STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265863	A. Building B. Wing	10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tiffany Springs Rehabilitation & Health Care Cente	9191 N Ambassador Drive Kansas City, MO 64154

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26006 Based on record review and interviews, the facility failed to ensure the physician was notified when pain medications were unavailable to be administered per physician's order for one of three residents (Resident (R) 4) reviewed for pain of 27 sample residents. This failure had the potential to contribute to uncontrolled pain and fall risk. The facility census was 116. Findings include: Review of R4's Admission Record, located under the Profile tab of the electronic medical record (EMR), revealed she was admitted to the facility on [DATE] with diagnoses including: polymyalgia rheumatica (a chronic inflammatory disorder that causes pain and stiffness in the neck, shoulders, and hips); chronic pain syndrome; rheumatoid arthritis; dementia; depression, and anxiety. Review of R4's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/15/24 and located in the MDS tab of the EMR, revealed a Brief Interview for Mental Status (BIMS) score of 10 out of 15 which indicated the resident was moderately cognitively impaired. R4 did not exhibit any mood or behavioral symptoms. R4 received scheduled pain medications but did not receive as-needed pain medication or non-pharmacological approaches for pain management. She had pain almost constantly which occasionally interfered with daily activities. R4 rated her pain at a two out of ten. Review of R4's August 2024 Medication Administration Record (MAR) revealed an order for Norco (an opioid pain medication comprised of hydrocodone/acetaminophen), 7.5/325 mg (milligrams) every four hours for chronic pain, which was discontinued on 08/09/24, and a new order for Norco 5/325 mg every four hours that originated on 08/09/24. The MAR and associated Orders-Administration Notes, located in the Progress Notes tab of the EMR, documented the Norco was not administered on: -08/08/24 at 8:00 AM for a reason of Other: No corresponding note was documented. -08/0/24 at 12:00 PM: Medication not available. Speaking with physician. -08/08/24 at 4:00 PM: Medication not available. Order to be changed. Review of R4's August 2024 MAR also included an order for a lidocaine (pain medicine) patch, 5%, to be applied at 8:00 AM and removed at 8:00 PM, which originated on 07/03/24. The MAR and associated Orders-Administration Notes, documented the lidocaine patch was not administered on: (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-08/15/24: Pt [patient] did not have any patches on today, she said she had the pain cream. -08/16/24: Patch not available (back oreder [sic]). -08/17/24: No patches (back order). -08/18/24: This medication is on back order. Review of R4's September 2024 MAR revealed the order for Norco 5/325 mg every four hours. The MAR and associated Orders-Administration Notes, documented the Norco was not administered on: -09/18/24, 12:00 PM: No reason code or corresponding note was documented. -09/18/24, 4:00 PM: for a reason of Other: No corresponding note was documented. -09/26/24, 8:00 PM: Waiting on pharmacy to deliver. -09/27/24, 12:00 AM: Waiting on pharmacy to deliver. -09/27/24, 4:00 AM: Waiting on pharmacy for delivery. -09/28/24, 12:00 AM: Not available needs script. -09/28/24, 4:00 AM: Not available. -09/28/24, 12:00 PM: Medication unavailable, pharmacy needs a new script. Provider/oncall [sic] notified. Review of R4's September 2024 MAR also included the order for a lidocaine patch, 5%, to be applied at 8:00 AM and removed at 8:00 PM, which originated on 07/03/24. The MAR and associated Orders-Administration Notes, documented the lidocaine patch was not administered on: -09/27/24: No patches. During an interview on 10/04/24 at 1:05 PM, R4's Physician stated she could not recall if she was notified of missed doses and pharmacy requests for Norco or lidocaine. The Physician stated the Nurse Practitioner (NP) may have more information. During an interview on 10/04/24 at 1:19 PM, the Director of Nursing (DON) stated the nursing staff were to notify the physician of any unavailable medication or missed doses, and the physician should send the prescription to the pharmacy and/or authorize use of the emergency supply. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/04/24 at 1:28 PM, the Infection Preventionist/Assistant Director of Nursing ADON (IP/ADON) 3 stated the MAR, and Orders-Administration Notes indicated the Norco and lidocaine patch were not administered as ordered. She stated the staff had not reported the unavailability of the medication to her and she was not aware of the resident's several missed doses of pain medication. The IP/ADON3 stated nurses were expected to notify the physician of any missed doses of medications and document the follow-up; however, there was insufficient documentation to determine if notifications were made in the above instances. During an interview on 10/04/24 at 1:56 PM, the NP stated the expectation was that staff would notify him of any missing medications so he could write a prescription for an emergency dose and communicate with the pharmacy. The NP stated he had not been notified of R4's continued missed doses of medications and stated he was unaware R4 went several days without receiving her scheduled Norco and stated, that is unacceptable. The NP stated he would have gone to any extent to get the pain medications R4 needed, up to sending her to the hospital for pain medication, but he was unaware of the situation. The NP stated he was not notified of missed lidocaine doses. The NP stated there should never be an instance where medication was not given, as it was available in the emergency kit and the process should be followed to ensure the emergency dose was given.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39857 Based on interview and record review, the facility failed to ensure a resident who had a negative Preadmission Screening and Resident Review (PASARR) Level I and then later had a significant change in status with a new serious mental illness diagnosis was accurately and timely referred for a PASARR Level II for one of two residents (Resident (R) 29) reviewed for PASARRs out of 27 sample residents. This failure placed the residents at risk of qualifying for specialized services but not receiving the services due to the inaccuracy of the PASARR Level I. The facility census was 116. Findings include: During an interview on 10/03/24 at 2:00 PM, the Administrator revealed the facility had no policy on PASARR. Review of R29's Admission Record, located in the resident's electronic medical record (EMR) under the Profile tab revealed the resident was admitted to the facility on [DATE] with diagnoses which included acute heart failure. On 07/12/21, the resident was placed on a psychiatric hold and sent to a psychiatric facility, returning on 07/29/21 with a diagnosis of major depressive disorder with severe psychotic symptoms. Review of R29's EMR under the Progress note tab revealed