been having increasing behaviors and imagining things that are not there. Thinking that everyone is talking about her and spreading her personal information around .Unable to redirect. The Psychotropic Medication Change Progress Note did not show that R65 or her representative was informed of risks and benefits prior to the initiating a new Physician Order for Seroquel. Review of a 12/05/23 Nursing Progress Note, located in the Progress Notes tab of the EMR, revealed Resident with new order received .Rexulti [an antipsychotic medication] 0.5 mg by mouth every day for Depression/Behaviors. The Progress Note indicated that R65's representative was notified of the medication however, the documentation did not show that R65 was informed or that the risks and benefits of the medication were explained to the resident representative or to the resident. During an interview on 04/05/24 at 8:19 AM, Licensed Practical Nurse (LPN) 1 was asked what the process was to explain the risks and benefits for psychotropic medications, when ordered by the physician. LPN1 stated, We have never had a form for them to sign, we just call and tell them a new medication was ordered. We are then to document it [the phone call] in the progress notes. LPN1 further stated, If it's not documented in the Progress Notes then it didn't happen. (continued on next page)

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

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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/05/24 at 11:29 AM, the Director of Nursing (DON) was asked what her expectation was regarding informing the resident and/or representative of new orders for psychotropic medications including the risk and benefits. The DON stated, We just document it in the 'Progress Notes' that the family was called.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32513 Based on observation, interview, record review, and review of facility policy, the facility failed to investigate an injury of unknown source for one resident (Resident (R) 65) of one resident reviewed in a total sample of 21. This failure to investigate a fractured leg placed the resident at risk for potential abuse. Review of the facility policy titled, Policy and Procedure Regarding Investigation and Reporting of Alleged Violation of Federal and State Laws involving Mistreatment, Neglect, Abuse, Injuries of Unknown Source and Misappropriation of Residents property, dated 11/20/03 revealed, Investigation: All investigations shall be conducted by the Administrator or DNS (Director of Nursing Services) .The investigation shall include interviews of employee's, visitors or residents who may have knowledge of the alleged incident .Written statements from involved parties should be requested .The medical record should be reviewed to determine the resident's past history and condition and its relevance to the alleged violation . Review of the Face Sheet located in the Face Sheet tab of the electronic medical record (EMR) revealed R65 was admitted to the facility on [DATE] with diagnoses that included osteoarthritis, history of falls, and heart failure. Review of a 10/27/23 at 10:24 AM, Psychotropic Medication Change Progress Note located in the Progress Notes tab of the EMR revealed, .Resisting Care: Resident called this nurse to room stating she was unable to stand d/t knee popped. Resident's ROM WNL [range of motion within normal limits]. Resident was using BLE [bilateral lower extremities] to move around her room while in her W/C [wheelchair], but when came to standing to pivot to her bed, resident was stating she was unable to stand on her leg . Review of a 10/28/23 at 5:47 AM, Nursing Progress Note located in the Progress Notes tab of the EMR revealed, .Resident called this nurse to her room to ask this nurse to put a piece of furniture on her leg. This nurse asked her why she would want me to do that. Resident stated you know I broke my femur again . Review of a 10/28/23 at 12:13 PM Psychotropic Medication Change Progress Note located in the Progress Notes tab of the EMR revealed, .Resident tearful and crying at times this morning. Calling family telling them that she fell last night and that CMT [Certified Medication Tech] that has not been working last couple of days is one that picked her up off of the floor then told her daughter that 2 people she didn't know picked her up and lifted her back to bed this morning. No noted falls and or reports from previous shift . (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a 10/28/23 at 12:17 PM Nursing Progress Note located in the Progress Notes tab of the EMR revealed, .Resident c/o left knee pain this morning .Stated she fell last night and named a CMT that has not been working last couple of days is [sic] the one that picked her up and put her to bed. Then while her daughter was here visiting, resident stated that 2 staff she didn't know picked her up and 'heaved' her back to the bed. This nurse was raising PJ pant leg up over left knee to apply pain cream when resident stated, 'I broke my femur down there on my knee, look I have 36 stitches in there' .left knee does appear slightly swollen at this time In addition to the voltaren gel application, prn [as needed] NORCO administered and ice pack applied to left knee x20 min. Resident appeared to be resting with eyes closed The Nursing Progress Note did show that pain medication was administered. Review of a 10/31/23 at 12:22 PM Nursing Progress Note located in the Progress Notes tab of the EMR revealed, .Resident's daughter came to the desk and stated, 'Mom's lips are so dry, I want her sent to the hospital.' Resident sent to the hospital per family request . Review of an 11/03/23 at 4:29 PM, Nursing Progress Note located in the Progress Notes tab of the EMR revealed, .Res. readmitted to the facility from the hospital due to a diagnosis of UTI [urinary tract infection] . Report from the hospital states: there is an intramedullary rod which extends down femur. The acuity of this fracture is uncertain. Cannot exclude that is an acute fracture . Review of a significant change Minimum Data Set (MDS) located in the MDS tab of the EMR with an Assessment Reference Date (ARD) of 11/07/23 revealed, R65 had a Brief Interview of Mental Illness (BIMS) score of 14 out of 15 which indicated R65 was cognitively intact, had range of motion impairment on one side, lower extremity, was dependent on staff for transfers and did not ambulate. During an interview on 04/02/24 at 1:41 PM, R65 was observed seated in her recliner. She was alert, oriented and easily conversed with this surveyor. She stated that she had been to the hospital for a broken knee. R65 further stated that she could not longer walk and needed help to getting into her wheelchair as her legs no longer worked. During an interview on 04/04/24 at 3:36 PM, Family Member (FM) 1 stated, .When they brought her back, it wasn't too long that when mom started calling me with increased hallucinations .I asked the nurses, and they said her knee was hurting. My mom kept saying 'they dropped me.' Several days went by, she stopped walking and then got another UTI. When she got to the hospital, they took x-rays and said she had a 'crack' in her femur.' We asked staff about it, and they said they 'heard a low pop' and now she no longer walks . During an interview on 04/05/24 at 8:19 AM, Registered Nurse (RN) 1 was asked about the Nursing Progress Note in which she documented about the x-ray report from the hospital indicating the acute fracture was an investigation started. RN1 stated, I did not start an investigation when I became aware of it. During an interview on 04/05/24 at 11:32 AM, the Director of Nursing (DON) was asked if an investigation into R65's statements had been investigated as possible abuse due to the fracture of unknown origin. The DON stated, I wasn't aware of the x-ray report or the resident's statements as documented in the progress notes. The DON further stated had she been made aware of the allegation, she would have investigated it, but no one told her.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32513 Based on observation, interview, record review, and review of facility policy, the facility failed to ensure resident Care Plans were updated/revised for two residents (Residents (R) 84, R6) of 21 sampled residents. The facility failed to update the Care Plan for R84 related to her behaviors and oxygen usage for R6. This failure created an increased risk for the residents to care and services that may not be appropriate for their current clinical condition. Review of the facility policy titled, Updating Care Plans, dated 04/05/18 revealed, . Care Plans need to be continually updated as the resident's needs change. The Care Plan needs to reflect the resident's current status at any given moment . 