| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265784 | A. Building<br>B. Wing | 01/02/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Living Community of St Joseph | 1202 Heartland Road<br>Saint Joseph, MO 64506 |

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| F 0554<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Allow residents to self-administer drugs if determined clinically appropriate.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 11599<br><br>Based on observation, interview and record review the facility failed to ensure two of 25 sample residents (Resident (R) 54 and R23) reviewed for self-administration of medications were permitted to exercise their resident rights. Specifically, the facility failed to ensure medications were not left at the bedside of R54 who was not assessed to be able to self-administer medications safely; and the facility failed to ensure R23, who desired to self-administer medications and was assessed to be safe to do so was permitted to. The facility census was 80.<br><br>Findings include:<br><br>Review of the facility's Self-Administration of Medications policy, dated 08/31/23, revealed the purpose was, To enhance resident independence to self-administer medications. The policy indicated, . Residents have the right to self-administer medications if the interdisciplinary team has determined it is clinically appropriate and safe . The nursing associates will assess each resident's mental and physical abilities to determine whether self-administering medications is clinically appropriate for the resident .<br><br>1. Review of R54's Face Sheet, located in the electronic medical record (EMR) under the Dashboard tab, revealed R54 was admitted on [DATE] with diagnoses that included unspecified dementia, unspecified severity, with mood disturbance.<br><br>Review of R54's admission Minimum Data Set (MDS), with an assessment reference date (ARD) of 10/23/24 and located under the RAI (Resident Assessment Instrument) tab in the EMR, revealed R54 had a Brief Interview for Mental Status (BIMS) score of 12 out of 15, which indicated R54 was moderately cognitively impaired.<br><br>During an interview on 01/02/25 at 11:19 AM, R54 was observed to have a medication cup on his overbed table. The medication cup contained three pills. R54 stated, Those were left about an hour ago. I don't know what they are. I just have to take them. The medications left at the bedside were confirmed by the MDS Coordinator (MDSC1) on 01/02/25 at 11:22 AM. At 11:24 AM, the Certified Medication Technician (CMT1) entered R54's room and stated, I never leave them. I don't know why I did. CMT1 revealed, as entered on the Medication Administration Record (MAR) dated 01/2025, that the medications were aspirin, Gemtesa, senna, and vitamin D3. CMT1 stated, The vitamin D3 was not in the cup. CMT1 did not look for the medication, ask R54 if he had taken the medication, or look to see if it was in the trash directly under the overbed table where the medications had been placed or dropped on the floor.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0554<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of R54's MAR for 01/02/25 revealed the medications were signed as administered at 10:25 AM.<br><br>Review of R54's EMR Assessments tab revealed no assessment to determine if R54 could self-administer medication. Review of R54's Orders tab of the EMR revealed no physician's order to self-administer medications.<br><br>In an interview on 01/02/25 at 12:10 PM, the Director of Nursing (DON) and Clinical Manager (CM)1 confirmed they were aware of the medications left at the bedside of R54. The DON stated, That should not have happened.<br><br>15406<br><br>2. Review of R23's undated Face Sheet, located in the EMR under the Resident tab, revealed R23 was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD) and chronic respiratory failure.<br><br>Review of R23's annual MDS, with an ARD of 08/06/24 and located under the RAI tab of the EMR, revealed R23's cognition was intact with a BIMS score of 15 out of 15.<br><br>Review of R23's Observation Detail List Report [Self Administration of Medication Assessment], dated 11/04/24 and located in the EMR under the Document tab, revealed that R23 wanted to self-administer some medications. The report read, List of medications resident would like to self-administer - Nebulizer treatments, Advair Diskus inhaler nasal spray, Icy Hot - resident keeps vials at bedside and has order to self-administer. The Observation Detail List Report indicated R23 was appropriate to self-administer medications, and she was able to name the dosage, frequency, and reason for each medication, tell the time and state when each medication was due, and could read the label and identify each medication. It was recorded R23 was able to pour pills out of the bottle and properly dispense inhalers and nebulizers. It was recorded the appropriate medications for the resident to self-administer were, Nebulizer treatments, nasal spray and icy hot.<br><br>Review of R23's Care Plan, dated 11/10/24 and located in the EMR under the RAI tab, revealed a problem of, I may self-administer nebulizer treatments, medication will be kept in the med [medication] cart. The goal was, Resident will safely demonstrate to the staff that she can complete this task. The approach was Staff will educate resident on the use of this medication, and keep it safely locked in the medication cart.<br><br>(continued on next page) |

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| F 0554<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of R23's Care Plan, dated 11/10/24 and located in the EMR under the RAI tab, revealed a problem of, Self-administration, Resident has a physicians' order to keep the following medications at bedside and self-administer: Resident has been assessed by Interdisciplinary care plan team to be capable of self-administration. Resident demonstrates ability to: Follow simple directions. Remember directions consistently. Read prescription labels adequately. Identify medications by appearance. The goal was, Resident will take medications safely and as Prescribed. Resident will demonstrate ability to take medications at correct dose, route, and time. Resident will verbalize and demonstrate understanding of: What each medication is supposed to do. What foods, drinks and other medications should be avoided while taking each medication. What the possible side effects are, and what should be done if they occur. Approaches in pertinent part were, Assess residents' ability to self-administer Ipratropium Bromide [medication treating breathing problems] 0.5 mg and Albuterol Sulfate [bronchodilator relaxing muscles in the airways] 3 mg, Cool Therapy Roll on Pain reliever, and Zinc 50 mg, 1 cap PO [orally], every other day, Albuterol Inhaler with admission, quarterly, with each assessment, and as needed .<br><br>Review of R23's Physician Order Report, dated 12/02/24 - 01/02/25 and located in the EMR under the Orders tab, revealed current Physician's Orders for self-administration of medications for R23 as follows:<br><br>Resident is ok to self-administer medications and keep locked in bedside drawer/key when not in room, initiated on 11/10/23.<br><br>Cough drops (kept at bedside whenever [family member] will bring) Special Instructions: as needed for cough/throat lozenges, initiated on 07/04/24.<br><br>May self-administer nebulizer treatments, initiated on 10/03/24.