that R29 had been receiving psychiatric services since returning to the facility in August 2021. Review of R29's Preadmission Screening and Resident Review summary, provided by the facility, revealed on 04/01/21, the facility initiated a PASARR Level I. Following R29's return on 07/29/21, a new Level I Screen was not done. During an interview on 10/04/24 at 2:45 PM, the Social Services Designee (SSD) stated that R29 should have had a new Level I PASARR Screening and then Level II Screening initiated when she was readmitted to the facility on [DATE] and that she had initiated the process on 10/03/24 when they were made aware of the mistake. The SSD stated, I screen all residents that are admitted if the PASARR screening was not done in the hospital. She also stated, this should not have fallen through the cracks. During an interview on 10/04/24 at 3:15 PM, the Director of Nurses (DON) stated, After reviewing [R29's] records, she should have been treated as a new admission, when she returned to the facility following a psychiatric hospital stay. The DON also stated, We have initiated the process to screen [R29] yesterday 10/03/24, we are all new here and reviewing all charts and making corrections.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 20706 Based on interview and record review, the facility failed to develop a comprehensive patient centered care plan related to an Implantable Cardioverter Defibrillator (ICD) device one of 27 sample residents (Resident (R) 82) reviewed for care plans. The failure to update care plans to reflect the residents' needs can result in potential harm. Findings include: Review of the undated John Hopkins Medicine, titled article Living with a ICD located at https://www.hopkinsmedicine.org/health/wellness-and-prevention/living-with-a-pacemaker-or-implantable-cardioverter-defibrillator-icd revealed that there are post implant precautions that a patient has too abide by usually for life. Those precautions may include setting off some alarms in close proximity, not having a certain type of magnetic scans done, not using heat therapy, staying away from high voltage machines, careful use of cell phones and other electronic devices, just to name a few. Review of R82's undated Face Sheet located under the Profile tab of the electronic medical record (EMR), revealed the resident was admitted to the facility on [DATE] with diagnoses which included chronic combined systolic (congestive) and diastolic (congestive) heart failure with a pacemaker and implantable cardioverter defibrillator (ICD, done 04/21), chronic obstructive pulmonary disease (COPD), chronic respiratory failure with hypercapnia, and Oxygen Dependent. The facility census was 116. Review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/24/24 revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated the resident was cognitively intact. Record review of R82's Care Plan tab of the EMR, revealed no focus area for ICD care interventions. The Implantable device was not on the care plan. Review of the Progress Notes tab of the EMR, revealed that the most recent cardiac visit was on 07/18/24 by the facility cardiac nurse practitioner. Additionally, the visit revealed that R82 was being seen for his cardiac follow-up and plans for R80 to have the ICD interrogation done at a cardiac center nearby. Concluding remarks on this visit revealed that the plan of care was discussed with the nursing staff. During an interview on 10/04/24 at 2:40 PM, the Medical Director and the Director of Nursing (DON) revealed that R82 was not care planned for an ICD and did not need to be care planned for an ICD because staff would know to just call 911 if anything happened.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 20706 Based on observations, interviews, and record reviews, the facility failed to maintain current abilities for one of one resident (Resident (R) 80) reviewed for activities of daily living (ADL) of 27 sample residents. Failure of the facility to provide proper assistance for a resident that has ADL decline could result in psychological and physical harm. The facility census was 116. Findings include: Review of R80's undated Face Sheet located under the Profile tab of the electronic medical record (EMR) revealed the resident was admitted to the facility on [DATE] with diagnoses which included Parkinson's disease without dyskinesia, lymphedema, dementia moderate, with other behavioral disturbance, glaucoma, blindness, right eye, and major depressive disorder. Review of the quarterly Minimum Data Set (MDS) located under the MDS tab of the EMR, with an Assessment Reference Date (ARD) of [DATE] revealed a Brief Interview for Mental Status (BIMS) of nine out of 15 which indicated the resident was moderately cognitively impaired. The MDS revealed the resident's functional ability as ambulatory with a walker. The MDS coded the resident for toileting, showering, dressing, and personal hygiene as being Independent to set-up assistance. Review of R80's Care Plan, located under the Care Plan tab of the EMR, dated [DATE] with a revision date of [DATE], revealed Impaired visual function with intervention to monitor and report to the physician any change in the ability to perform activities of daily living (ADLs). Other care plan focus revealed that the resident refused to be shaved by staff and preferred to do it himself with an intervention for staff to offer to shave his face and encourage to assist. Additional care plan focus area for ADL self-care performance related to Parkinson's revealed intervention that resident could perform his personal hygiene care independently and may need set up assistance. Review of the Progress Notes tab of the EMR, by the physician on [DATE] for a service date of [DATE], revealed that R80's evaluation showed ADL dysfunction, neuromuscular deconditioning, and gait dysfunction. The recommendation was to continue with therapy. Observation and interview on [DATE] at 9:25 AM revealed R80 in room lying on his bed, dressed in clothing, hair appeared greasy, un-kept, face unshaved, eyebrows long, fingernails with brownish debris and very long. R80 was pleasant and denied having any concerns. During an observation on [DATE] at 11:16 AM, the resident was found in his bathroom alone with his walker in front of him and appeared to be finishing up from toileting. The resident took more than 30 minutes attempting to clean himself without assistance. The resident's nails remained very long with brownish debris beneath them. During an interview on [DATE] at 9:31 AM, Certified Nurse Assistant (CNA) 2 revealed that R80 stayed mostly in his room, and he did his own thing. CNA2 stated he usually needed help with pulling up his pants, and he did not come out much since his wife died . CNA2 admitted she did not notice a decline with ADLs for R80. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 9:32 AM, the Assistant Director of Nursing (ADON) 3 revealed that the resident was sometimes confused but could ambulate with a walker. ADON3 accompanied the surveyor to a resident's room where R80 was lying on his bed with a soiled looking brown jacket, pants, and his shoes on. The resident was asked about his nails being long and he said he could not recall the last time they were cut. The ADON3 confirmed that his nails were too long and dirty, needed cutting, and R80 could not cut his own nails. ADON3 confirmed that R80 needed grooming like shaving which he could not do on his own. Observation of the resident's feet after the ADON3 removed his socks revealed both feet with yellowish appearance skin to both feet, and long yellowish toenails. The ADON3 responded that He needs to see a Podiatrist. The ADON3 confirmed that although the resident may say he could do his own ADLs, he still needed additional assistance for those care needs and may be declining with self-care. She agreed that R80 needed to be re-assessed appropriately for his care needs. During an interview on [DATE] at 10:40 AM, CNA2 revealed that R80 did everything for himself, the nurse applied his lower extremity boots that were supposed to be used for edema. CNA2 stated if his nails needed cutting the nurses did that. She also revealed that he got his showers in the evenings and showed as having one last evening. She also revealed that they offered him help but he told them he could do it, but he obviously needed more help. During an interview on [DATE] at 11:43 AM, the Director of Nursing (DON) revealed the resident was just recently assessed by MDS nurses and scored a three for his physical assessment and agreed that his assessment should be re-done to reflect his true current abilities. During an interview on [DATE] at 11:47 AM, MDS Coordinators (MDSC), revealed that R80 was more independent in his previous assessments than what he appeared to be now and that he did require more assistance with ADL care needs.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 observation, interview, and record review, the facility failed to safely store an oxygen emergency tank (e-tank) for one of three (Residents (R) 272) reviewed for respiratory care of 27 sample residents. This failure placed the residents at risk of injury. The facility census was 116. Findings include: Review of the Admission Record located in the Profile tab of the electronic medical record (EMR), revealed R272 was admitted to the facility on [DATE] with a diagnosis of emphysema (a lung condition that causes shortness of breath). Review of a Physician Order, dated 09/21/24 and located in the Orders tab of the EMR, revealed O2 [oxygen] at 2L [liters] as needed to keep oxygen saturation greater than 90%. During an observation on 10/02/24 at 2:59 PM, R272 was observed asleep in his wheelchair. He was connected to the oxygen concentrator via nasal cannula tubing. The e-tank was observed standing against the wall unsupported with the oxygen carrier nearby. During an interview on 10/02/24 at 3:01 PM, Minimum Data Set Coordinator (MDSC) who was walking by his room, was asked about the oxygen e-tank. The MDSC stated the e-tank should have been in the carrier and confirmed that it was unsupported. During an interview on 10/02/24 at 3:18 PM, the Director of Nursing (DON) stated, The e-tanks are to be secured.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32513 Based on observation, interview, record review, and facility policy review, the facility failed to ensure an occlusive, peripherally inserted central catheter (PICC) line was changed every seven days, as required for one of one resident (Resident (R) 108) reviewed for intravenous (IV) antibiotic use of 27 sample residents. This failure placed the residents at risk of increased infection and complications. The facility census was 116. Findings include: Review of the facility's policy titled, Central Vascular Access Device (CVAD) Dressing Change,: dated January 2004, revealed .The catheter insertion site is a potential entry site for bacteria that may cause a catheter-related infection .Perform sterile dressing changes .upon admission .If transparent dressing is dated, clean, dry, and intact, the admission dressing change may be omitted and scheduled for 7 days from the date on the dressing label . Review of the Admission Record located in the Profile tab of the electronic medical record (EMR) revealed R108 was admitted to the facility on [DATE] with a diagnosis of arthritis due to bacteria in the right knee and right wrist. Review of a Physician Order, dated 09/11/24 and located under the Orders tab of the EMR, revealed Ceftriaxone (an antibiotic) 2 GM (grams) intravenously one time a day for septic arthritis right knee until 09/30/24. Review of the admission Minimum Data Set (MDS) located under the MDS tab of the EMR with an Assessment Reference Date (ARD) of 09/16/24 revealed R108 had a Brief Interview for Mental Status (BIMS) score of 10 out of 15 which indicated he was moderately impaired in cognition and was not administered an antibiotic during the seven-day observation period. Review of the Comprehensive Care Plan, dated 09/11/24 and located in the Care Plan tab of the EMR, revealed The resident has IV access PICC LINE which was revised on 09/16/24. Interventions included the following: Check dressing at site daily. Dated 09/11/24. Monitor/document/report to MD PRN (Medical Doctor as needed) s/sx (signs and symptoms) of infection at the site: Drainage, Inflammation, Swelling, Redness, Warmth. Dated 09/11/24. Review of the Care Plan located under the Care Plan tab of the EMR, revealed it did not contain an intervention to change the occlusive dressing every seven days, as required to decrease potential complications of infection. During an observation on 10/01/24 at 10:07 AM, R108's right PICC line dressing was coming off around half of the occlusive dressing and was not adhered to the skin. The date on the dressing was 9/16/24 (15 days). (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/01/24 at 10:20 AM, the Assistant Director of Nursing (ADON) 1 for the 100-hall confirmed that the dressing on the PICC line was dated 09/16/24 and should have been changed every seven days. ADON1 further confirmed that the dressing was not occlusive, but did not know how long it had been that way.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20706 32513 Based on observation, interview, and record review, the facility failed to ensure pain medication and timely interventions were provided for three of three residents (Residents (R) 107, R82, and R4) reviewed for pain management of 27 sample residents. This failure placed residents at risk of harm when pain was not assessed, monitored, with timely interventions provided. The facility census was 116. Findings include: 1. Review of R107's Admission Record located under the Profile tab of the electronic medical record (EMR) revealed R107 was admitted to the facility on [DATE] with diagnoses that included malignant neoplasm of the splenic flexure (the bend where the transverse colon and the descending colon meet in the upper left portion of the abdomen), liver cirrhosis, and deep vein thrombosis (DVT). Review of R107's admission Minimum Data Set (MDS) located under the MDS tab of the EMR revealed R107 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated she was cognitively intact and had frequent pain rated