1. Review of the Face Sheet located in the Face Sheet tab of the electronic medical record (EMR) revealed R84 was admitted to the facility on [DATE] with a diagnosis of Alzheimer's disease. Review of the admission Minimum Data Set (MDS) located in the MDS tab of the EMR with an Assessment Reference Date (ARD) of 02/27/24, revealed R84 had a Brief Interview of Mental Status (BIMS) score of four out of 15 which indicated she was severely impaired in cognition, had physical and verbal behaviors, rejected care for one to three days during the observation period. In addition, it was documented that R84's behaviors had worsened since admission. Review of the 03/05/24 Behavior Care Plan located in the Care Plan tab of the EMR revealed, R84 has episodes of inappropriate behavior which interfere with her care and the care of other residents. She can be combative and strike out. Approaches, dated 03/05/24 include the following: .R84 has a scheduled anti-psychotic medication for management her [sic] behavior and anxiety. She also has a prn [as needed] for management of breakthrough behavior which presents as a safety issue . R84 verbalizes delusions about family and events. Provide reassurance and distract as much as possible with activities or conversations. R84's anxiety sometimes presents with verbal and physical behavior. Try to remove her from the situation, allow her to calm [sic]. Limit stimulation if she appears upset. When she refuses or resists care, reapproach at a later time. Wandering: R84 is up wandering and pacing throughout the unit. She tries doors to find her care/family, etc. She also wanders into other resident rooms. Staff to [sic] monitor her where abouts [sic] and redirect as needed to keep her safe. Take her to group activities or common areas and encourage her participation. During an observation on 04/02/24 at 1:19 PM, R84 was observed sitting on the floor in the common area. Certified Medication Technician (CMT) 4, upon observing the surveyor having entered the secured dementia unit, stated She is care planned to be sitting on the floor. CMT 4 tried to assist R84 to stand up however, R84 was able to stand independently without assistance. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 04/04/25 at 9:28 AM, R84 was observed to ambulate independently in the common area, then lean over and sit on the floor, then stand up again and continue to ambulate, then repeat this behavior. Review of the Behavior Care Plan did not show the behavior of sitting on the floor as a problem nor was there an approach which included how staff were to address this behavior with R84 safely. During an interview on 04/04/24 at 12:21 PM, Licensed Practical Nurse (LPN) 4 was asked when the behavior of sitting on the floor start. LPN 4 stated, It's been that way all along. During an interview on 04/04/24 at 12:23 PM the Unit Manager (UM) 1 was asked about the behavior of sitting on the floor. UM 1 stated, Her family at home stated she was a floor sitter. It was reported to MDS about the behavior so it could be care planned. UM 1 was told that that information was not in the Care Plan. UM 1 reviewed the comprehensive Care Plan and the Care Plan book located at the nurses' station and stated, There is nothing in her Care Plan about the behavior. 2. Review of R6's Face Sheet, located in the resident's electronic medical records (EMR) section titled Face Sheet, revealed the resident was admitted to the facility on [DATE] with diagnoses that included chronic congestive heart failure and chronic atrial fibrillation. Review of R6's significant change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/25/24, located in the resident's EMR under the MDS tab indicated the facility assessed R6 to have a Brief Interview for Mental Status (BIMS) score was 15 out of 15, indicating R6 had intact cognition. Review of R6's Care Plan, located on Unit five in the Care Plan book, revised 03/28/24 revealed the resident did not have a oxygen care plan to address their continuous oxygen order. Review of R6's Physician's Orders, located in the resident's EMR under the Orders tab, revealed R6 the following orders: -O2[oxygen] Titrate via nasal cannula to maintain O2 sats>PRN [as needed] with 2 Liters and O2 sats with start date of 03/20/24. Observation and interview on 04/02/24 at 10:00 AM, R6 was observed sitting in wheelchair with oxygen on face. R6 stated they had been using oxygen since their last hospital visit last month in March 2024. An interview on 04/05/24 at 1:55 PM, with the Assistant Director of Nursing (ADON) revealed they were the MDS Coordinator and ADON and they were responsible for initiating and updating care plan as they are completing any quarterly, annual, or significant change MDS's. ADON revealed they updated R6's care plan when they updated their last significant change MDS, and they just missed the oxygen. ADON stated it was important to include oxygen on the care plan so that staff would be aware of and know how to care for R6.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32513 Based on interview and record review, the facility failed to provide showers to two residents who preferred showers (Residents (R)8, and R73) of five residents reviewed in a total sample of 21 residents. This failure placed the residents at risk of a diminished quality of life. Findings include: 1. Review of the Face Sheet located in the Face Sheet tab of the electronic medical record (EMR) revealed R8 was admitted to the facility 03/01/10 with diagnoses that included Parkinson's disease (a progressive neurological disorder), dementia, and anxiety. Review of the quarterly Minimum Data Set (MDS) located in the MDS tab of the EMR with an Assessment Reference Date (ARD) of 02/06/24 revealed R8 had a Brief Interview of Mental Status (BIMS) score of 15 out of 15 which indicated she was cognitively intact for daily decision-making. In addition, the assessment revealed she required substantial assistance with showering. Review of an 01/22/19 ADL [activities of daily living] Care Plan, revised on 11/16/23 which was located in the Care Plan tab of the EMR, revealed R8 is at risk for decline in ADL abilities related to progressive dementia and general weakness. At this time, she is independent with her ADLs, only needing help if having illness or when she requests. A 01/22/19 intervention revealed, Bathe per choice of whirlpool, shower, or bed bath twice weekly. R8 requires extensive assist of 1 for bathing. During an interview on 04/02/24 at 12:15 PM, R8 was asked if she was provided showers per her schedule. R8 stated, I am to get two showers [her choice of bathing] per week . I haven't had a shower since last Tuesday [lapse of seven days]. R8 was asked if she was aware of any reason as to why she had not received her showers. R8 stated, I haven't heard a word as to why, but I think it's due to being short staffed. Review of the Shower Sheet located in a binder at the nurses' station, revealed the following dates that there was no documentation of R8 having received a shower. January 2, 2024. January 9, 2024. February 16, 2024. March 26, 2024. March 29, 2024. 2. Review of the Face Sheet located in the Face Sheet tab of the EMR revealed, R73 was admitted to the facility on [DATE] with diagnoses that included cerebral palsy (a condition marked by impaired muscle coordination) and mental illness. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the quarterly MDS located in the MDS tab of the EMR with an ARD of 03/19/24 revealed R73 had a BIMS score of 15 out of 15 which indicated she was cognitively intact for daily decision-making. In addition, R73 required substantial assistance with showering. Review of the 01/19/23 ADL Care Plan, located in the Care Plan tab of the EMR revealed, Self-Care Deficit: R73 showers herself with supervision for safety and assistance to safely transfer to the shower chair . During an interview on 04/02/24 at 10:06 AM, R73 was asked if she received her showers per her preference. R73 stated, I never refuse a shower as it is important to me. My showers are twice a week, they are short-staffed, and they can't always give me one. R73 was asked if they were able to provide a shower later in the day or the next day. R73 stated, No, I just have to wait until next week. I wish it didn't happen. Review of the Shower Sheet located in a binder at the nurses' station, revealed the following dates that there was no documentation of R73 having received a shower. January 4, 2024. January 15, 2024. February 1, 2024 March 25, 2024. April 1, 2024. During an interview on 04/02/24 at 2:25 PM, Licensed Practical Nurse (LPN)5 was asked about the missing documentation in the shower book. LPN 5 stated, It was probably due to a staffing issue. If we have two CNAs [Certified Nurse Aides], it cannot be done. If we have three CNAs, I will assign an aide to showers. I do try and help out with showers, but it's not always possible.