<br><br>Medicated body Powder (menthol) [OTC - over the counter] powder; 0.15%; amt [amount] small amount; topical, Special Instructions: Resident keeps at bedside in locked cabinet, may self-administer, initiated 12/30/24.<br><br>Neosporin (neo-bac-polym) (neomycin-bacitracin-polymyxin) [OTC] ointment; 3.5 mg [milligrams] - 400 unit - 5,000 unit/gram; amt: small amount; topical, Special Instructions: Resident and family request to keep at bedside. Order to keep at bedside and may self-administer, initiated on 12/30/24.<br><br>Voltaren Arthritis Pain (diclofenac sodium) [OTC] gel; 1/5; amt: 2 gms [grams]; topical, Special Instructions: apply to shoulder and neck pain: PRN [as needed] pain. May keep at bedside, in locked cabinet, initiated on 12/30/24.<br><br>During an interview on 12/30/24 at 11:02 AM, R23 stated that on this morning, while she was out of her room, the staff had come into her room and removed Tums and other medications/lotions from a locked drawer in her bedside table. R23 stated she was upset about the medications being removed and not being informed. R23 stated she was going to ask the nurse about it.<br><br>During an observation on 12/30/24 at 11:05 AM, CM1 spoke to R23 and told her she had removed R23's medications because R23 did not have orders for the medications.<br><br>(continued on next page) |

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| F 0554<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 12/31/24 at 2:56 PM, CM1 stated she told Family Member (F)1 to stop bringing in medications for R23. CM1 stated she had removed an unlabeled bottle of Tums from R23's beside table on 12/30/24 when R23 was out of the room. CM1 stated R23 had physician's orders to self-administer medicated powder, an inhaler (there was no order for the inhaler), and her nebulizer. CM1 stated physician orders were required for R23 to be able to self-administer medications. CM1 verified the cough drops and throat spray had been removed and stated the nursing staff would have to get orders for self-administration (R23 had a current order for self-administration of the cough drops).<br><br>During an interview on 01/01/25 at 8:36 AM, R23 stated the nursing staff had returned the medicated powder but not the Tums, throat/cough lozenges (she had an order to self-administer cough drops) and throat spray that were removed from the locked drawer in her bedside table. R23 stated she wanted these items returned to her. R23 stated she currently self-administered her nebulizer and inhaler by herself (there was no order for self-administration of the inhaler). R23 stated she knew when and how to take the medications that had been removed (Tums, cough drops, and throat spray). R23 stated the facility was holding the confiscated medications for F1 to come and pick up.<br><br>During a Resident Council meeting on 01/01/25 at 2:00 PM, R23 stated, The unit manager [CM1] came in on Monday and took all the medications that I keep in my room on my table. I've had them for a long time. Why is it a problem now? R23 stated the medications were removed from her room without her knowledge and when she was not in her room.<br><br>During an interview on 01/02/25 at 11:21 AM, F1 stated she brought the Tums to R23 because R23 had indigestion and Tums helped. F1 stated family had brought in throat spray and lozenges/cough drops which were also beneficial to R23. F1 stated the facility staff had not contacted her about the medications that had been confiscated on 12/30/24.<br><br>During an interview on 01/02/25 at 11:36 AM, R23 identified the medications she kept at her bedside as, Tums, Coricidin 10 cream, body powder, cough drops, and throat spray. Only the body powder was returned to me.<br><br>During an interview on 01/02/25 at 12:10 PM, CM1 stated, I only took a cup with what may have been Tums, but I can't assume they were Tums, they were not in the original bottle. I don't know where the other medications are. I'll have to call the [family member] to bring in more. CM1 was asked if she had entered R23's room without the resident present to remove the Tums. CM1 stated, Yes.<br><br>During an interview on 01/02/25 at 1:38 PM, Licensed Practical Nurse (LPN) 4 stated R23 self-administered her nebulizer and she could have cough drops at bedside. LPN4 stated nursing staff administered the inhaler as needed. LPN4 stated R23 could not have medicated powders or creams at bedside (R23 had a current order for self-administration of Neosporin and medicated body powder). LPN4 stated nursing staff administered Voltaren Gel (R23 had a current order to self-administer the Voltaren Gel). |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Respond appropriately to all alleged violations.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 11599<br><br>Based on interviews, record review, and facility policy review, the facility failed to conduct a thorough investigation of an allegation of verbal abuse by a staff member for two of two residents (Resident (R) 26 and R32) reviewed for abuse out of a total sample of 25. This failure created the potential for abuse of other residents. The facility census was 80.<br><br>Findings include:<br><br>Review of the facility's Abuse Prevention Plan, dated 07/21/22, revealed, Any person with the knowledge or suspicion of suspected abuse, neglect, misappropriation of resident property, and/or financial exploitation must report immediately, without fear of reprisal and/or retaliation . Any allegations involving abuse, neglect, misappropriation of resident property and/or financial exploitation will be investigated . Measures will be taken to identify the source of the alleged abuse and prevent future incidents. Investigative packets will be utilized to systematically direct the team through the investigative process. Any evidence gathered will be handled with caution to ensure no tampering, destruction or alteration occurs . Identify and interview all who might have knowledge of the incident including the alleged victim, perpetrator, witnesses, or others who may have had related contact with the alleged perpetrator, related to the incident in question. The focus of the investigation is to determine the extent, cause and future prevention with thorough documentation of the investigative process .<br><br>Review of R26's Face Sheet, located under the Dashboard tab in the electronic medical record (EMR), revealed R26 was admitted to the facility on [DATE] and passed away on 12/29/24. R26 had diagnoses that included dementia.<br><br>Review of R26's annual Minimum Data Set (MDS), with an assessment reference date (ARD) of 11/24/24, revealed a Brief Interview for Mental Status (BIMS) score of six out of 15, which indicated R26 was severely cognitively impaired. R26 was noted to require one to two staff members to assist with activities of daily living (ADL) needs.<br><br>Review of R32's Face Sheet, located under the Dashboard tab in the EMR, revealed R32 was admitted on [DATE] with diagnoses that included congestive heart failure.<br><br>Review of R32's annual MDS, with an ARD of 12/10/24, revealed a BIMS score of 13 out of 15, which indicated R32 was cognitively intact.<br><br>Review of the monthly Resident Council Minutes, dated 02/23/24 at 11:00 AM and provided by the Wellness/Activity Director (AD), revealed, . [R32] stated that on the 19th the nurse aide was inside his room on his roommate's side and was yelling at him. [R32] stated that he asked her to talk to him when she was done and he then asked her why she was yelling at his roommate [R26] and the nurse responded back that his roommate was not listening to her. [R32] stated that he does not sleep well at night when this stuff is going on .