STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065399	A. Building B. Wing	03/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rio Grande Rehabilitation and Healthcare Center	39 Calle Miller LA Jara, CO 81140

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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 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** 46849 Based on interviews and record review, the facility failed to incorporate recommendations from the preadmission screening and resident review (PASRR) level II determination and evaluation from the State Mental Health Agency in the case of residents with serious mental illness or a related condition for one (#31) of three residents reviewed for PASRR out of 23 sample residents. Specifically, the facility failed to arrange and incorporate recommendations from the PASRR level II notice of determination for Resident #31. Findings include: I. Resident status Resident #31, age 73, was admitted on [DATE]. According to the March 2024 computerized physician orders (CPO), diagnoses included bipolar disorder, anxiety and Huntington's disease (a genetic disease causing progressive degeneration of the nerve cells in the brain). The 1/7/24 minimum data set (MDS) assessment revealed the resident had a moderate cognitive impairment with a brief interview for mental status (BIMS) score of 12 out of 15. The assessment revealed the resident had been identified as having a level II PASRR. II. PASRR level II notice of determination for MI (mental illness) evaluation and facility failures The PASRR level II, dated 12/5/23, included the evaluation which revealed the resident had been evaluated for mental illness (MI) due to a qualifying diagnosis of bipolar disorder. Specialized services were recommended to include psychiatric case consultation (psychiatry) and individual therapy. The PASRR revealed the resident had wanted to see a rheumatologist for her rheumatoid arthritis. The resident wanted to see the specialist to determine options for her pain and contracted hands related to rheumatoid arthritis. The PASRR evaluator determined there was insignificant evidence to support a diagnosis of Huntington's disease and the facility was to rule out the inaccurate diagnosis and remove it from the resident's medical record to ensure she received accurate treatment and care. III. Record review (continued on next page)

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

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The comprehensive care plan, revised 4/15/23, revealed the resident had impaired neurological status related to Huntington's disease. Interventions included monitoring labs and diagnostic tests per physician orders. The resident had impaired cognitive functioning with confusion, disorganized thinking and incoherent and irrelevant conversations related to Huntington's disease. -The care plan failed to include a PASRR focused care plan. The March 2024 CPO revealed the following physician orders: -Venlafaxine (Effexor) (antipsychotic) 150 MG (milligrams)-give one tablet by mouth one time a day for unspecified psychosis-ordered on 10/24/23. -Abilify (antipsychotic) 5 MG-give one tablet by mouth one time a day for depression ordered on 2/17/23. -No orders for a rheumatologist were located. -A review of progress notes dated 12/01/23 to 3/26/24 failed to reveal any PASRR progress notes indicating the status of the PASRR recommendations. No PASRR progress notes showing communication with the State Mental Health Agency regarding a delay or inability to follow the recommendations were located. Physician visit notes dated 3/31/22 revealed the resident had a previous diagnosis of Huntington's disease. -There was no evidence of chorea movements (involuntary, irregular, or unpredictable body movements) consistent with the diagnosis. -Physician visit notes dated 6/26/23 to 3/25/24 had the diagnosis of Huntington's disease included in the resident's diagnosis list despite the physician's note on 3/31/22 and PASRR recommendations made on 12/5/23. IV. Staff interviews The medical director (MD) was interviewed on 3/25/24 at 11:08 a.m. He said Resident #31 did not present with the chorea movements (involuntary, irregular, or unpredictable body movements) consistent with a diagnosis of Huntington's disease. It was not his opinion she suffered from Huntington's disease and her spastic movements were not classic for that diagnosis. He had not requested a genetic panel to officially rule out the diagnosis and he had not been made aware she had requested to be seen by a rheumatologist. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The social services director (SSD) was interviewed on 3/25/24 at 1:42 p.m. She said the process for managing the recommendations made on the level II PASRR were to advise the resident of the recommendations. If the resident refused specialized services, a progress note and an update to the care plan were made. The MD managed the psychotropic medications and the facility worked with an external behavioral health agency for the psychological services. If any services on the PASRR required outside referrals, those referrals went to the medical records (MR) clerk and he scheduled the appointments. The PASRR recommendations on the level II were to provide the services identified. If they were refused by the resident or could not be met, the SSD notified PASRR and made a progress note. She said it was important to meet the recommendations to ensure the resident's needs were being met. If the recommendations were not met, it could result in increased behaviors from the resident. The SSD said in regard to the recommendations for Resident #31, the resident had refused therapy and the MD was managing her psychotropic medications. The SSD did not know if a referral had been received for a rheumatologist or if an appointment had been made. The SSD did not know what had been done regarding correcting the resident's diagnosis of Huntington's disease. The MR was interviewed on 3/25/24 at 2:58 p.m. He said he had been in his position since September of 2023. He had not received any referrals or made any appointments for Resident #31 to be seen by a rheumatologist or to have any testing related to her diagnosis of Huntington's disease. The corporate social services resource (CSR) was interviewed on 3/26/24 at 9:55 a.m. He said he had provided education to the SSD on PASRR since she had taken the position in October 2023. The PASRR recommendations made were for the facility to follow through on the services. If the recommendations could not be met or the resident refused, communication should be made with the State Mental Health Agency. The SSD was to make a PASRR progress note and update the resident's care plan. The director of nursing (DON) was interviewed on 3/26/24 at 11:39 a.m. She said there was no process of communication between herself and social services regarding PASRR recommendations. If the PASRR had recommendations requiring the DON's assistance, the SSD should be passing on that information. She was not aware of the recommendations for Resident #31. The DON did not believe the resident suffered from Huntington's disease based on her body movements being inconsistent with the diagnosis. She did not know why the diagnosis had never been changed in the records. If a resident had an inaccurate diagnosis it could affect the treatments the resident received and the care provided to the resident.