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32513 Based on observation, interview, and record review, the facility failed to consistently provide a program of meaningful activities in accordance with the resident's preferences for one resident (R84) of nine residents reviewed for activities in the secured dementia unit out of a total sample of 21 residents. This failure placed R84 at risk of a diminished quality of life. Review of the Face Sheet located in the Face Sheet tab of the electronic medical record (EMR) revealed R84 was admitted to the facility on [DATE] with a diagnosis of Alzheimer's disease. Review of the Admission Minimum Data Set (MDS) located in the MDS tab of the EMR with an Assessment Reference Date of 02/27/24 revealed R84 had a Brief Interview of Mental Status (BIMS) score of four out of 15 which indicated she was severely impaired in cognition. In addition, her staff assessed activity preferences revealed R84 liked to spend time away from the nursing home, doing her favorite activities including religious activities. Review of the 04/01/24 Activity Care Plan located in the Care Plan tab of the EMR revealed, Problem: Need for Activity Involvement .R84 was always on the go and did not like to sit still. She attended the Baptist Church. She was very involved with her church. She would be found there every Wednesday evening and on Sundays. She enjoys watching TV. She enjoyed the Dr. [NAME] show and [NAME] News channel. R84 loved hiking around the (name withheld). R84 loves all things chocolate. She enjoys drinking Mountain Dew. In the past R84 enjoyed reading the newspaper every day. During an observation on 04/02/24 at 1:19 PM, R84 was observed sitting on the floor, then would get up and start walking around. There was one other resident observed in the common room, watching a game show on TV. All other residents were observed in their room, lying in bed except for one resident whose family was visiting with her, in her room. During an observation and interview on 04/04/24 at 9:28 AM, Certified Nurse Aide/Certified Medication Aide (CNA/CMA) 2 was observed trying to help and redirect R84 off the floor. She obtained washcloths out of the cabinet and encouraged R84 to fold them for her. R84 was unable to perform this activity due to not being able to sit down long enough before getting up and walking around and then sitting on the floor. The CNA/CMT 2 was asked why there were no other residents in the common area. She stated, I don't know why they are not here. CNA/CMA2 was asked if she was the only staff person in the unit. She stated, Yes. CNA/CMA2 stated, We just moved all the residents from the 400 hall to this unit to consolidate for staffing. We are all just getting used to it here. In an interview, CNA/CMA 2 was asked how she knows what activities R84 was interested in or enjoyed. CNA/CMA 2 stated, I just try things like the washcloths. She was asked if there was an activity logbook so staff could account for what the residents were able to do for their activity preferences. CNA/CMA 2 stated, I thought there was a book on the desk. An observation with CNA/CMA 2 of the desk in the secured dementia unit, showed no activity logbook. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/04/24 at 1:10 PM, the Activity Director (AD) was asked why R84's Activity Care Plan was not developed for over 30 days after admission to the facility. The AD stated, I had trouble getting in touch with her family [to find out what activities interested R84]. The AD further stated, I spend a lot of time with all the residents on the unit, but with R84 we do hand holding and walking with her. The AD stated, I know the residents are laying [sic] in bed more, the aide on the dementia unit is supposed to do activities with them. They have games and widgets which are in the new cabinet. My activity assistant does not do one-on-one activities in the unit The AD further stated, We used to be on the 400 hall and there was a patio for the residents to go and sit in the sun on nice days during the summer. We would have popsicles and reminisce, now we don't have that. We tried bingo on the unit the other day as a trial, and it went well, considering it took awhile for the residents to find the numbers.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32513 Based on observations, record review, staff and family interviews, and facility policy review, the facility failed to (1) assess resident (R) 23's falls, monitor the effectiveness of the interventions, or modify the interventions to prevent further falls and/or injuries for one of three residents reviewed for falls (R23, R46, and R57); (2) provide a fire blanket and fire extinguisher in the three designated resident smoking areas to reduce the risk of harm for the three residents who smoke (R26, R30, and R42); and (3) to conduct a smoking assessment for one of three residents (R)26, to determine independent versus supervised smoking needs. 1. Review of the facility's 2006 policy titled, Unusual Occurrences, provided by the Administrator, revealed the following: All incidents will require that an incident report be filled out by the charge nurse. Incidents are falls, bruises, skin tears and anything that the charge nurse would consider an unusual occurrence. Once the incident report is complete . the coordinator will log all incidents to the unusual occurrence tracking log. From the tracking log, the unit coordinator will report at the monthly quality assurance meeting as to whether there has been any trending of these occurrences and what measures were put in place for prevention of further occurrences. Review of R23's Census, located in the electronic medical record (EMR) under the Resident tab, revealed R23 was admitted to the facility on [DATE] with diagnoses that included unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety; other intervertebral disc degeneration, lumbar region; other abnormalities of gait and mobility; unspecified lack of coordination; difficulty in walking; muscle weakness; cognitive communication deficit; unsteadiness on feet; syncope and collapse; and epilepsy, unspecified, not intractable, without status epilepticus. Review of the Quarterly Minimum Data Set (MDS) assessment, dated 03/12/24, located under the RAI tab of the EMR, revealed a Brief Interview for Mental Status (BIMS) score of 13 out of 15 indicating R23 was cognitively intact. Review of the facility's Incident Reports for R23 revealed fourteen falls in a six month time period. Falls were reported to have occurred on 09/06/23, 10/9/23, 10/22/23, 11/8/23, 11/15/23, 11/19/23, 11/19/23 (second fall same day), 01/20/24, 01/25/24, 01/27/24, 02/3/24, 02/7/24, 02/10/24, and 02/11/24. R23 was identified to have been ill December 2023 and initiated hospice care on 12/08/23. Each fall noted as found on floor. There was no documentation of fall assessments or root causes analysis after the falls. During an interview with the Unit Manager (LPN1) on 04/04/24 at 9:52 AM, regarding R23's fourteen falls. LPN1 was asked about a timeline of interventions, what was put in place when for R23. LPN1 stated, you'll have to look in the care plan book, at the nurses' station, I don't know. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R23's most recent care plan, located at the nurses' station, updated 03/21/24, revealed R23 was at risk for falling d/t (due to) taking an antidepressant for DX (diagnosis): depression and anxiety. She has been on this medication since her admission to this facility and is stable on this med (medication). and having a seizure d/o (disorder) . due to a decline in mobility and functional status. The interventions were listed as: Maintain a safe environment. Limit clutter and keep frequently used items within reach. Keep bed in lowest position with brakes locked. Reinforce safety precautions as (R23) does not always remember. Remind her to use call light and how to use it. She is not to attempt to get up without assistance. Remand resident not to ambulate/transfer without assistance. (R23's) ability to bear weight is limited, she is to transfer via Hoyer lift and two helpers. (R23) has been prescribed antiplatelet therapy, may take longer to stop bleeding if an injury. On 04/03/24 at 11:43 AM, R23 was observed in her room seated in a Geri-chair visiting a family member (FM2). R23 and FM2 were interviewed regarding the numerous falls sustained by R23. FM2 stated, the fall in November was the big one where (R23) hurt her back, then they put her in this (Geri chair) or in the bed. When asked about interventions post falls, FM2 stated, the bed was changed, but it's not always down low when we visit and she's in the bed, but the mats are usually on the sides of the bed now. During the family visit, R23 was transferred into bed which remained in the high position after family left. This was observed on 04/03/24 at 1:27 PM. On 04/04/24 at 11:19 AM, a telephone interview was conducted with R23's family member (FM3). FM3 stated, she has had multiple falls, I am concerned about the falls and making sure (R23) always has her call light, that is her only lifeline. FM3 stated, I requested a bed alarm and was told no. Observation of R23 on 04/02/24 at 9:44AM, revealed the resident in her room, in bed which was raised. A staff member walked into the room to provide personal care. Observation of R23 on 04/04/24 at 11:57 AM, revealed R23 in bed. The bed was not in a low position. During an interview with the Director of Nurses (DON), on 04/05/24 at 1:10 PM the DON was asked if a root cause analysis and/or evaluation of R23's fourteen falls had been completed. The DON stated, She had that many? No, we don't do that. When asked if R23 was reviewed in the facility's weekly clinical meeting, the DON looked at three pages of typed notes from a meeting and said, not since January. When asked what interventions had been put in place and when, the DON stated, I cannot tell you when interventions were put in place, I don't know. When asked if the DON could locate when interventions were implemented to prevent further falls and/or injuries for R23, the DON stated, no, it's not in the medical record. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of the facility's undated Resident Smoking Policy, provided by the Administrator, revealed Residents of [NAME] Nursing and Rehabilitation Center are allowed to smoke under to levels of supervision: 1) If the resident has been assessed by the nursing dept. to be physically and cognitively able to smoke without supervision, then we ask that the resident inform their unit if going outside. Residents may continue to smoke unsupervised so long as their condition continues to allow. If there is an injury to the smoker, i.e. they burn themselves or become inattentive, then they will be placed on supervised smoking schedule. 2) If the resident has been assessed not to be safe due to physical or cognitive issues, then the resident will have to comply with the supervised smoking times. All smokers will use the designated smoking areas regardless of whether you are supervised or not. There is never to be any smoking within the facility. Violation of this policy can result in facility issuing a 30 day notice of discharge. Review of the posted smoking times, at the 200 hall nurses' station, revealed the times to be 9:00 AM, 1:00 PM, 3:00 PM, 6:00 PM, and 9:00 PM. Review of R 26's Face Sheet, located in the EMR under the Resident tab revealed R26 was admitted on [DATE] with diagnoses that included cervical disc disorder with myelopathy, metabolic encephalopathy, muscle weakness, unspecified lack of coordination, and cognitive communication deficit. Review of the quarterly MDS, located under the RAI tab with an ARD of 01/02/24, revealed a Brief Interview for BIMS score of 14 out of 15 indicating R26 is cognitively intact. Review of R26's care plan, located under the RAI tab in the EMR, revealed R26 may smoke as desired unless condition changes and requires supervision. Smoking materials are kept by nursing staff. (R26) is to turn in all smoking materials after smoking. Offer smoking apron for protection from burns. He often declines to use it. Edited 03/30/23. The last date, written at the bottom of the care plan page was 10/16/23, and read Cont. (continue) with POC (plan of care) x90d (times ninety days). Observation of one of the designated smoking areas, on the 200 hall, on 04/02/24 at 10:32 AM, revealed R26 in his electric wheelchair, with a smoking apron on, and Registered Nurse (RN) 1 supervising. A self-extinguishing ashtray was visible. There was not a smoking blanket or fire extinguisher available in the designated smoking area in case of a fire emergency. RN1 and the Infection Preventionist (IP), smoking at the time, both stated there had never been a smoking blanket or a fire extinguisher at any of the smoking areas. When asked about resident smoking assessments, the IP stated, the Director of Nurses (DON) completes the smoking assessments. Observations were conducted of the three designated smoking areas, 200 hall, the front of the building, and the 500 hall on 04/02/24 at 10:45 AM, 04/03/24 at 12:30 PM, and 04/04/24 at 9:30 AM. All areas had self-extinguishing ashtrays. No area had a fire blanket or a fire extinguisher available for an emergency. On 04/04/24 at 9:45 AM, R26 drove, in his electric wheelchair, to the 200 hall nurses' station and requested a cigarette and a cigar from the Licensed Practical Nurse (LPN) 4. LPN4 was observed to hand R26 the cigarette, cigar, and lighter and R26 drove to the 200 hall smoking area. R26 was outside smoking for approximately five minutes before LPN4 left the nurses' station to supervise R26. LPN4 was asked if R26 was an independent smoker, she stated, no, he has to be supervised. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/05/24 at 9:52 AM, the Unit Manager (LPN1) was asked for R26's smoking assessment for review. LPN1 stated, if there is one, it's in the care plan book at the nurses' station, I don't do them. Review of the care plan book, located at the nurses' station, nor the EMR contained a smoking assessment for R26 when reviewed on 04/04/24 at 10:33 AM. In an interview with the DON on 04/05/24 at 1:15 PM, she stated we don't do smoking assessments, should we? When asked where information was documented to show the facility assessed R26 for his smoking abilities, the DON stated, it's in the care plan, (R26) was independent until he burned a hole in his blanket, then he was supervised. When asked when did R26 burn a hole in his blanket, the DON said, I don't know. The DON was informed of the observation of LPN4 providing R23 a cigarette, cigar, and lighter as she stayed at the desk on the computer, the DON said, she should not have given him the cigarette, cigar, or lighter until she was ready to supervise him. On 04/05/24 at 1:45 PM, the MDS Coordinator (LPN3), in charge of care plans, was asked for documentation that R26 had been assessed for smoking. LPN3 showed the care plan that read resident is a smoker. The facility had no documentation to present that R26's smoking abilities had been assessed.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32513 Based on observations, interviews, record review and facility policy review, the facility failed to: have a system in place to ensure respiratory equipment to include oxygen tubing was dated/labeled when changed out, failed to ensure documentation of cleansing of C-pap masks(Continuous positive airway pressure- a form of positive airway pressure that is continuously applied to the upper respiratory tract of a person), C-pap tubing, and water chamber were being cleaned and changed as per physician orders on Sundays, failed to ensure a C-pap machine was kept off the floor, and failed to have clean oxygen filters, maintain oxygen in the nose, and apply oxygen continuously for two of two residents (Resident (R) 51 and R48) reviewed for respiratory therapy out of a total sample of 21 residents. This failure placed the residents at risk for respiratory illnesses, and further increased the risk of contamination of the respiratory equipment. Review of the facility's untitled policy, dated 02/28/2019and provided by the Director of Nursing (DON), indicated, All oxygen concentrator filters need to be cleaned every week on Sunday night. Even concentrators that are not being used. Oxygen tubing must be changed weekly and dated. Oxygen tubing and nebulizer tubing must be stored in a plastic bag, and CPAP's hose, mask, and H20 (water) chamber must be cleaned weekly 3 parts water and 1 part vinegar. 1.During an observation of R51 made on 04/02/24 at 2:35 PM, upon entrance into R51's room R51 was observed to be lying in bed with oxygen on via nasal cannula. The oxygen tubing was observed to have no date/label as to when the oxygen tubing had been changed out. Further observation revealed R51's C-pap machine was located on the floor on the left side of the resident's bed by the head of the bed. At this time, R51's C-pap machine mask, hose, and H20 chamber were observed to be sitting on a ledge of a window. The C-pap tubing was observed to be hanging down off the window ledge. There was no evidence of when the C-pap mask, H20 chamber or tubing had been cleaned, or changed out. During an interview made on 04/02/24 at 3:30 PM, R51 stated that she was on oxygen for shortness of breath. When asked if staff were changing out the oxygen tubing or cleaning her C-pap mask and H20 chamber regularly, R51 stated, I don't know. During a second observation of R51 made on 04/03/24 at 9:41 AM, Certified Nursing Assistant (CNA) 7 was observed pushing R51 in her wheelchair from the 500-unit dining room with the oxygen concentrator behind it. At this time, observation of the oxygen tubing on the oxygen concentrator was still not dated/labeled as to when it was changed out. During an observation of R51 made on 04/03/24 at 12:17 PM, CNA1 was observed pushing R51 in her wheelchair from the 500-unit dining room with the oxygen concentrator behind it. At this time, observation of the oxygen tubing on the oxygen concentrator was still not dated/labeled as to when it was changed out. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview made on 04/03/24 at 12:22 PM, R51 was observed to be sitting in her wheelchair in her room. At this time R51 was wearing her oxygen via nasal cannula. During the interview, when asked if staff were cleaning her C-pap mask with warm water and vinegar, R51 stated, Well, no. Not really. When asked if staff were coming to change the oxygen tubing either from the oxygen concentrator, or changing the C-pap hose and H20 water chamber regularly, R51 stated, Well, no. At this time, R51's C-pap machine was again observed sitting on the floor on the left side of the resident's head of the bed. The C-pap machine mask, hose, and H20 chamber were observed again to be sitting on a ledge of the window. The C-pap tubing was observed to be hanging down off the window ledge. There was no evidence of when the C-pap mask, H20 chamber or tubing had been cleaned, or changed out. During an interview on 04/03/24 at 12:30 PM regarding R51's oxygen tubing and C-pap machine, CNA7 and CNA1 stated, If they need to be changed then we will just do that on a as needed basis. CNA7 stated, We change out the water and oxygen tubing. When asked how often, CNA7 stated, Just whenever. CNA 7 further was asked if there would be any documentation of when the oxygen tubing is changed out, she stated, We are supposed to put a piece of tape on the oxygen tubing with the date and our initials when we change it out. That is the same with the humidifiers. We are supposed to put the date and our initials when we change those out, but with [name of R51] she has her own humidifier bottle, so we just add distilled water to when needed. Regarding R51's C-pap machine mask, tubing, and H20 water chamber, CNA7 stated, The night shift is supposed to change out the water and clean the C-pap masks. Review of an undated Face Sheet located in R51's electronic medical record (EMR) under the Resident tab indicated diagnoses to include Acute and chronic respiratory failure with hypoxia, COPD (Chronic Obstructive Pulmonary Disease), acute respiratory distress syndrome, congestive heart failure, and obstructive sleep apnea. Review of a Significant Change Minimum Data Set [MDS] located in R51's EMR under the RAI (Resident Assessment Instrument) tab with an Assessment Reference Date (ARD) of 01/02/24 revealed R51 was receiving oxygen therapy and had a Brief Interview for Mental Status [BIMS] score of 14/15 indicated no cognitive impairment. Review of Physician Orders, dated 12/27/23, located in R51's EMR under the Orders tab indicated, Admit to [name of hospice] d/t (due to) Respiratory failure. Review of Physician Orders, dated 01/01/24, located in R51's EMR under the Orders tab indicated, Cleanse C-pap mask, tubing and H20 chamber weekly on Sunday with 3 cups of warm water and 1 cup of white vinegar, let air dry and be ready for use by HS (evening) once a day on Sunday 7am-7pm. Review of Physician Orders, dated 04/03/24, located in R51's EMR under the Orders tab indicated, Change all oxygen and nebulizer tubing the last Sunday of each month on day shift. (CMT's, nurse to monitor to assure it was completed) once a day on last Sunday of the month at 5pm. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/03/24 at 12:37 PM, Licensed Practical Nurse (LPN)3 was asked who changes out the oxygen tubing and who cleans the residents C-pap masks, changes out the tubing and ensures the H20 water chamber is clean, LPN3 stated, The med tech would change out the tubing. It used to be weekly, but now I think its monthly just as needed. Regarding the humidifiers, The med tech or me can change those out when we see it needs to be changed. We are supposed to be documenting when they are changed out on the MARS [Medication Administration Record]. LPN3 stated, With the C-pap, she just has distilled water in her room, so we just replace that when we see its low. LPN3 then stated, Regarding the cleaning of the C-pap mask, that is supposed to be done weekly by the night shift. That would be documented in the ADL [Activities of Daily Living] book. The CNAs are supposed to clean the C-paps, sanitize, and wipe down after each use. That would be the night shift. Review of the ADL (Activities of Daily Living) Flowsheets dated 01/02/24-01/31/24 indicated no documentation of cleansing R51's C-pap mask, tubing & H20 chamber was being documented as completed on Sundays as ordered. Review of the ADL Flowsheet dated 02/01/24-02/29/24 indicated three inconsistencies on Sunday 02/04/24, Sunday 02/18/24, and on Sunday 02/25/24 in which there was no documentation of cleansing R51's C-pap mask, tubing & H20 chamber as ordered to be done on Sundays. Review of the ADL Flowsheet dated 03/01/24-03/31/24 indicated inconsistencies on Sunday 03/03/24, Sunday 03/10/24, Sunday 03/17/24, Sunday 03/24/24 and on Sunday 03/31/24 in which there was no documentation of cleansing R51's C-pap mask, tubing, & H20 chamber as ordered to be done on Sundays. During an observation made on 04/03/24 of R51 at 12:49 PM with LPN3, R51 was observed to be lying in her bed with the oxygen on. When observing the oxygen tubing connected to the oxygen concentrator not being dated/labeled, LPN3 confirmed and stated, No, I do not see a date or initials as to when the oxygen tubing was changed out. At this time, R51's C-pap machine was again observed to be on the floor on the left side of the resident's bed. R51's C-pap mask and tubing were again observed to be still sitting on the window seal ledge. During interview, LPN3 stated, I will have to get a table and put her C-pap machine on it because I see its on the floor and it should not be. LPN3 stated, The C-pap mask should be cleaned every Sunday but I'm not seeing a date as to when it was cleaned last. I will need to get some new oxygen tubing as well because I don't know the last time this was change out. During an interview made on 04/3/24 at 1:00 PM, regarding resident's oxygen tubing, and C-pap machines, Certified Medication Aide (CMA)1 stated, We are supposed to change out the oxygen tubing once a week. We run the C-pap masks through water, and I believe it is the med techs and the nurses that do that, but I'm not sure. CMA1 stated that she had not cleaned R51's C-pap mask or changed out the oxygen tubing that she could recall. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview made on 04/03/24 at 1:16 PM, regarding oxygen tubing, respiratory equipment, and C-pap machines, the DON stated, The oxygen tubing is changed out monthly and its usually the last day of the month. The C-pap mask, and tubing should be in a plastic bag. That would be my expectation. The DON further stated, I'm thinking anybody can change out the humidifiers anytime they are empty, and with the oxygen tubing, it should be changed out by the night shift aides. The nurse would ensure its done and should be signing off on that. The DON further stated, It would be my expectation the C-pap masks are being cleaned as ordered as well. When the documentation of the inconsistencies was shown to the DON regarding R51's C-pap mask not being cleaned and 02 not being dated/labeled, the DON stated, I was not aware that it wasn't being done. Unfortunately, if it wasn't documented, then it didn't happen. 2. Review of the Face Sheet located in the Face Sheet tab of the EMR revealed R48 was admitted to the facility on [DATE] with diagnoses which included dementia, stroke, and heart failure. Review of an 07/30/22 Physician Order located in the Orders tab of the EMR revealed, Oxygen titrate to maintain sats above 90%. Diagnosis is hypoxia. Review of the quarterly MDS located in the MDS tab of the EMR with an Assessment Reference Date (ARD) of 01/02/24 revealed, R48 had a BIMS score of three out of 15 which indicated she was severely impaired in cognition and used oxygen daily. During an observation on 04/02/24 at 10:32 AM, R48 was observed sitting in her high-back wheelchair, in her room. The nasal cannula was not positioned in both nares and was only observed in one naris. The oxygen concentrator filter was covered with white lint and there was no humidifier bottle attached. During an observation 04/02/24 at 11:46 AM, R48 was observed with the oxygen nasal cannula was observed on her face, but not in her nares. During an observation on 04/02/24 at 12:03 PM, Certified Medication Technician (CMT) 4 was asked why her nasal cannula was not in her nares. CMT 4 was then observed to reposition R48's nasal cannula into her nares. CMT 4 was asked who was responsible for ensuring the filter was clean and there was a humidifier bottle. CMT 4 confirmed that the filter was dirty and stated, We all are responsible for ensuring that it is clean, and tubing is changed. During an observation on 04/03/24 at 9:25 AM, R48 was observed sitting in her wheelchair at the dining room table. R48 was not wearing her oxygen and the concentrator was observed in her room. Certified Nurse Aide (CNA) 3 was asked why she wasn't wearing her oxygen. CNA 3 confirmed she wasn't wearing her oxygen but then stated, I don't know why she isn't wearing [the oxygen].