<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of the facility's investigation of the allegation, provided by the Director of Nursing (DON), revealed Fefiuary [sic] 23,2024 AT approximately 2:45pm. [AD] came into writer's office to review council meeting nursing concerns. One of the concerns was Resident [32] stated an agency aide on Monday who worked was yelling at his roommate [R26] calling him 'dumbass' and other things [R32] stated he could not repeat. [R32] stated he went over to speak to the aide telling her she should not speak to [R26] that way and wanted his shower. [R32] stated he was told by the aide it was not his business and if he contlnued [sic] to complain the aide would wait to give him his shower until last. Resident [32] did not get a shower until the next day when [Certified Medication Technician (CMT)1] gave him a shower first th ing [sic] .<br><br>The facility's summary of the investigation recorded to refer to [Former Social Service Coordinator] notes for R32's interview. The notes were not contained in the investigative documentation and were not located by the DON; therefore, they were not reviewed. R26 was identified as not interviewable.<br><br>An interview with R32, contained within the summary, read, [R32] told her the aide who worked days on Monday had been yelling and speaking aggressively to [R26]. When she asked what he meant by that, [R32] further stated that he stopped the aide on the way out of the room and told her she had no business talking to [R26] that way as he isn't capable of defending himself. [R32] also stated that the aide told him to mind his own business and let her do her job. The aide began to yell at him and he told her to leave his room and not come back.<br><br>There was no documented evidence contained in the investigative documentation that the allegation of verbal abuse was investigated. There was no documentation that R26 was assessed. There was no documentation that other residents were interviewed. There was no documentation that non-interviewable residents cared for by the Certified Nurse Aide (CNA) were assessed. There was no documented evidence that the CNA was interviewed. It was recorded that the facility notified the employment agency that the identified CNA was not allowed to return to work in the facility.<br><br>During an interview on 01/02/25 at 8:30 AM, R32 stated that he remembered what he reported in February 2024. R32 stated, I don't remember her name. My issues with the CNA were not addressed, not about me. I told her don't you speak to him [R26] like that, get out of this room and don't you ever come back in this room again or I'll call the police. R32 stated he did not remember the CNA's name but did remember the CNA yelling at his roommate (R26).<br><br>During an interview on 01/02/24 at 6:00 PM, the DON was asked why the allegation was not investigated. The DON did not say why the allegation involving R32 and R26 were not investigated. The DON stated, I'm still looking for more paperwork. No additional information was provided as of exit on 01/02/25 at 7:30 PM. |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives an accurate assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20243<br><br>Based on observation, interview, record review, facility policy review, and review of the Resident Assessment Instrument (RAI) Manual, the facility failed to ensure one of 25 sampled residents (Resident (R) 21) residents had an accurate Minimum Data Set (MDS) assessment. This had the potential to cause the resident to have unmet care needs. The facility census was 80.<br><br>Findings include:<br><br>Review of R21's Face Sheet, found under the Profile tab in the electronic medical record (EMR), indicated an admitted [DATE] with diagnoses of dementia, anxiety disorder, major depressive disorder, and Alzheimer's disease.<br><br>Review of the RAI Manual, dated 10/01/19, indicated, . It is important to note here that information obtained should cover the same observation period as specified by the Minimum Data Set (MDS) items on the assessment and should be validated for accuracy (what the resident's actual status was during that observation period) by the IDT completing the assessment.<br><br>Review of the facility's undated policy titled Comprehensive Assessments and Care Planning, provided by the facility, indicated, . provide a comprehensive person-centered interdisciplinary care assessment of the residents' condition, in order to develop consistent quality care that will attain or maintain the highest practicable physical, mental and psychological functioning possible, a facility must make a comprehensive assessment of a resident's needs, using the RAI specific by the State . The assessment must accurately reflect the resident's status, and each person who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment .<br><br>Review of R21's Elopement Risk assessment, dated 08/24/24 and located under the Assessments tab of the EMR, revealed that R21 wandered with no rational purpose and attempted to open doors and was a high elopement risk.<br><br>Review of R21's quarterly Minimum Data Set (MDS), with an assessment reference date (ARD) of 08/27/24, recorded R21 did not exhibit the behavior of wandering.<br><br>Review of R21's annual MDS, with an ARD of 11/27/24 and found under the Assessments tab in the EMR, indicated R21 had a BIMS score of four of 15, which indicated R21 was severely cognitively impaired. It was recorded that R21 did not exhibit wandering.<br><br>Review of R21's Care Plan, with a revision date of 12/02/24 and found under the Care Plan tab of the EMR, indicated a plan for Behavioral Symptoms with a start date of 04/21/23. The plan indicated that R21 . exhibited wandering with no rational purpose, seemingly oblivious to needs or safety. Approaches indicated to, . check double doors if alarm goes off to make sure I do not get off unit, monitor every shift if 'Wander Guard' is in place, to place [R21] in a secure environment, and to provide comfort measure for basic needs (e.g. Pain, hunger, toileting, too hot/cold, etc.) .<br><br>(continued on next page) |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of R21's Care Plan, with a revision date of 12/02/24 and found under the Care Plan of tab of the EMR, indicated a plan for Cognitive Loss/Dementia with a start date of 06/05/24. The plan indicated that R21 wanders on the hall of floor, may call out and ask where she is, what she should be doing, or how she got here. Reorient resident to the best of ability. Approaches indicated to place a green sign outside R21's room to help identify her room, to check the Wander Guard functionally each week, change the battery annually, check every shift for proper placement, distract from wandering by offering pleasant diversions, structured activities, food, conversation, television or book and help finding her room.<br><br>During an observation on 01/01/25 at 2:53 PM, R21 ambulated in the hallway slowly using her walker and stopped to talk to a staff member. The staff member led R21 to her room. An observation on 01/01/25 at 3:06 PM revealed R21 ambulated out of her room using her walker into the hallway. A staff member met R21 and walked with her back to her room. An observation on 01/01/25 at 3:19 PM revealed R21 ambulated out of her room using her walker into the hallway, then walked up to staff member and spoke to the staff member. R21 then turned and went back to her room. An observation on 01/01/25 at 3:22 PM revealed R21 ambulated out of her room using her walker into the hallway, walked slowly and approached a staff member and began talking. R21 then walked using her walker and entered the dining area on her unit and seated herself at a table.