at a nine on a zero to 10 on the pain scale during the observation period. Review of the Pain Care Plan, dated [DATE] and located in the Care Plan tab of the EMR, revealed [R107] is at risk for pain d/t [due to] decline and acute embolism and Thrombosis (blood clots). Interventions included the following: Monitor/record/report to Nurse resident complaints of pain or requests for pain treatment. Dated [DATE]. Notify physician if interventions are unsuccessful or if current complaint is a significant change from residents past experience of pain. Dated [DATE]. Monitor/document for side effects of pain medication. Observe for constipation, new onset or increased agitation, restlessness, confusion, hallucinations, dysphoria, nausea, vomiting, dizziness, and falls. Report occurrences to the physician. Dated [DATE]. Observe and report changes in usual routine, sleep patterns, decrease in functional abilities, decrease ROM [range of motion], withdrawal, or resistance to care. Dated [DATE]. Review of the Treatment Administration Record (TAR), dated [DATE] and located under the Orders tab of the EMR, revealed the following Pain Scale record q [every] shift. ,d+[DATE]: No pain; ,d+[DATE]: Mild pain; , d+[DATE]: Moderate pain; ,d+[DATE]: Severe pain; ,d+[DATE]: Very severe pain; 10: Worst possible pain. Start date on the order was [DATE]. Review of the Physician Orders located under the Orders tab of the EMR, revealed Norco (an opioid pain medication) ,d+[DATE]mg [milligram] Give 1 tablet by mouth every 4 hours as needed for pain x 14 days. Start Date: [DATE] and Discontinue Date: [DATE]. Review of a Nursing Progress Note, dated [DATE] and located under the Progress Notes tab of the EMR, revealed Patient reported to writer that she hasn't peed since yesterday. She reports lower abdominal pain that she rates ,d+[DATE] . (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of an SBAR [Situation, Background, Assessment, and Recommendation], dated [DATE] and located under the Assessments tab of the EMR, indicating that R107 had a change in condition which included abdominal pain, +3 pitting edema (swelling that causes an indentation when pressed that rebound in 60 seconds or less) and difficulty urinating. Review of the Physician Orders located under the Orders tab of the EMR, revealed on [DATE], the opioid pain medication was discontinued, and Tramadol (a non-opioid pain medication) 50 mgs [milligrams] Give 1 tablet every 6 hours as needed for pain. Review of the TAR pain scale, on [DATE] and under the Orders tab of the EMR, revealed R107 had a documented pain level of 10 on the day shift. There was no documentation that R107 had received Norco or Tramadol that day. Review of the Nursing Progress Note located under the Progress Notes tab of the EMR, revealed on [DATE], Resident reports no urine this day, c/o [complaint of] abdominal pain . Review of the TAR, dated [DATE] and located under the Orders tab of the EMR, revealed R107 had a pain level completed [DATE] with a level of nine out of 10 and was administered Tramadol. During an interview on [DATE] at 11:33 AM, R107 was awake, alert but was guarded. R107 was asked about her pain. She stated, It's all over, but mostly in my lower abdomen. She was asked if she could rate her pain level now. R107 stated, It's an 11 (on a ,d+[DATE] pain scale). R107 further stated that she wanted to go into hospice care as she was aware that her pain would be better managed. R107 was asked if she had spoken to the nurses regarding her pain. She stated, Oh, yes, I tell them all the time. R107 was asked if she had spoken to the provider regarding her pain. She stated, I believe I have but, I know that I have spoken to the nurses about it. During an interview on [DATE] at 1:17 PM, the Director of Nursing (DON) stated, If she was having that much pain, the pain medication should have been scheduled, we don't have to wait for her to ask for it. I agree that she has declined. During an interview on [DATE] at 9:23 AM, Nurse Practitioner (NP) 1 stated, [R107] has clear cognitive deficits even with the pain medication sometimes she would tell me she wasn't in pain. I had her on Norco first but with her liver issues, I switched her to Tramadol. NP1 was asked why he continued with as needed pain medication instead of scheduling it routinely. NP1 stated, I never questioned her ability to ask for pain medication, I only schedule it when the resident cannot ask for the medication. The staff did not tell me that she was having continued pain. During an interview on [DATE] at 12:45 PM, the Medical Director was asked if she was aware the facility did not have a policy and procedure for pain management. She stated, No, I was not aware. 2. Review of R82's undated Face Sheet located under the Profile tab of the EMR revealed the resident was admitted to the facility on [DATE] with diagnoses which included chronic combined systolic (congestive) and diastolic (congestive) heart failure with a pacemaker and implantable cardioverter defibrillator (ICD), and type two diabetes mellitus with autonomic neuropathy, Review of the quarterly MDS with an ARD of [DATE] and located under the MDS tab of the EMR, revealed a BIMS score of 15 out of 15 which indicated the resident was cognitively intact. (continued on next page)

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	265863	A. Building B. Wing	10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Care Plan located under the Care Plan tab of the EMR, revealed a focus area for pain, initiated [DATE] with updates for [DATE]. Care plan interventions revealed that as needed analgesics (Norco) would be available, and that the resident would be assessed for the effectiveness for pain relief. The care plan further revealed that complaints of pain and request for pain meds would be reported to the nurse and interventions for pain relief would be implemented. On-going monitoring of these interventions each shift and as needed would be assessed for the effectiveness of pain relief. Review of the Orders tab of the EMR, revealed pain scale monitoring order every shift and at night with a date of [DATE] as an active order. It also revealed an order for Norco oral tablets with an active date of [DATE]. Review of the Medication Administration Record (MAR), [DATE] and located under the Orders tab of the EMR, revealed that the resident received one acetaminophen tablet on [DATE] with a pain level of four out of 10 on the pain scale. Review of the Progress Notes tab of the EMR, revealed a note entered on [DATE] at 13:09 PM (1:09 PM) that staff went in to do R82's weekly weight and R82 refused to do his weight check stating, No my feet are hurting, and I have been waiting for a pain pill since this morning. Reported to charge nurse, he has to have a new script. Additional progress notes revealed that on [DATE] at 7:04 PM, R82 had refused two meals. On [DATE] at 4:14 PM, R82 had finally received a Norco tablet for pain. Observation on [DATE] at 8:45 AM revealed R82 was in his room in bed, alert and oriented and cognitively intact. He reported that he had been in pain since [DATE] and the facility took five days to provide him with