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48114 Based on record review and interviews, the facility failed to ensure proper treatment and assistive devices to maintain vision and hearing abilities for two (#54 and #40) of three residents reviewed for vision and hearing out of 23 sample residents. Specifically, the facility failed to ensure: -Resident #54 had an eye exam; and, -Resident #40 obtained necessary hearing devices. Findings include: I. Facility policy and procedure The Care of Visually Impaired Resident policy, revised March 2021, was received by the nursing home administrator (NHA) on 3/25/24 at 11:56 a.m. It revealed in pertinent part, Residents with visual impairment will be assisted with activities of daily living as appropriate. Assistive devices to maintain vision include glasses, contact lenses, magnifying lenses and any other devices used by the resident to assist with visual impairment. While it is not required that our facility provide devices to assist with vision, it is our responsibility to assist the resident and representatives in locating available resources (Medicare, Medicaid or local organizations), scheduling appointments and arranging transportation to obtain needed services. II. Resident #54 A. Resident status Resident #54, age 66, was admitted on [DATE]. According to the March 2024 computerized physician orders (CPO), the diagnoses included type II diabetes mellitus. The 2/11/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 13 out of 15. She required partial/moderate assistance with showering/bathing self, upper body dressing, lower body dressing, putting on and taking off footwear, personal hygiene, lying to sitting on side of bed, sitting to standing, chair/bed to chair transfer, toileting transfer and tub/shower transfer. It indicated the resident had adequate vision (with glasses or other visual appliances). B. Resident interview (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #54 was interviewed on 3/20/24 at 2:11 p.m. She said she came in with glasses but said she did not wear them because she could not see out of them. She said she could see up close but could not see far away. Resident #54 said she would like to have her eyes checked. Resident #54 said she had not been offered the opportunity to see an eye doctor. C. Record review The care plan for vision documented Resident #54 had visual impairment and used eyeglasses as needed. Interventions included arranging a consultation with the eye care practitioner as needed; encouraging the resident to keep their room free of clutter with personal belongings; encouraging the resident to wear glasses; assist with applying as needed; occupational therapy (OT), physical therapy (PT) and speech therapy (ST) evaluation and treat as needed; and placing call bell, water pitcher, and personal belongings in the same place. C. Staff interviews The social service director (SSD) was interviewed on 3/25/24 at 1:32 p.m. She said she was not responsible for arranging medical and ancillary appointments. She said the medical records director (MRD) was in charge of appointments. She said if the resident requested to be seen for an eye exam then she would let medical records know. She said she was not aware that the resident needed to be seen for an eye exam and did not know the last time she had her eyes checked. She said she would let the medical records staff know so that he could make an appointment for the resident to be seen. The MRD was interviewed on 3/25/24 at 2:58 p.m. He said he was responsible for scheduling residents for medical and ancillary appointments. He said if the resident notified him that they needed to be seen he would call and get the resident scheduled as soon as possible. He said once the appointment was scheduled he would write the appointment date in the transportation book. He said he would then notify the resident verbally when their appointment was. He said sometimes it took a while before someone would be scheduled for ancillary services. He said depending on what services the resident needed some appointments were way out a month or further. He said he was not aware Resident #54 needed to be seen by the eye doctor. The director of nursing (DON) was interviewed on 3/26/24 at 11:29 a.m. She said MRD was responsible for scheduling medical and ancillary appointments. She said residents should be referred for ancillary services as often as the resident requested them. She said if the resident reported having issues with not seeing then an appointment should have been made as soon as possible. She said she did not know if the resident had been seen for an eye exam. She said it was a problem that the resident had not been seen by the eye doctor and said she would look into it. 46849 III. Resident #40 A. Resident status (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #40, age under 65, was admitted on [DATE]. According to the March 2024 CPO, diagnoses included mild cognitive impairment, anxiety, depression, obsessive compulsive disorder and mild intellectual disabilities. The 2/11/24 MDS assessment documented the resident was cognitively intact with a BIMS score of 14 out of 15. The resident had difficulty hearing in noisy settings or when people spoke softly. The resident wore hearing aids. B. Resident interview and observation The resident was interviewed on 3/20/24 at 2:20 p.m. He stated he could not hear very well and not being able to hear increased his anxiety. When he felt anxiety, he would pick at his skin until the skin bled. The resident said he could not understand people when the people attempted to speak to him. He had a hearing exam last year but did not know exactly when or the status of his new hearing aids. The