<br><br>During an interview on 01/02/25 at 10:35 AM, MDS Coordinator (MDSC)2 stated that social services completed the behavioral and wandering section of the MDS. When asked who was responsible for signing off on the accuracy of the MDS, she stated that the MDS Coordinators were.<br><br>During an interview on 01/02/25 at 10:45 AM, Social Services Director (SSD)1 stated that it was her responsibility to complete the behavioral and wandering section of the MDS. She stated that she accepted the responsibility that nothing was entered on this section for R21. SSD1 stated that she did not know the resident wandered and that she should have asked more questions at team meetings regarding the resident. The SSD stated that she should have dug into it more.<br><br>In an interview on 01/02/25 at 5:57 PM, the Director of Nursing (DON) stated that the reason the MDS assessment did not indicate that R21 was wandering was because wandering did not trigger in the look back period. The DON stated that her expectation would be that the MDS Coordinators and other staff members responsible for completing portions of the assessments would review progress notes, elopement risks, and review care plans during the completion of the assessment. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15406<br><br>Based on observation, interview, record review and policy review, the facility failed to ensure two of 25 sampled residents (Residents (R)37 and R21) were provided with sufficient supervision and assistive devices to prevent accidents. R37 experienced a fall in which she fell forward out of the bed onto the floor on 09/20/24. There was a lack of interventions implemented in response to the fall and seven days later, R37 experienced another fall onto the floor. R37 sustained injuries including abrasions to her knees, a nosebleed, bleeding gums, bruise to her right cheek, and experienced hip and knee pain. R21 wandered through out the First-Floor [NAME] unit and into residents' rooms, including the rooms of R37 and R32, putting herself and other residents at risk of injuries. R21 wandered at night into residents' rooms when there was less staffing on the unit to supervise her and when she had the potential to startle residents who were sleeping. The facility census was 80.<br><br>Findings include:<br><br>Review of the facility's Integrated Fall Management policy, dated 09/2023, revealed the purpose of the policy was, Fall risk assessment, identification and implementation of appropriate interventions as necessary, to maintain resident safety, prevent falls and reduce further injury from falls . Residents at risk for falls have an individualized resident centered care plan developed. Care plan interventions are based on the finding of the fall risk assessment .<br><br>1. Review of R37's Face Sheet, located under the Resident tab of the electronic medical record (EMR) revealed R37 was admitted to the facility on [DATE] with diagnoses that included muscle weakness, need for assistance with personal care, muscle wasting and atrophy, acute and chronic respiratory failure, sleep apnea, adjustment insomnia, and end stage renal disease with dependence on renal dialysis.<br><br>Review of R37's Care Plan, dated 02/26/21 and located in the EMR under the RAI [Resident Assessment Instrument] tab, revealed a problem of Falls, I am at risk for falls due to decreased cognition, bipolar-psychotropic & antidepressants medication use, DM [diabetes mellitus], neuropathy. The goal was, I will be free of injuries due to falls in the next 90 days. The approaches in total were:<br><br>Keep my frequency used personal items within reach, initiated on 06/12/21.<br><br>Assessed for proper Hoyer sling size, which is large, and what is being used initiated on 06/04/21.<br><br>Increased staff supervision with intensity based on my need initiated on 02/26/21.<br><br>Comprehensive medication review by pharmacist assess for polypharmacy and medications that increase the fall risk as needed initiated on 02/26/21.<br><br>(continued on next page) |

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| | 265784 | A. Building<br>B. Wing | 01/02/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Living Community of St Joseph | 1202 Heartland Road<br>Saint Joseph, MO 64506 |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of R37's quarterly Minimum Data Set (MDS), with an assessment reference date (ARD) of 09/07/24 and located in the electronic medical record (EMR) under the RAI [Resident Assessment Instrument] tab, revealed R37 was admitted to the facility on [DATE] and was unimpaired in cognition with a Brief Interview for Mental Status (BIMS) score of 15 out of 15. It was recorded R37 required substantial/maximal assistance with toileting hygiene and lower body dressing, was independent for rolling left to right, going from sitting to lying, and lying to sitting on the side of the bed. It was recorded that R37 was dependent for chair to bed transfers, had not walked during the assessment period, and had not experienced any falls since the previous MDS assessment.<br><br>Review of R37's Nurse's Note, dated 09/20/24 at 2:15 AM and located in the EMR under the Progress Notes tab, revealed, . CNA [Certified Nursing Assistant] heard resident table fall and resident crying, attended immediately and saw resident lying in [sic] the floor. This writer was notified by CNA and attended as well. Resident was seen on right side lying position, facing the nightstand, feet were almost under the bed. When asked what she was doing and how she fell , the resident said she was sitting on the edge of her bed as she used to and fell asleep. Table was pushed, as she drops to her knees and fell completely. Physical assessment done, noted with abrasion on both knees. Resident claims her hips hurt but does not think she had fracture, just sore as verbalized. Res [resident] denies hitting her head claiming her face is the one that hit the floor, no bruise noted on face. Notified resource and came assess with the writer. Resident was able to move her legs and hand grips were equal. Neuro assessment done and recorded. Vital signs WNL [within normal limits]. No bruise nor other discoloration noted on hip and back, no visible fracture. Resident was able to roll over by herself while placing the Hoyer pad underneath to lift her. Transferred her back to bed safely with Hoyer Lift. Advised to refrain from sitting on edge of bed specially when she is sleepy, resident acknowledged. Safety measures ensured, kept her things within reach and reminded to call for any assistance needed .<br><br>Review of the Event Report (fall investigation), dated 09/20/24 and provided by the facility, revealed R37 was in bed prior to fall that occurred at 3:15 AM. R37 was documented as being alert and oriented, not being able to ambulate (walk), complaining of mild pain to her hips. R37's range of motion (ROM) was normal, she was alert and without any changes to her mental status. Under the section Interventions - Immediate measures taken, the assessment was blank. Under the section Possible Contributing Factors, the assessment was blank. R37's physician and family were notified on 09/20/24 at 8:07 AM. There was no documentation of what the resident was doing prior to the fall. Registered Nurse (RN)1 was the nurse on duty and completed the Event Report.