effective pain management relief. He said they had been making excuses that my pain pill medication had expired, and a new script was needed. He revealed a pain of ,d+[DATE] as his current pain level during this observation. During an interview on [DATE] at 9:04 AM, Assistant Director of Nursing (ADON) 3 revealed R82 told her about his pain on [DATE] after the resident had received a dose that day. She stated that the resident also told her that he had been asking for pain med since [DATE] with no follow up. ADON3 also confirmed that she did not find any follow up documented on R82's response to pain med given. During an interview on [DATE] at 9:16 AM, Licensed Practical Nurse (LPN) 3 revealed that R82 complained of pain yesterday with a pain scale of eight out of 10 and was given a dose of his hydrocodone. She stated she was not aware if his pain affected his abilities and stated he got out of bed when he wanted to. During an interview on [DATE] at 9:45 AM, R82 revealed and confirmed that his pain this morning was about a seven and that he did finally get two doses of pain med yesterday. He also revealed that no one had done any follow-up about his pain management. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 9:59 AM, the DON revealed that she did speak to the resident on Monday [DATE] about his pain and told him that his prescription for hydrocodone had expired and a hard copy was needed. She stated she was aware that the resident did get a dose on Tuesday and said he was ok with getting an as needed (PRN) Ibuprofen for pain until his pain medication came. The DON further revealed that the facility had no pain management policy or protocol, but the expectation was that when pain med was given, there should have been a follow-up documented about the resident's response to the pain med given. She also revealed that the pharmacy Cube-X system would not dispense a narcotic without a hard script and not sure why it took more than a day to get that done. She further revealed that the R82's regular physician was not the in-house physician, but the in-house physician could provide pain medication if the primary physician was not available. The DON stated there was no evidence was documented that the nursing staff attempted to contact the physician. During an interview on [DATE] at 10:44 AM, Restorative Aide (RA) 1 revealed that the resident did report to her that his legs were in pain and refused to have his weight done. RA1 also revealed that she reported this to the nurse and documented this in the progress notes. During an interview on [DATE] at 9:42 AM, Nurse Practitioner (NP) revealed that the facility should have contacted him for this resident's pain management and the resident should not have been left without effective pain medication for Norco. He stated the facility could have just called him. 3. Review of R4's Census tab of the EMR revealed she had been admitted to the facility on [DATE]. Review of R4's Medical Diagnosis tab of the EMR revealed her diagnoses included rheumatoid arthritis, chronic pain syndrome, and anxiety. Review of R4's quarterly MDS with an ARD of [DATE] and located under the MDS tab of the EMR revealed a BIMS score of 10 out of 15 which indicated the resident was moderately cognitively impaired. R4 did not exhibit any mood or behavioral symptoms. R4 received scheduled pain medications but did not receive as-needed pain medication or non-pharmacological approaches for pain management. She had pain almost constantly which occasionally interfered with daily activities. R4 rated her pain at a two out of ten. Review of R4's Care Plan dated [DATE], revised on [DATE] and located under the Care Plan tab of the EMR, revealed she had chronic pain syndrome with polymyalgia rheumatica (a chronic inflammatory disorder that causes pain and stiffness in the neck, shoulders, and hips). Interventions included: 1. Apply analgesics as ordered. Assess for effectiveness and for side effects of medications: Lidocaine patch to left and right shoulders topically daily--on in the AM [morning] and off at HS [bedtime] 2. Monitor/record/report to Nurse resident complaints of pain or requests for pain treatment. 3. Notify physician if interventions are unsuccessful or if current complaint is a significant change from residents past experience of pain. 4. Monitor/ record/ report to Nurse any s/sx [signs or symptoms] of non-verbal pain: Changes in breathing (noisy, deep/shallow, labored, fast/slow); Vocalizations (grunting, moans, yelling out, silence); Mood/behavior (changes, more irritable, restless, aggressive, squirmy, constant motion); Eyes (wide open/narrow slits/shut, glazed, tearing, no focus); Face (sad, crying, worried, scared, clenched teeth, grimacing) Body (tense, rigid, rocking, curled up, thrashing). 5. Administer appropriate pain medication as per orders. Give ,d+[DATE] hour before treatments or care. 6. Evaluate the effectiveness of pain interventions Q [every] shift. Review for compliance, alleviating symptoms, dosing schedules and resident satisfaction with results, impact on functional ability and impact on cognition. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on [DATE] at 3:31 PM, R4 was in her room and revealed she had pain on a daily basis, and it got worse when she did not get her pain medication. She stated she was supposed to get her pain medication every four hours but during the night, it was either late or she did not receive it all. She stated when she did not get her pain medication as scheduled, she did not want to do anything. Review of R4's Physician's Orders, located under the Orders tab of the EMR, revealed she had order for Norco (hydrocodone/acetaminophen (APAP) - an opioid pain medication) 7.5 milligrams (mg)/325 mg every four hours. This was changed on [DATE] to 5 milligrams (mg)/325 mg every four hours for pain. The schedule for her medication was 12:00 AM, 4:00 AM, 8:00 AM, 12:00 PM, 4:00 PM, and 8:00 PM. Review of R4's [DATE] and [DATE] MAR located under the Orders tab of the EMR and her Progress Notes in the Progress Notes tab of the EMR revealed: -On [DATE] at 5:19 AM, R4 did not receive her hydrocodone/APAP 7.5 mg/325 mg as the medication was not available. Order to be changed. -[DATE] at 10:11 PM, medication had not been given by the day nurse. -[DATE] at 12:18 PM Medication not available. Her hydrocodone/APAP order was changed on -[DATE]. -[DATE] at 9:36 PM, R4 did not receive her hydrocodone/APAP 5 mg/325 mg with no reason given, was not marked as not given. -[DATE] at 6:57 PM Too late, HS [hour of sleep] due shortly after. -[DATE] at 8:00 AM Speaking with physician. -[DATE] at 11:43 PM, [DATE] at 5:29 AM, [DATE] at 5:52 AM, 11:43 AM and at 12:36 AM Waiting on pharmacy to deliver. -[DATE] at 4:00 AM, dose marked as not given due to sleeping and no documentation the medication had been given on [DATE] for 12:00 PM dose. During an interview on [DATE] at 1:05 PM, R4's Physician stated she could not recall if she was notified of missed doses and pharmacy requests for Norco. The Physician stated the NP may have more information. During an interview on [DATE] at 1:19 PM, the DON stated narcotic medications required a written prescription to be pulled from Cubex. She stated the nursing staff were to notify the physician of any unavailable medication, and the physician should send the prescription to the pharmacy and/or authorize use of the Cubex. The DON stated R4's physician group was not as responsive to prescription requests and the facility was at the mercy of that group. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 1:28 PM, the Infection Preventionist/Assistant Director of Nursing ADON (IP/ADON) 3 stated the MAR, and Orders-Administration Notes indicated the Norco, Ativan, and lidocaine were not administered as ordered. She stated the staff had not reported the unavailability of the medication to her and she was not aware of the missed doses of pain medication. The IP/ADON3 stated the nurses should have contacted the pharmacy to obtain the necessary medication or contact the physician to get a prescription to pull the medication from the Cubex (emergency medication kit). The IP/ADON3 stated nurses were expected to notify the physician of any missed doses of medications; however, there was insufficient documentation to determine if notifications were made in the above instances. During an interview on [DATE] at 1:56 PM, the NP stated the expectation was that staff would notify him of any missing medications so he could write a prescription for a dose from Cubex. The NP stated he had not been notified of R4's missed doses of pain medications. He stated he was unaware R4 went several days without receiving her scheduled Norco and stated, that is unacceptable. The NP stated he would have gone to any extent to get the pain medications R4 needed, up to sending her to the hospital for pain medication, but he was unaware of the situation. The NP stated there should never be an instance where a medication was not given, as it was available in the Cubex, and the process should have been followed to ensure the emergency dose was given. The NP stated pain management for R4 was a delicate balance and she typically wanted more than what she received. MO242918 51678

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51678 Based on interviews and record review, the facility failed to ensure one of 27 sample residents (Resident (R) 4) medications were ordered and received for timely administration. This put residents at risk of complications from not receiving their medications. The facility census was 116. Findings include: Review of R4's Census tab of the electronic medical record (EMR) revealed she was admitted to the facility on [DATE]. Review of R4's Medical Diagnosis tab of the EMR revealed she had diagnoses that included rheumatoid arthritis, chronic pain syndrome, and anxiety. Review of R4's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/15/24 and located in the MDS tab of the EMR revealed a Brief Interview for Mental Status (BIMS) of 10 out of 15 which indicated the resident was moderately cognitively impaired. R4 received scheduled pain medication and had not received any as needed medication or non-pharmaceutical pain interventions. She had pain Almost Constantly, it rarely affected her sleep, occasionally affected her therapy activities and day-to-day activities. She had rated her pain as two out of ten on the pain assessment. Review of R4's August 2024 and September 2024 Medication Administration Records (MAR) located in the Orders tab of the EMR and her Progress Notes in the Progress Notes tab of the EMR revealed: 1. Hydrocodone/acetaminophen 7.5 milligram (mg)/325 milligram on 08/08/20 for 4:00 AM, 12:00 PM, and 8:00 PM doses. The medication was not available as the order had been changed. 2. Hydrocodone/acetaminophen 5 mg/325 mg was ordered by her physician on 08/09/24. She missed doses due to no prescription having been received by the pharmacy, on 09/26/24 for the 12:00 AM and 4:00 AM doses, and on 09/27/24 for the 12:00 AM and 4:00 AM doses. The nurses documented she had received the medication for the 8:00 AM, 12:00 PM, 4:00 PM, and 8:00 PM doses. On 09/28/24 she did not receive that medication for the 12:00 AM and 4:00 AM doses with the reason of Waiting for pharmacy to deliver. 3. She did not receive her Lidoderm Patch 5 percent (%) apply to bilateral shoulders topically in the morning for pain and removed per schedule on the following dates: 08/16/24, 08/17/24, and 08/18/24, the pharmacy did not send them as they are on back order. 4. She did not receive her Ativan 0.5 mg one-half tablet three times a day on 08/31/24 and 09/01/24 for two doses as medication was not available. On 08/31/24 the medication had not been available for all three doses, 12:00 AM, 8:00 AM, and 8:00 PM. On 09/01/24 the medication was not available for the 12:00 AM and 8:00 AM doses. The pharmacy was waiting for a prescription from the physician. The nurse had not notified the physician that the pharmacy needed a new prescription until 09/01/24 at 12:19 AM. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/04/24 at 1:05 PM, R4's Physician stated she could not recall if she was notified of missed doses and pharmacy requests for Norco, Ativan, or lidocaine. The Physician stated the Nurse Practitioner (NP) may have more information. During an interview on 10/04/24 at 1:19 PM, the Director of Nursing (DON) stated narcotic medications required a written prescription to be pulled from the Cubex (emergency medication kit). She stated the nursing staff were to notify the physician of any unavailable medication, and the physician should send the prescription to the pharmacy and/or authorize use of the Cubex. The DON stated R4's physician group was not as responsive to prescription requests and the facility was at the mercy of that group. During an interview on 10/04/24 at 1:28 PM, the Infection Preventionist/Assistant Director of Nursing ADON (IP/ADON) 3 stated the MAR, and Orders-Administration Notes indicated the Norco, Ativan, and lidocaine were not administered as ordered. She stated the staff had not reported the unavailability of the medication to her and she was not aware of the resident's missed doses of pain medication. The IP/ADON3 stated the nurses should have contacted the pharmacy to obtain the necessary medication or contact the physician to get a prescription to pull the medication from the Cubex (emergency medication kit). The IP/ADON3 stated nurses were expected to notify the physician of any missed doses of medications; however, there was insufficient documentation to determine if notifications were made in the above instances. During an interview on 10/04/24 at 1:56 PM, the NP stated the expectation was that staff notify him of any missing medications so he could write a prescription for a dose from the Cubex. The NP stated he had not been notified of R4's missed doses of pain medications. He stated he was unaware R4 went several days without receiving her scheduled Norco and stated, that is unacceptable. The NP stated he would have gone to any extent to get the pain medications R4 needed, up to sending her to the hospital for pain medication, but he was unaware of the situation. The NP stated he was not notified of missed Ativan or lidocaine doses. The NP stated there should never be an instance where medication was not given, as it was available in the Cubex, and the process should be followed to ensure the emergency dose is given. The NP stated pain management for R4 was a delicate balance and she typically wanted more than what she received. The NP stated missed doses of Ativan put her at risk for increased anxiety, thus increasing her fall risk.