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 32513 Based on observations, interviews, record reviews, and review of the facility assessment, the facility failed to ensure sufficient nurse staffing to meet the needs of the residents resulting in residents not receiving showers for two (Residents (R) 73, R8) of five sampled residents, activities to meet residents' needs in the secured dementia unit. These failures placed residents at risk of a diminished quality of life and potential unmet care needs. 1. This tag is cross-referenced to F676; ADL [maintain activities of daily living] as not diminish or decline. Based on interview and record review, including shower schedules, the facility failed to consistently provide showers for R73, and R8. Review of the quarterly Minimum Data Set (MDS) located in the MDS tab of the electronic medical record (EMR) with an Assessment Reference Date (ARD) of 02/06/24 revealed R8 was cognitively intact for daily decision-making. During an interview on 04/02/24 at 12:15 PM, R8 stated, I am to get two showers [her choice of bathing] per week .I haven't had a shower since last Tuesday [lapse of seven days]. R8 was asked if she was aware of any reason as to why she had not received her showers. R8 stated, I haven't heard a word as to why, but I think it's due to being short staffed. Review of the quarterly MDS located in the MDS with an ARD of 02/06/24 revealed R65 was cognitively intact for daily decision-making. During an interview on 04/02/24 at 1:36 PM, R65 stated, Yes, I don't think there is enough staff. It is mostly on the afternoon shift. When I put my call light on, sometimes they don't come at all (to answer the call light). Review of the quarterly MDS located in the MDS tab of the EMR with and ARD of 03/19/24 revealed R73 was cognitively intact for daily decision-making. During an interview on 04/02/24 at 10:06 AM, R73 stated, I never refuse a shower as it is important to me. My showers are twice a week, they are short staffed, and they can't always give me one. 2. This tag is cross-referenced to F679: Activities. Based on observation, interview, and record review, the facility failed to provide a program of meaningful activities for residents who reside in the secured dementia unit. During observations on 04/02/24 and 04/04/24, in the secured dementia unit, there were nine residents in total who resided on the unit. During these observations, residents were not observed in an activity but instead were laying in the beds. One resident, R84, was observed wandering around the unit, sitting on the floor and then getting up and walking again. (continued on next page)

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Shirkey Nursing and Rehabilitation Center	804 Wollard Blvd Richmond, MO 64085

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the survey from 04/02/24 to 04/04/24The secured dementia unit showed that only one staff member was available to assist the residents with ADL [activities of daily living] needs, pass medications, intervene if there were behaviors and provide activities for the nine residents. During an interview on 04/04/24 at 9:08 AM, Certified Nurse Aide (CNA) 2 [who was also a CMA-Certified Medication Aide) was asked why there were no residents in the common area. She stated, I have no idea why. CNA2 was asked if she was the only person to care for the nine residents on the unit. She stated, Yes. CNA 2 confirmed that she provided the nine residents with ADL care, their medications, handled behaviors, and provided activities. CNA 2 further stated that we just moved to this unit, on the 200 hall from the 400 hall this week, so we are just getting used to it here. During an interview on 04/04/24 at 12:21 PM, Licensed Practical Nurse (LPN) 3 stated, I used to be on the secured dementia unit prior to coming to the 200 hall, so I am familiar with the residents on the dementia unit. LPN3 further stated, The dementia unit used to be on the 400 hall, we had a nurse and a CNA/CMA available on the unit and we were able to do activities but now I have to be at the desk on the 200 hall and be available to the dementia unit. During an interview on 04/04/24 at 1:10 PM, the Activities Director (AD) stated, I know they (the dementia unit residents) are laying in their beds. The Administrator told me that the census is low so the aides have to the activities. We moved to the 200 hall to consolidate staffing. The Administrator stated they couldn't put anyone back their so the CNAs had to do activities. The AD was asked if she felt the facility was short-staffed. She stated, Yes, I do. The AD further stated that on 400 hall, we used to have a patio, and during the summer we would take the residents outside, have popsicles and reminisce but with the new unit on the 200 hall, we don't have a way for them to go outside. During an interview on 04/05/24 at 8:50 AM, the Infection Preventionist (IP) stated that she was also responsible for staffing. The IP stated that she was on a 30 hour per week employee, and it was difficult to both jobs. The IP was asked if she attended the weekly QAA (Quality Assessment and Assurance) meetings. She stated, No, they hold the meetings when I am not here. The IP stated that she has to make a list for the to discuss regarding infection control and staffing. Review of the 02/28/24 Facility Assessment, (based on information from 2023) provided by the Administrator, revealed the average daily census on the 400 hall was 13.6 residents. Staffing the unit included the following breakdown: DAY SHIFT: Unit Manager: 0.5 (part-time) Licensed Nurse; 1.0 (full-time) CMT: 1.0 (full-time) CNA: 1.0 (full-time) NIGHT SHIFT: CMT: 1.0 (full-time) (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	CNA; 1.0 (full-time) During an interview on 04/05/24 at approximately 12:00 PM, the Administrator stated, If we don't have money for a staff position, we just won't have a position.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 32513 Based on observation, interview, and record review, the facility failed to ensure one of four Certified Medication Aide (Certified Medication Aide (CMA) 3) observed during medication pass, had the skills and competency to safely perform medication administration. Refer to F761. Review of the Staff Roster provided by the Director of Nursing (DON) revealed CMA 3 was hired by the facility on 07/11/02. Review of the 2023 and 2024 Skills and Drills sheet provided by Licensed Practical Nurse (LPN) 5 showed CMA 3 had not been assessed for medication competency since 04/11/23. The Skills and Drills sheet further revealed that CMA 3 was only observed for insulin, eye drops, and inhalers and had not been assessed for any other medication pass requirements. During an interview on 04/05/24 at 10:39 AM LPN 5 confirmed that CMA 3 had not been assessed for competency since 2023 and that overall medication pass observation had not been done.