<br><br>Review of R37's Care Plan, located under the RAI tab of the EMR, revealed no documented evidence that any interventions were identified and implemented in relation to the fall on 09/20/24.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of R37's Nurse's Note, dated 09/27/24 at 11:30 PM and located in the EMR under the Progress Notes tab, revealed, . Writer and CNA heard a noise coming from resident room followed by a cry for help. Went to resident room immediately and saw resident sitting on the floor, her head under her bedside table. When asked what happened, she said she is trying to lay down on the bed but instead of going backwards, she slipped and eventually fell forward. Resident noted with nosebleed and bleeding on her front gums as a result of hitting the table in front of her, she also claims her Rt [right] eye was hit, light bruise noted on Rt cheek, no redness nor bleeding noted on rt eye. Ice pack applied on nose and mouth and instructed to lean forward while applying ice pack. Instructed to gurgle as well to wash blood in the mouth. Bleeding stopped after around 5 minutes of ice application. She also c/o [complained of] pain on L [left] knee that was hurt during the fall. Able to move upper and lower extremities with good ROM. Neuro vitals signs checked. Transferred to bed safely with Hoyer lift. Advised to refrain dangling her legs and to keep her whole body in the bed when sleeping, resident agrees and shows understanding. Tried to reach her [family member] to update but to no avail, left VM [voice message] instead including call back number .<br><br>Review of R37's Event Report, dated 09/27/24 and provided by the facility, revealed the fall occurred at 11:30 PM. The fall was unwitnessed. R37 fell forward out of the bed onto the floor. R37 was assessed, ROM completed, and neuro checks were initiated. The physician was notified on 09/28/24 at 1:53 AM and the family on 09/28/24 at 12:53 AM. There was no documentation of immediate measures being implemented, and the pattern of the resident falling forward out of the bed onto the floor was not identified. RN1 was the nurse on duty when the fall occurred and had filled out the Event Report.<br><br>Review of R37's Care Plan, dated 10/02/24 and located in the EMR under the RAI tab, revealed a problem of, Resident is at risk for falls due to lack of safety awareness. The goal was, Resident will be free of falls. Interventions in total were:<br><br>-Keep frequently used items within reach, initiated on 12/06/24.<br><br>-Keep my call light within reach while I'm in my room, initiated on 12/06/24.<br><br>-Increased staff supervision with intensity based on resident need, initiated on 10/02/24.<br><br>-Resident had two falls due to falling asleep at side of bed. Staff will get recliner for resident's room for her to sit in and resident will be educated not to sit on edge of bed, dated 10/02/24.<br><br>Review of R37's Interdisciplinary Note, dated 10/02/24 and located in the EMR under the Progress Notes tab, revealed, IDT [interdisciplinary team] met to discuss falls on 9/20/24 and 9/27/24. Staff to encourage [R37] to sit in a recliner and not on the side of her bed.<br><br>Review of a Work Order, dated 11/13/24 and provided by the facility, revealed R37 needed the rocker chair in her room replaced with a regular recliner. The work order was documented as being completed on 11/18/24.<br><br>Review of the annual Minimum Data Set (MDS) with an ARD of 12/04/24 in the EMR under the RAI tab revealed R37 continued to be unimpaired in cognition with a BIMS score of 15 out of 15.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 12/30/24 at 3:13 PM, R37 stated she had fallen a couple times a few months ago. R37 stated she fell asleep when she was sitting up on the edge of the bed, fell forward out of the bed, and landed on the floor when each of the falls occurred. R37 stated she hit her face and had a bloody nose. R37 stated she did not know what interventions were added by staff to prevent falls. R37 stated she tried to lay down when she was getting tired and falling asleep. R37 stated that recently she had fallen backward when she was sitting up in bed and had fallen asleep instead of falling forward. She stated when this occurred, she landed on the mattress and had not injured herself. R37 stated she was supposed to have a recliner chair in her room, but she had not been provided with one. R37 was observed to have an upright cushioned chair that did not recline. The chair had an ottoman that pulled out for propping her feet up.<br><br>During an interview on 01/02/25 at 9:10 AM, RN1 stated she had been working the night shift and was R37's nurse when the falls occurred on 09/20/24 and on 09/27/24. RN1 stated for the first fall on 09/20/24, R37 fell while going to sleep. RN1 stated she was at the nursing station at the time of the fall, and both she and the CNA heard a noise so they went to the rooms on that side and found R37 on the floor. RN1 stated R37 had said she fell asleep and fell out of bed onto the floor but was okay. RN1 stated R37 tended to sleep on the edge of the bed, and R37 told her she was sitting up and fell asleep while she was sitting. RN1 stated R37's bedside table was there with everything in reach at the time of the fall. RN1 stated the resource nurse came and assisted with assessing the resident. RN1 stated the intervention she implemented was educating R37 to lay back whenever it was nighttime. RN1 stated the staff made rounds and kept things R37 might need near her. RN1 stated that the fall on 09/27/24 was the same story on how it happened, with R37 falling forward again out of bed. RN1 stated the intervention was to continue to do rounds. RN1 stated on the night shift, she had two halls (First Floor South and West) that she covered with one CNA on each hall. RN1 stated someone should be on the hall and checking residents every hour or so. RN1 stated she advised R37 to sit in a chair if she wanted to. RN1 stated R37 had a chair in her room but she preferred to sit on the bed. RN1 stated R37 was cooperative and she did not have any problems caring for her.<br><br>During an interview on 01/02/25 at 9:49 AM, the Environmental Services Director stated R37 wanted a reclining lift chair, but nursing approval was needed for that. The Environmental Services Director stated he was not able to provide a chair that electronically lifted residents up. The Environmental Services Director stated the chair currently in R37's room was the one he had placed in there when completing the work order on 11/18/24. He showed the surveyor the chair which was an upright sitting chair with an ottoman that pulled out; the chair did not recline. The Environmental Services Director stated R37 previously had a rocking chair in her room that he had to remove due to the facility's policy that no rocking chairs were allowed for safety reasons.<br><br>During an interview on 01/02/25 at 1:27 PM, CNA1 stated R37 required staff assistance with some ADLs, was dependent on staff for transfers, and was unable to stand or walk. CNA1 stated she was not aware of R37 being at risk for falls. CNA1 stated there was a CNA cheat sheet that was available that provided information such as fall risk and interventions needed.<br><br>During an interview on 01/02/25 at 1:41 PM, Licensed Practical Nurse (LPN) 4 stated R37 tended to sit on the side of her bed which put her at risk of falling due to going to sleep while she was sitting up. LPN4 stated she was not aware of any interventions to address the fall risk from sitting on the edge of the bed and going to sleep. LPN4 stated she had been informed that R37 did not sleep much at night; however, she slept a lot during the day.