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 26006 Based on observations, record review, interviews, and policy review, the facility failed to ensure residents who received a pureed diet of 116 total residents were served foods prepared in a pureed form to meet their needs. This failure had the potential to cause choking, aspiration [inhalation of food into the lungs], malnutrition, weight loss, or dissatisfaction with meals. The facility census was 116. Findings include: Review of the facility's policy titled, Therapeutic Diets, dated January 2017, revealed Mechanically altered diets, as well as diets modified for medical or nutritional needs, will be considered 'therapeutic' diets. Review of the facility's Order Listing Report, dated 10/04/24 and provided on paper, revealed five residents received a pureed diet. Review of the facility's Diet Extensions - Friday Week 4 menu, provided by the facility, revealed residents who received pureed foods were to receive pureed sausage links during breakfast on 10/04/24. During observation of the tray line in the kitchen on 10/04/24 beginning at 8:06 AM, revealed Cook1 served residents with a puree diet a scoop of pureed breakfast sausage. The sausage was dry and crumbly, appearing more of a ground texture, and did not hold its shape when scooped. Evaluation of a test tray in the 300 Hall with the Dietary Manager (DM) on 10/04/24 at 9:35 AM revealed the pureed sausage had a ground texture rather than a puree texture. It was dry, crumbly, and required chewing to be swallowed. The DM stated the pureed sausage looked more like ground or mechanical soft texture and needed to be smoother. The DM stated Cook1 made the pureed sausage, and it had not been prepared correctly; it should be more of a mashed potato consistency. During an interview on 10/04/24 at 9:45 AM, Cook1 stated he followed the recipe by blending the prepared breakfast sausage links and pork base. Cook1 stated he did not blend the sausage long enough to create the desired smooth texture. Review of the facility's recipe for P/PU4 [Pureed] Sausage Links, dated 10/01/24 and provided by the facility, revealed sausage links, pork base, and thickener were to be blended to puree. The instructions documented, Blend until a smooth mashed potato consistency is reached .mixture should be thick enough to hold its shape.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51678 Based on observations, staff interviews, and record review, the facility failed to ensure safe food handling practices, food was labeled, dated, and sealed in cold storage, and the kitchen was kept in a clean and sanitary manner. These failures had the potential to increase the prevalence and spread of foodborne illness and infection among all 116 facility residents. The facility census was 116. Findings include: Review of the facility's undated policy titled, Hand Washing & Glove Usage, revealed Employees would wash their hands before and after handling foods. Gloves were to be used whenever direct food contact was needed. Hands were to have been washed before putting them on and after removing gloves. Review of the facility's undated policy titled, Cleaning Schedule, revealed items to have been cleaned after each use included cutting boards, worktables, and counters; items to have been cleaned daily included stove top, grill, kitchen floors, microwave oven, steam table, food carts, and the exterior of large appliances; items to have been cleaned weekly included drawers, shelves, ovens, and cupboards; items to have been cleaned monthly included refrigerators, freezers, ingredient bins, food containers, and walls. Review of the facility's undated policy titled, Kitchen Sanitation, revealed the food service manager would monitor food safety and sanitation, develop a cleaning schedule for the department and was responsible for its completion, and provide written cleaning instructions for each area and piece of equipment. Observation on 10/01/24 at 9:12 AM revealed Cook1 was preparing breakfast plates. He was wearing gloves and had been handling utensils that other staff had touched. He also retrieved cartons of mixed eggs from the sandwich/salad refrigerator. He was wearing the same gloves and then retrieved six slices of bread from a bag on the counter by the toaster. He placed the bread in the toaster and when it was toasted, he took it out and placed it in a container on the steam table. He completed this task two times with the same pair of gloves during the observation. He had touched other surfaces that included the bag of bread, a knife from the counter to cut the bread in half, the handle of the warming oven, and a spatula that other staff had also touched. Continued observations on 10/01/24 between 9:20 AM and 10:00 AM of the kitchen revealed: -The two compartment vegetable prep sink had romaine lettuce in water on the left side of the sink and the right side of the sink had the parts of a dirty blender used to puree food. There was previously pureed food on those parts. -The standing mixer did not have a cover over it. Part of that cover was tucked under the mixer and the rest was hanging off the counter beside it. There was dried food on the splash guard. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-The covers of the three bulk food tubs that contained flour, sugar, breadcrumbs had food debris on them and were greasy to the touch. The outside of those tubs was also greasy to touch and had black marks on the outside of them. -The walk-in refrigerator floor had food debris and pieces of cardboard from boxes. -There was a cardboard box on the bottom shelf that had two large cylindrical packages of hamburger. One of them had been opened and was loosely covered with plastic wrap. There was no date on the open hamburger large cylindrical package of when it had been opened. -Another cardboard box was open and had an open package of pre-cooked [NAME] Dean sausage crumbles. There was no date on the sausage as to when it had been opened. -The walk-in freezer had ice on the floor under the condenser. There was ice hanging from the compressor. The floor also had food debris and pieces of paper and cardboard on it. -The floor throughout the kitchen had a greasy film, the grout was stained black in some places, there was a combination of grease and food debris that had been pushed up against the baseboards behind all the appliances and stainless-steel shelving units. -The warming oven, oven/stove combination, and the two convection ovens had a large amount of burned and baked-on food inside and had a greasy film on the outside of them. -Stainless steel shelves under the griddle, steam table, baking station, by the two-compartment vegetable refrigerator had food debris and a greasy-dust film on