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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** 32513 Based on interview and record review, the facility failed to complete an Abnormal Involuntary Movement Scale [AIMS-a test that rates involuntary muscle movements (tardive dyskinesia) on residents who are administered antipsychotic medications] assessment for two residents (Resident (R) 65 and R84) and failed to re-evaluate the need for an antipsychotic medication for one resident (R4) of five residents reviewed for unnecessary medications in a total sample of 21. These failures placed residents at risk for unrecognized side effects. 1. Review of the Face Sheet located in the Face Sheet tab of the electronic medical record (EMR) revealed R65 was admitted to the facility on [DATE] with diagnoses that included heart failure, diabetes, and pulmonary disease. Review of a 10/24/23 Psychotropic Medication Change Progress Note, located in the Progress Notes tab of the EMR and recorded as a late entry on 11/07/23, revealed NEW ORDER: Seroquel [an antipsychotic medication] 12.5 mg at bedtime for increased behaviors, hallucinations, and paranoia. Seroquel can have the side effect of tardive dyskinesia which can be permanent. Review of an 11/03/23 Physician Order located in the Orders tab of the EMR revealed on 11/03/23, the Seroquel was discontinued. Review of the significant change Minimum Data Set (MDS) located in the MDS tab of the EMR with an Assessment Reference Date (ARD) of 11/07/23 revealed R65 had a Brief Interview of Mental Status (BIMS) score of 14 out of 15 which indicated she was cognitively intact and had hallucinations (a perception of something not present). Review of a 12/05/23 Physician Order located in the Orders tab of the EMR revealed, Rexulti [an antipsychotic medication] 0.5 mg daily for depression/behaviors. Rexulti can cause tardive dyskinesia. Review of the Observations tab and the Resident Documents tab of the EMR revealed no documentation that an AIMS assessment was completed at the time R65 was started on the antipsychotic medications. During an interview on 04/05/24 at 11:29 AM, the Director of Nursing (DON) was asked if the AIMS assessment was completed and what the expectation was regarding staff doing the assessment. The DON stated, The Unit Managers were responsible, and they are to be done upon admission and every six months afterwards. The DON was unable to confirm or deny the AIMS assessments were completed for R65. 2. Review of the Face Sheet located in the Face Sheet tab of the EMR revealed R84 was admitted to the facility on [DATE] with a diagnosis of Alzheimer's disease. Review of the admission MDS located in the MDS tab of the EMR with an ARD of 02/27/24 revealed R84 had a BIMS score of four out of 15 which indicated she was severely impaired in cognition, had physical and verbal behaviors, rejected care, and wandered daily. In addition, the MDS showed that she was administered an antipsychotic medication. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the 03/13/24 Psychotropic Medication Review located in the Resident Documents tab of the EMR revealed the following: Olanzapine 5 mg BID (02/28/24). Risperidone 0.5 mg BID (02/19/24). Review of the Observations tab and the Resident Documents tab in the EMR did not show an AIMS assessment was completed, at the time of admission and when the Olanzapine was started. Olanzapine and Risperidone can cause tardive dyskinesia. During an interview on 04/04/24 at 12:31 PM, Unit Manager (UM)1 was asked if AIMS was completed upon admission for the Risperidone and when the Olanzapine was started. UM1 stated, No, it wasn't done. I don't know why as she came in with them. 3. The facility failed to complete AIMS assessments, every three months, for R4 as directed in the care plan for psychotropic drug use. Review of R4's Continuity of Care Document, located in the electronic medical record (EMR) under the Resident tab, revealed R4 was admitted on [DATE] with diagnoses that included unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety; unspecified dementia with behavioral disturbance; bipolar disorder; and anxiety disorder. Review of the annual MDS assessment with an ARD of 01/02/24 revealed a BIMS score of 99 indicating an inability to participate in the assessment. Review of the physician's orders, located in the EMR under the Resident tab revealed R4 received the following medications: a. fluoxetine (Prozac) solution 5ml (milliliters) one time a day at 8:00 AM for depression /appetite, ordered 06/16/21. Fluoxetine (an antidepressant may cause tardive dyskinesia, a movement disorder). b. Seroquel 25 mg, one tablet twice a day for bipolar disorder, increased to twice a day on 09/22/23. Seroquel is an antipsychotic and may cause tardive dyskinesia. Review of R4's Psychotropic Drug Use care plan, initiated 02/05/21 and last updated on 04/04/24, revealed R4 takes Seroquel for bipolar disorder . Prozac for depression. Included in the care plan approaches was AIMS (abnormal involuntary movement scale) every three months for antipsychotic use; monitor and report signs of sedation, anticholinergic and/or extrapyramidal symptoms; and monitor for therapeutic and side effects of anti-psychotic medications. On 04/02/24 at 10:01 AM R4 was observed, , in her room seated in her geri-chair. The resident was awake and observed to exhibit tongue thrusting. R4 engaged in a very brief conversation/introduction and stated, thanks for stopping, upon exiting her room. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/02/24 at 11:44 AM, R4 was observed seated at a table in the assisted dining room. R4 was observed to exhibit tongue thrusting while feeding herself a pureed meal with thickened liquids. The resident responded with hello when spoken to. Review of a facility report titled Antipsychotic Medication Evaluation (AME), dated 09/26/23, located in the EMR under the documents tab, specific to Seroquel, revealed recent change to BID (twice a day), wait one month then reassess. There were no evaluations found in the EMR to address the specified reassessment. Review of a Nurses Progress Note, dated 02/18/24, located in the EMR under the Resident tab revealed Daughter here in facility. Complaints of resident saying unusual things. Resident was observed with hallucinations early this shift. Pointing across room and stated do you see those little boys over there? Reassured resident no little boys in room at this time. Daughter left and called facility. Would like resident to be checked for UTI (urinary tract infection). Placed resident on UTI protocol. Will speak to NP tomorrow. Daughter advised that resident usually sticks tongue out when UTI is present. In an interview with the Unit Manager (LPN1) on 04/05/24 at 9:52 AM, she stated, ask the DON (Director of Nurses) for AIMS assessments. When asked about R4's tongue thrusting, LPN1 stated, she is? When asked about the 02/18/24 progress note, written by LPN1, she stated she didn't have a UTI, I don't remember writing about sticking her tongue out. LPN1 stated, she doesn't have a UTI now. During an interview, on 04/05/24 at 1:01 PM, with the Director of Nurses (DON), the DON was asked about the follow up to the AME dated 09/26/23. The DON stated, I would hope the charge nurse would identify it. When asked if R4 had been reviewed in the facility's weekly Clinical Meeting, the DON stated, every resident on an antipsychotic would be reviewed. When asked what was discussed in regard to R4, the DON stated, I don't have any notes on her. The DON was asked to locate any AME evaluations, AIMS evaluations, or documentation that R4's psychotropic medication use was being evaluated on a routine basis, the DON stated there's nothing in her record, we don't have anything.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 32513 During an observation, interview, and review of facility policy, the facility failed to prepare, store, and label medications according to standard nursing practice for one of four Certified Medication Aide (Certified Medication Aide (CMA3) observed during medication pass. This failure placed prescription-based medications readily accessible to residents, increased health complications, and the possibility of giving the wrong medication to the wrong resident. Review of an untitled facility policy, dated 04/29/14, revealed, Medication is never to be left unattended. If you must leave your cart, then all medications are to be locked inside. During a medication pass observation on 04/05/24 at 7:40 AM, Medication cart 5 [NAME] was parked outside a room. CMA3 was not stationed at the cart but was in a resident's room. The cart showed that there were three individual plastic cups on top of the cart which were observed to contain powder mixed in liquid, which had gelled at the bottom of the cup. Inside each cup was a plastic spoon. The individual cups were not labeled. CMA 3 returned to the cart and was asked what was in the cups sitting on her medication cart. CMA3 stated, These are medications for the morning med pass. CMA3 was asked if she premixed medications often. CMA3 stated, Yes, I can't lie. CMA 3 further stated, I am supposed to lock them up and not prepare the meds until I administer them. CMA 3 was asked what was in the medication cups. She stated, Lactulose (a liquid medication for constipation), liquid protein and Miralax (a medication for constipation.) CMA3 returned the 5 [NAME] medication cart to the nurses' station and placed the medications into the bottom drawer and locked the cart. CMT3 then obtained the 5 East medication cart and proceeded down the hall. On top of the medication cart revealed five individual plastic cups of medications, unlabeled. CMA3 was asked what was in the cups. She stated, Miralax. CMA3was asked when the medications were premixed. She stated, I mixed them up about an hour ago. CMA3 was asked if the medications were labeled. She stated, No. CMA 3 was asked how she knew which medication was to be used for each resident. She stated, I just know. During an interview on 04/05/24 at 9:46 AM, the Director of Nursing (DON) was asked what her expectation was regarding labeling, storing, and preparing medications. The DON stated, My expectation is that meds are not prepared in advance and not left out unattended on the carts.