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 01/02/25 at 5:14 PM, the Director of Nursing (DON) and Clinical Manager (CM) 1 were interviewed and stated an IDT meeting was held daily, and in the meeting, falls were reviewed. The DON stated the Pharmacist reviewed R37's medications on 10/15/24 (two weeks after the second fall occurred on 09/27/24). The DON stated R37 was encouraged to lay down when she was tired and had been sleeping more. The DON stated therapy staff reviewed R37 on 09/27/24; however, she was at her baseline and they did not initiate therapy. They stated R37 tended to sit on the edge of the bed with her legs dangling and they wanted R37 to elevate her legs, and the family did not have the funds to purchase a recliner. They stated R37 did not want to sit in the chair that was currently located in her room.<br><br>2. Review of R21's Face Sheet, found under the Profile Tab in the EMR, indicated an admitted [DATE] with diagnoses of dementia, anxiety disorder, major depressive disorder, and Alzheimer's disease.<br><br>Review of R21's Elopement Risk assessment, dated 08/24/24 and located under the Assessments tab of the EMR, revealed that R21 wandered with no rational purpose and attempted to open doors and was a high elopement risk.<br><br>Review of R21's quarterly MDS, with an ARD of 08/27/24, recorded R21 did not exhibit the behavior of wandering.<br><br>Review of R21's Assessments, found under the Assessment tab of the EMR, indicated that a quarterly Elopement Risk assessment for November 2024 had not been completed.<br><br>Review of R21's annual MDS, with an ARD of 11/27/24 and found under the Assessments tab in the EMR, indicated R21 had a BIMS score of four of 15, which indicated R21 was severely cognitively impaired. It was recorded that R21 did not exhibit wandering.<br><br>Review of R21's Care Plan, with a revision date of 12/02/24 and found under the Care Plan tab of the EMR, indicated a plan for Behavioral Symptoms with a start date of 04/21/23. The plan indicated that R21 . exhibited wandering with no rational purpose, seemingly oblivious to needs or safety. Approaches indicated to, . check double doors if alarm goes off to make sure I do not get off unit, monitor every shift if 'Wander Guard' is in place, to place [R21] in a secure environment, and to provide comfort measure for basic needs (e.g. Pain, hunger, toileting, too hot/cold, etc.) .<br><br>Review of R21's Care Plan, with a revision date of 12/02/24 and found under the Care Plan of tab of the EMR, indicated a plan for Cognitive Loss/Dementia with a start date of 06/05/24. The plan indicated that R21 wanders on the hall of floor, may call out and ask where she is, what she should be doing, or how she got here. Reorient resident to the best of ability. Approaches indicated to place a green sign outside R21's room to help identify her room, to check the Wander Guard functionally each week, change the battery annually, check every shift for proper placement, distract from wandering by offering pleasant diversions, structured activities, food, conversation, television or book and help finding her room.<br><br>During an observation on 12/31/24 at 2:36 PM, R21 was observed wandering up and down the hall and come and ask LPN3 and the surveyor where she was supposed to go and what she should do.<br><br>During an observation on 01/01/25 at 8:46 AM, R21 was wandering in the hall near her room and was redirected by staff to her room.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an observation on 01/01/25 at 2:53 PM, R21 ambulated in the hallway slowly using her walker and stopped to talk to a staff member. The staff member led R21 to her room. An observation on 01/01/25 at 3:06 PM revealed R21 ambulated out of her room using her walker into the hallway. A staff member met R21 and walked with her back to her room. An observation on 01/01/25 at 3:19 PM revealed R21 ambulated out of her room using her walker into the hallway, then walked up to staff member and spoke to the staff member. R21 then turned and went back to her room. An observation on 01/01/25 at 3:22 PM revealed R21 ambulated out of her room using her walker into the hallway, walked slowly and approached a staff member and began talking. R21 then walked using her walker and entered the dining area on her unit and seated herself at a table.<br><br>a. Review of R32's undated Face Sheet, located in the EMR under the Resident tab, revealed R32 was admitted to the facility on [DATE].<br><br>Review of R32's quarterly MDS, with an ARD of 12/08/24 and located in the EMR under the RAI tab, revealed R32 had a BIMS score of 15 out of 15, which indicated the resident was cognitively intact.<br><br>During an interview on 12/30/24 at 2:31 PM, R32 stated R21 was lost, and she came in and used his bathroom quite a bit. R32 stated, One time she was sitting on my stool and I had to pee. R32 stated that between 2:00 - 3:00 AM, R21 was up and hunting for the bathroom and came into his room, which was right next to hers. R32 stated R21 had come into his room without clothing on. R32 stated he could usually get R21 to leave his room but he had used the call light before for staff to come and get her. R32 stated R21 came into his room several times per day.<br><br>During a subsequent interview on 01/01/25 at 8:48 AM, R32 stated, Everyone knows she [R21] has been in my bathroom. R32 stated R21 was confused and was not aware of what she was doing and that she would not hurt anyone; however, R32 stated he felt uncomfortable and thought it was against the law for him to see R21 undressed. R32 stated he felt like he was in trouble when R21, who was not dressed, came into his room during the night.<br><br>During an interview on 12/31/24 at 2:34 PM, LPN3 stated R21 wandered in the unit and had a Wanderguard (wrist or ankle band alert system to alarm and lock monitored doors for wander-prone residents) to prevent her from leaving. LPN3 stated R21 was very confused and the staff kept an eye on her, redirected her, and did room checks to keep track of her whereabouts. LPN3 stated she did not work nights and had not heard of R21 wandering into other residents' rooms.<br><br>During an interview on 12/31/24 at 3:01 PM, CM1 stated she was not aware of R21 wandering into other residents' rooms.<br><br>During an interview on 01/02/25 at 9:10 AM, RN1 stated she routinely worked night shift on the hall where R21, R32, and R37 resided. RN1 stated R21 wandered at night. RN1 stated R21 got up around midnight to go to the bathroom and came out to the nursing station and asked staff, Where am I? Where is my room? RN1 stated she and the CNAs oriented R21 and put her back to bed. RN1 stated R21 often tried to go into one of the rooms right next to hers during night shift, and they redirected her out of the room.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 01/02/25 at 1:27 PM, CNA1, who worked day shift, stated R21 wandered and this was not a new behavior. CNA1 stated R21 occasionally went into other residents' rooms. CNA1 stated yesterday she observed R21 wandering into a resident's room that was not her own or that of R32 or R37. CNA1 stated residents, mostly R32, let her know if R21 was wandering into their rooms. CNA1 stated she had notified the nurse on duty when residents told her R21 wandered into their rooms. CNA1 stated R32 had notified her twice of R21 coming into his room and she had passed the information to the nurse on duty.