them. -The sandwich/salad refrigerator doors had dried food particles and were greasy to the touch. Inside of refrigerator had a moderate amount of food debris on the bottom shelf. Observation of Cook1 on 10/01/24 at 12:30 PM revealed he plated food for the noon meal and used the same gloved hands (from handling the used fryer handles and spatula) to take a grilled cheese sandwich off the griddle with a spatula and holding the top of the sandwich, picked up a hamburger on a bun made by Cook2 and placed it on a plate with chicken nuggets and French fries. He then used his gloved hands to put the chicken nuggets and French fries on a different plate. Observation of Cook3 on 10/01/24 at 12:45 PM revealed she was preparing hamburger and other sandwiches on the cutting board area of the sandwich/salad table. With her gloved hands reached into the refrigerator underneath that table to retrieve raw hamburgers to put on the griddle, took chicken nuggets and French fries and put them in the fryer. Put together hamburgers with buns and condiments. She took a plastic container from the clean dish rack and put ground chicken in it. She then opened two packages of mayonnaise and added it to the ground chicken. She combined the chicken and mayonnaise and used the same gloved hands to mix it together. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265863	A. Building B. Wing	10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tiffany Springs Rehabilitation & Health Care Cente	9191 N Ambassador Drive Kansas City, MO 64154

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation and interview of Cook2 on 10/01/24 at 1:00 PM revealed with gloved hands she was labeling the individual containers on the sandwich/salad table, went to the dish rack, and retrieved a large metal mixing bowl, stopped back at the sandwich/salad table and took four hard boiled eggs out and went to the counter near the two-compartment vegetable sink. She took boiled macaroni from a different container and placed it in the mixing bowl, chopped the eggs, and added those to the bowl. She mixed those ingredients with her gloved hands. She stated she was not aware she should not have used her gloved hands to mix the macaroni salad ingredients together. She did not remember if she had received any food safety education. During an interview on 10/02/24 at 1:00 PM, Cook3 revealed it was a usual practice to use her gloved hands to handle food. She was not aware she should have used utensils or used new uncontaminated gloves before she touched each food. She could not remember if she had received any education on safe food handling practices when she had been hired. She knew she had not received any recently. During an interview on 10/02/24 at 1:30 PM the Dietary Manager (DM) revealed he was aware the kitchen was not kept in a sanitary manner. He stated he was aware the cooks' used gloves, but thought they used utensils and not their gloved hands to handle food. He stated he had just been hired as the DM in May 2024 and the kitchen looked better now than before. He stated he was in the process of making up new cleaning sheets. He stated the condenser for the walk-in freezer required maintenance to fix the leak, resulting in ice build-up.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32513 Based on interview, record review, and review of facility policy, the facility failed to document the death of a resident and include a physician order to release the body for one of one resident (Resident (R) 115) reviewed for death of 27 sample residents. This failure had the potential for residents to have a medical record that did not reflect care provided by the facility. The facility census was 116. Findings include: Review of a facility's policy titled, Charting and Documentation, dated ,d+[DATE], revealed .Chart all pertinent changes in the resident's condition, reaction to treatments, medications, etc., as well as routine observations .Be concise, accurate, and complete and use objective terms. Document only the facts .Death of a Resident .Pertinent information before death. (i.e., symptoms, vital signs, treatment, etc.) .Date and time of death .Name of physician notified and when notified .Name of funeral home, time notified and by whom . When and to whom the resident is released .Disposition of medications and personal belongings .Time of Coroner Notification . Review of the Admission Record located in the Profile tab of the EMR, revealed R115 was admitted to the facility on [DATE] and died on [DATE]. R115 was admitted with diagnoses that included a lumbar (lower end of the spine) fracture, congestive heart failure, and COVID-19 prior to his death. Review of a Nursing Progress Note, dated [DATE] at 5:42 AM and located under the Progress Notes tab of the EMR, revealed At 0400 (4:00 AM), while assessing the patient's vital signs due to respiratory distress and concerns for post COVID-19 complications, the patient's oxygen saturation was persistently below 90%, despite interventions. After increasing the oxygen flow to 4 liters via nasal cannula (NC), the patient's oxygen saturation stabilized at 90%. However, the patient exhibited audible gurgling sounds upon inspiration, indicative of fluid accumulation in the airways, and appeared visibly distressed with labored breathing. The patient's granddaughter (name withheld) was informed of the patient's condition and expressed the family's wishes to avoid hospitalization despite worsening respiratory status. The family has requested continued care in the current setting, considering hospice. There was no further documentation in the Nursing Progress Notes regarding what occurred after 4:00 AM with R115. During an interview on [DATE] at 12:56 PM, Assistant Director of Nursing (ADON) 1 stated, [R115] had COVID, fell multiple times, his body was started shutting down. He ended up going to a funeral home that was far away. ADON1 further stated, When the aide went into transfer him, his eyes rolled back in his head and the family was notified. ADON1 was asked why a Nursing Progress Note was not written regarding this change in condition. ADON1 stated, Absolutely a note should have been written, 100%. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 1:11 PM, the Medical Director stated, I remember him. He was declining fast; we needed a family meeting right away. I barely made it back to the facility. He was not with it enough to know if he wanted to be on hospice or not. The granddaughter was active in his care and wanted him to be comfortable. The Friday before, he did not want to go on dialysis and no aggressive measure. I wrote the comfort measures order that day. I was concerned that hospice was not going to make it before he passed. The nurse was unable to get the medication out of the emergency kit (e-kit) before he passed away. The Medical Director was asked about the lack of documentation regarding what occurred with R115 at the end of his life. The Medical Director stated, I agree that a note should have been written by nursing even though I was driving at the time he passed, I was notified. I should have put an order in to release the body to the funeral home.