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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. 32513 Based on observations, interviews, and facility policy review, the facility failed to keep the scoops out of food storage bins and ensure stored food was dated. This had the potential to affect 86 of 86 residents who resided in the facility and consumed food prepared from the facility's kitchen. Review of the facility's undated policy titled Resident Food Storage, revealed 1 .Food or beverages brought into the facility for resident consumption will be labeled and dated for monitoring food safety. Food or beverages in the original container marked with manufacturer expiration dates and unopened do not have to be re-labeled for storage During an initial tour of the kitchen on 04/02/24 at 8:55 AM, with the Dietary Manager (DM), the following observations were made: Dry Storage and kitchen: a. One 5-pound bag, containing yellow cake mix, was observed open and undated. b. A large clear container labeled, containing thickener, were observed with scoops lying in the thickener. The thickener was also undated. Interview on 4/03/24 at 8:55 AM, DM stated scoops should not be kept in the containers. DM stated they expect scoops to be placed in a plastic bag and placed on top of the container. During a follow-up tour of the kitchen on 04/03/24 at 11:48 AM, with the DM, the following observations were made: Freezer and kitchen: a. Two loafs of Rye bread covered in ice crystals, was observed undated. b. 1 large bag of frozen chicken breast, was observed undated. During an interview on 04/03/24 at 8:55 AM, the DM stated they expect staff to place opened bagged items into an empty clear container and label and date or place in a clear bag and date. During an interview on 04/03/24 at 11:48 AM, the DM stated their expectation is for items to be closed when they were done being used. DM stated the two loaves of bread were left over and should have been dated. DM stated the chicken package must have been the last one in the box and someone took it out because normally keep items in the box and date the box. DM stated all dietary staff were responsible for ensuring items were dated and their expectation was that it would be done.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 32513 Based on interview and record review, the facility failed to have the Medical Director and/or designee attend the last two quarterly QAPI (Quality Assurance and Performance Improvement) committee meetings. Review of the 11/28/23 QAPI sign-in sheet for the quarterly meeting revealed the Medical Director did not attend and was marked, unable to attend. Review of the 02/20/24 QAPI sign-in sheet for the quarterly meeting revealed the Medical Director did not attend and was marked as, unable to attend. During an interview on 04/05/24 at 11:53 AM, the QAPI Nurse was asked if the Medical Director or their designee attended the quarterly meetings. The QAPI Nurse stated, He does attend the meetings, but not the last ones. The QAPI Nurse was asked if she was aware that the Medical Director or their designee are to attend the meetings, as required in the regulation. She stated, Yes.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 32513 Based on employee record review and interviews, the facility failed to have documentation of completion of a minimum of 12 hours of required in-service training to include Dementia care and Abuse, Neglect, and Exploitation for five of five Certified Nursing Assistants (CNAs) (CNA 1, 2, 4, 6, and 7). By not ensuring employees are meeting the required trainings and in-services, residents may be at risk and unable to get their needs met. Review of the facility's Facility Assessment updated February 28, 2024, indicated, Staff Education: Orientation, Annual: Required annual education/training (minimum of 12 hours annually for Nursing Assistants) . During an interview on 04/04/24 at 9:52 AM, CNA1 was asked about trainings and in-services on dementia care and abuse and neglect. CNA1 stated, We have annual in-services, and we cover abuse and neglect. When specifically asked about dementia care, the CNA stated, Prior to coming here, I got trainings, but not really here. No, I don't believe so. During an interview on 04/04/24 at 9:55 AM, CNA7 was asked about annual trainings on abuse, neglect and dementia care. CNA7 stated, Once a month we get trainings, and also on abuse and neglect. When specifically asked about dementia care, the CNA stated, No, not really. We learn on the go. Review of the Employee Personnel files for CNA1, date of hire 08/30/21, indicated annual trainings that were conducted throughout 2023 to include abuse/neglect and dementia care, however there was no evidence of the required 12 hours completed. Review of the Employee Personnel file for CNA2, date of hire 09/04/07,indicated annual trainings that were conducted throughout 2023 to include abuse/neglect and dementia care, however there was no evidence of the required 12 hours completed. Review of the Employee Personnel file for CNA4, date of hire 12/15/10, indicated annual trainings that were conducted throughout 2023 to include abuse/neglect and dementia care, however there was no evidence of the required 12 hours completed. Review of the employee Personnel file for CNA6, date of hire 02/18/20 indicated annual trainings that were conducted throughout 2023 to include abuse/neglect and dementia care, however there was no evidence of the required 12 hours completed. Review of the employee Personnel file for CNA7, date of hire 05/16/18, indicated annual trainings that were conducted throughout 2023 to include abuse/neglect and dementia care, however there was no evidence of the required 12 hours completed. (continued on next page)

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/04/24 at 10:27 AM with the Infection Preventionist (IP) (person who conducts the annual trainings) stated, do most of the in-services with the assistance of the Director of Nursing (DON). We cover abuse/neglect and dementia care. The IP then stated, I don't keep track of the actual hours though. We do not keep track of employee hours completed. I only make sure I train them on the required trainings for the year. The IP then stated, We have trainings and meetings that can be 30 minutes or up to 1-hour 1/2, just depends. Once a year, we do trainings and that usually takes a couple of hours to go through all our policies, etc. We do orientation, then skills drills annually. During an interview on 04/04/24 at 11:50 AM, with the DON she stated, At least once a month we are doing trainings, or addressing something. When specifically asked how do you ensure the staff are meeting the required 12 hours of trainings and in-services, the DON stated, Well, other than the fact that they sign in when we do our trainings, I don't have a way to track how many hours they are completing. I've never been questioned about the number of hours before. I haven't kept track of their hours, and I don't have a specific policy. During orientation, there is a checklist that we go by. During a second interview on 04/05/24 at 8:15 AM, the IP stated, I do general orientation and we sign all paperwork, do background checks, etc. With dementia care, we talk about dementia care, and give various scenarios. I know they are supposed to have the 12 hours of in-services. I've never been asked to document the number of hours they are completing. I'm aware they have to have at least 12 hours of trainings on things like Abuse, neglect, and dementia care, I just haven't been documenting that.