<br><br>b. Review of R37's annual MDS, with an ARD of 12/04/24 and located in the EMR under the RAI tab, revealed R37 was admitted to the facility on [DATE] and had a BIMS score of 15 out of 15, which indicated the resident was cognitively intact.<br><br>During an interview on 12/30/24 at 3:30 PM, R37 stated R21 had dementia, was confused, and frequently wandered into her room. R37 stated R21's room was right next door to hers, which was confirmed by observation. R37 stated R21 came into her room three to five times a day, did not know where she was, and stated she wanted to go home. R37 stated she asked R21 to leave which she generally did; however, if she did not leave, R37 stated she pushed the call light for staff to come and get her out.<br><br>During an interview on 01/02/25 at 5:27 PM, CM1 and the Director of Nursing (DON) stated night shift staff consisted of one nurse and two CNAs to cover First Floor South and First Floor [NAME] halls, each hall with 16 residents, and the night shift nurse was responsible for the medication pass on both units which occurred until 10:00 PM - 11:00 PM. They verified there could be times when there were no staff on the hallway on either side of the First Floor if the nurse was on the other side and the CNA on the hall was in a room with a resident. Both stated R21 had dementia, and it was common for her to be up early in the morning around 4:30 AM. They stated the facility did not have a memory care unit and they could not meet the needs of residents with significant wandering and had discharged residents to memory units when necessary. The DON stated the staff and residents had not reported that R21 was wandering into residents' rooms. |

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| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42440<br><br>Based on interview, record review, and policy review, the facility failed to have an end date for an as needed (PRN) psychotropic medication for two of six residents (Resident (R) 16 and R282) reviewed for unnecessary medications out of a total sample of 25. The failure had the potential for residents to receive psychotropic medications without ongoing assessment by a physician or practitioner for continued appropriateness. The facility census was 80.<br><br>Findings include:<br><br>Review of the facility's Psychotropic Medication Use policy, reviewed on 09/07/23, revealed, . Psychotropic drug is any drug that affects brain activities associated with mental processes and behavior . PRN orders for psychotropic drugs are limited to 14 days. If the medical provider believes that it is appropriate for the PRN order to be extended beyond 14 days, the medical provider should document their rationale in the resident's medical record and indicate the duration for the PRN order .<br><br>1. Review of R16's Resident Face Sheet, located in the Face Sheet tab of the electronic medical record (EMR), revealed R16 was admitted to the facility on [DATE] with diagnoses that included anxiety with depression.<br><br>Review of R16's [Hospital] DC [Discharge] Summary, dated 12/02/24 and located in the Admission Documents portion of the Resident Documents tab of the EMR, revealed an order upon discharge from the hospital to continue alprazolam (an anti-anxiety medication) 0.5 milligrams (mg) in the morning, at noon, and at bedtime PRN for anxiety.<br><br>Review of R16's Orders tab of the EMR revealed an order dated 12/02/24 for alprazolam 0.5mg every eight hours PRN for anxiety. There was no end date for the PRN anti-anxiety medication until it was added on 12/31/24.<br><br>Review of the facility's December SNF [skilled nursing facility] Review, completed by the pharmacist, revealed R16's medications were reviewed on 12/03/24, without mention of the alprazolam.<br><br>Review of R16's admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/08/24 and located in the RAI tab of the EMR, revealed R16 scored 15 out of 15 on her Brief Interview for Mental Status (BIMS), which indicated she was cognitively intact.<br><br>During an interview on 01/01/25 at 11:10 AM, R16 reported she took the PRN alprazolam frequently at night to help her settle for the night and into the next morning.<br><br>2. Review of R282's Resident Face Sheet, located in the Face Sheet tab of the EMR, revealed R282 was admitted to the facility on [DATE]with diagnoses that included pneumonia and chronic respiratory failure.<br><br>(continued on next page) |

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| | 265784 | A. Building<br>B. Wing | 01/02/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Living Community of St Joseph | 1202 Heartland Road<br>Saint Joseph, MO 64506 |

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| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of R282's [Hospital] DC Summary, dated 12/06/24 and located in the Admission Documents portion of the Resident Documents tab of the EMR, revealed an order upon discharge from the hospital to start taking hydroxyzine pamoate (an antihistamine medication which can be used to help control anxiety) 50mg every six hours if needed for anxiety for up to 10 days.<br><br>Review of R282's Orders tab of the EMR revealed an order dated 12/06/24 for hydroxyzine pamoate 50mg every six hours PRN for anxiety. The order had no end date.<br><br>Review of the facility's December SNF Review, completed by the pharmacist, revealed R282's medications were reviewed on 12/07/24, without mention of the hydroxyzine.<br><br>Review of R282's admission MDS, with an ARD of 12/12/24 and located in the RAI tab of the EMR, revealed R282 scored 14 out of 15 on his BIMS, which indicated he was cognitively intact.<br><br>During an interview on 12/31/24 at 8:30 AM, R282 reported he did not think he had used the PRN hydroxyzine.<br><br>During an interview on 01/01/25 at 11:23 AM, Licensed Practical Nurse (LPN) 2 stated PRN psychotropic medications or medications used as an anti-anxiety medication needed an end date. LPN2 stated she thought the end date was 14 days from the start of the medication.<br><br>During an interview on 01/01/25 at 2:35 PM, LPN1 stated she believed scheduled psychotropic medications had an end date but PRN psychotropic medications did not have end dates.<br><br>During a concurrent interview on 01/01/25 at 3:19 PM, with LPN Infection Preventionist (IP) and Registered Nurse, Clinical Manager (CM) 2, the IP stated if a PRN psychotropic medication was not needed, the facility checked with the provider about discontinuing it. The IP stated the pharmacist reviewed medications and rounded with the nurse practitioner, seeing residents weekly. The IP was uncertain what the regulatory requirement was regarding end dates for PRN psychotropic medications. CM2 stated she reviewed medication orders for newly admitted residents as did the pharmacist. CM2 stated the nurse practitioner or doctor set the end dates for PRN psychotropic medications. CM2 was unsure what the regulatory requirement was regarding end dates for PRN psychotropic medications.<br><br>During an interview on 01/01/25 at 3:35 PM, the Director of Nursing (DON) reported she expected nurses to enter an end date of 14 days for PRN psychotropic medication orders, and after 14 days, the doctor could renew the order or discontinue the medication if it was not used. The DON stated consequences of not having an end date included falls, oversedation, and polypharmacy. The DON stated that R282 had not used his PRN hydroxyzine, so the facility would check on discontinuing it. The DON stated that since R16 used her PRN alprazolam frequently, hers was renewed for 14 days. |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15406<br><br>Based on interview, record review, and policy review, the facility failed to ensure the medical record was accurate and complete for one out of 25 sampled residents (Resident (R) 37). R37's record did not include the updated Preadmission Screening and Resident Review (PASRR) Level 1 form, and R37 was documented with a serious mental illness diagnosis of bipolar disease that was not accurate. This created the potential for R37 to experience the stigma associated with mental illness and for staff and medical providers not to have full and accurate information about R37's mental health condition. The facility census was 80.<br><br>Review of the facility's Admission Prescreening for Individuals with Mental Retardation or Mental Illness policy, dated 2021, revealed, Missouri law mandates preadmission screening for all individuals with mental illness (MI) or mental retardation (MR) who apply to long term care facility . The policy indicated if the resident had a serious mental illness diagnosis, a referral would be made to the designated state agency titled COMRU. COMRU would determine whether a PASRR Level 2 screening would be required, and this should be completed prior to the resident's admission to the facility.<br><br>Review of the facility's Charting and Documentation in the Medical Record policy, dated 2023, revealed the purpose was, To ensure objective, accurate, timely and clinically complete information in the individual resident medical record . The medical record facilitates communication between the interdisciplinary team regarding the resident's condition and response to care .<br><br>Review of R37's annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/04/24 and located in the electronic medical record (EMR) under the RAI [Resident Assessment Instrument] tab, revealed R37 was admitted to the facility on [DATE] and had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident was cognitively intact. It was recorded that R37 did not have a serious mental illness.<br><br>Review of R37's Physician Order Report, dated 02/22/21 - 03/22/21 and provided by the facility, revealed documentation that R37 had a diagnosis of bipolar disorder.<br><br>Review of R37's EMR revealed it did not have the most current PASRR Level 1 located within the record. Review of R37's PASRR Level 1, dated 02/16/21 and provided by the facility, revealed documentation R37 did not have a serious mental illness. The diagnosis of bipolar disorder was not identified. The PASRR Level 2, therefore, did not trigger to be completed and was not completed or found in the medical record.<br><br>Review of the undated CCD [Continuity of Care Document], located in the EMR under the Resident tab and reviewed on 12/31/24, revealed a diagnosis of bipolar disorder, current episode hypomanic, initiated on 07/31/23.<br><br>Review of R37's Care Plan, dated 07/12/24 and located in the EMR under the RAI tab, revealed a problem of Behavioral Symptoms, I have serious mental illness bipolar disorder, current episode hypomanic .<br><br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of all the Progress Notes, from 01/01/2023 - 12/31/24 and located in the EMR under the Resident tab, revealed only one entry with documentation of bipolar disorder.<br><br>Review of R37's IDT [Interdisciplinary] Psych Medication Note, dated 02/22/24 and located in the EMR under the Progress Notes tab, revealed, . Resident remains on Trazodone 150 mg [milligrams] at HS [hour of sleep] depression . Olanzapine [antipsychotic medication] 2.5 mg at HS, 5 mg [milligrams] at noon, Bipolar .<br><br>Review of R37's medical record revealed additional conflicting information regarding whether R37 had a diagnosis of bipolar disorder. The Physician Order Report, dated 02/22/21 - 03/22/21 and provided by the facility, revealed R37 had a diagnosis of bipolar disorder; however, the current Physician Order Report, dated 12/02/24 - 01/02/25 and located in the EMR under the Orders tab under the heading of Diagnoses, did not document bipolar disorder.<br><br>Review of R37's comprehensive MDS assessments, provided by the facility and from admission through the survey (admission MDS with an ARD of 02/24/21, annual MDS with an ARD of 02/08/22, annual MDS with an ARD of 12/21/22, and annual MDS with an ARD of 12/04/23), reviewed no documentation that R37 had a serious mental illness.<br><br>Review of the untitled Discontinued Diagnoses Report, from admission through 01/02/25 and provided by the facility, revealed the diagnosis of bipolar disorder was first added on 02/18/21 and was discontinued on 10/27/22. The diagnosis of bipolar disorder was added a second time on 07/31/23 and was discontinued during the survey on 01/01/25.<br><br>During an interview on 12/31/24 at 3:55 PM, the Administrator stated the PASRR Level 1 completed on 02/16/21 did not document presence of a serious mental illness. The Administrator stated if serious mental illness and/or a psychiatric stay or other indicator had been documented on the PASRR Level 1 form, the form would have been sent to the state agency COMRU (Central Office Medical Review Unit) to make the decision whether a PASRR Level 2 was needed.<br><br>During an interview on 01/01/25 at 3:44 PM, the Director of Nursing (DON) stated she was not sure how the diagnosis of bipolar disease got added to the CCD/Face Sheet document. The DON stated the resident's attending Physician did not document bipolar disorder in the Physician Notes and neither did the Psychiatrist. The DON stated after the issue was brought to her attention during survey, she called R37's psychiatry physician group, and they reviewed R37's information and instructed the DON to discontinue the bipolar diagnosis from R37's record, which had been done.<br><br>Review of R37's Nurse's Note, dated 01/01/25 and located in the EMR under the Progress Notes tab, revealed, Writer spoke to [Psychiatrist's name] resident's psychiatrist regarding bipolar diagnosis not found on recent past psych visits. [Psychiatrist's name] stated dc [discontinue] bipolar disorder and use major depressive disorder diagnosis. Bipolar diagnosis dc'd [discontinued] per MD [Medical Doctor] order. Call out to [family Member] to let her know Bipolar diagnosis was removed and keep Major Depressive Disorder. [Family Member] stated, 'Good, I have been telling them for years she is not Bipolar .<br><br>Review on 01/02/25 of the undated CCD in the EMR under the Resident tab showed the diagnosis of bipolar disorder had been deleted.<br><br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 01/02/25 at 2:35 PM, the Administrator stated the bipolar diagnosis was first noted on 03/11/21 by the Nurse Practitioner (NP). The Administrator verified inconsistent documentation in the record regarding the bipolar disorder diagnosis. The Administrator stated R37 had several admissions in and out of the hospital since she was originally admitted to the facility. The Administrator stated an additional PASRR Level 1 form was found that identified serious mental illness with the diagnosis of bipolar disorder. The Administrator stated this PASRR Level 1 had not been in R37's EMR.<br><br>Review of R37's PASRR Level 1, dated 02/16/24 and provided by the Administrator on 01/02/25 at 2:35 PM, revealed R37 had received intensive psychiatric treatment for a diagnosis of bipolar. This PASRR Level 1 had been referred to COMRU to determine whether a PASRR Level 2 was needed.<br><br>An attempt to interview R37 was made on 01/02/24 at 11:40 AM; however, the resident was sleeping and was not available for interview. |