social services director (SSD) had not given him any updates on his new hearing aids. During the interview, the resident did not have either hearing aids in his ears. He struggled to hear and had to be spoken to loudly and on his left side. C. Record review The ancillary care plan, revised 2/28/23, revealed the resident had decreased hearing and required the use of hearing aids. Interventions were to ensure hearing aids were in place. A review of the progress notes from 2/1/24 to 3/24/24 revealed: Health status progress note dated 2/22/24 revealed the resident had started ear drops after complaining he could not hear very well. Alert charting dated 2/26/24 revealed the resident's sister called the facility and requested the resident be sent to the emergency room (ER) for his difficulty hearing. She wanted the ER to clean his ears because he could still not hear even after the facility had cleaned his ears. The nurse went to speak to the resident and the resident said he wanted to go to the hearing clinic to have his hearing aides turned up because he could not hear. The nurse advised the resident if he used his hearing aids, he would be able to hear. The nurse helped the resident put his left hearing aid into his ear and the right hearing aid was missing. Order administration note dated 3/2/24 revealed the resident had been sitting in the front lobby crying all day and expressed feelings of anxiety. Order administration note dated 3/3/24 revealed the resident had been sitting in the front lobby crying all day. He requested medication for his anxiety. He told the nurse he felt like he was going crazy because he could not hear. -No further progress notes related to the residents' difficulty hearing or missing hearing aids. A review of the certified nursing aide (CNA) documentation failed to reveal the resident was receiving any assistance with his hearing aids. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the audiology notes revealed: A letter from the audiologist dated 9/12/23 with the resident's hearing test results documented the resident had profound hearing loss in his right ear and mild hearing loss in his left ear. The audiologist included recommendations for digital hearing aids in order to be able to adjust the instrument for the various environments requiring the resident to need hearing aids. An estimate was attached and an insurance claim. The audiologist had submitted the insurance claim on 9/12/23. An audiology visit note dated 12/7/23 revealed the resident had his ears cleaned. He asked about his new hearing aids and was told by the audiologist approval was still needed for the payment. -No additional audiology notes were located. D. Staff interviews CNA #1 was interviewed on 3/25/24 at 10:22 a.m. She said Resident #40 had behaviors of scratching himself when he became anxious. The resident only had one hearing aid, the left one. He had lost the right hearing aid and was waiting for new hearing aids. CNA #1 said the resident was very hard of hearing and if he was not looking at the staff, he required tactile cueing to be directed to who was speaking to him. The difficulty with hearing caused the resident to misunderstand the staff at times and this increased his behaviors. Registered nurse (RN) #1 was interviewed on 3/25/24 at 11:40 a.m. She said the resident used an as needed (PRN) Lorazepam for anxiety when he would scratch himself. He had a developmental delay and could be challenging to redirect. She thought the resident had a right hearing aid and was missing the left hearing aid. The staff had to speak very loudly when talking to him. She did not know if being unable to hear affected his behaviors. The SSD was interviewed on 3/25/24 at 1:42 p.m. She said Resident #40 had very impaired hearing loss. He had seen the audiologist in December 2023. She worked with an organization who provided grants to pay for ancillary services but had not reached out to the organization for Resident #40's hearing aids. She was not aware if the audiologist had submitted any insurance claims, she believed it was her job to submit the claim. The SSD was not familiar with the State program for Medicaid reciprocate residents called the post eligibility treatment of income (PETI). She said the prior SSD had used the PETI program for payment for resident's ancillary services but she did not know how the PETI program worked. The grant organization she worked with would approve all or part of the bill for assistive devices like hearing aids, glasses and dentures. If the organization did not approve the entire amount, the resident or the responsible party would have to pay the difference. If the resident or responsible party could not afford to pay, she would encourage saving money. The resident would go without an assistive device in the meantime. The SSD did not believe Resident #40's hearing loss affected his behaviors. The SSD said the negative outcome for residents having to wait for devices were health declines and impaired psychosocial wellbeing. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The corporate social services resource (CSR) was interviewed on 3/26/24 at 10:54 a.m. He said the residents or the responsible parties did not have to save up money to pay for assistive devices. The facility had a change of ownership and had to become reestablished with the State PETI program again. In the meantime, an external organization used grants for payment and were assisting with resident's ancillary bills. If a bill had not been approved in full, the facility would help with paying the difference. The director of nursing (DON) was interviewed on 3/26/24 at 11:39 a.m. She said Resident #40 did not currently have functional hearing aids. She was not sure of the status of his new hearing aids. He had very impaired hearing and the staff would have to come very close to him to be heard. The staff having to yell at him in order for him to hear caused the resident agitation. The DON did not know who held onto the resident's hearing aides or if the staff helped him put his hearing aids in.

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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** 31820 Based on observations, record review and interviews, the facility failed to ensure the resident environment remained as free of accident hazards as possible for one (#26) of three residents reviewed for accidents/hazards out of 23 sample residents. Specifically, the facility failed to ensure Resident #26 had an order for a medication (icy hot) found at his bedside. Findings include: I. Resident status Resident #58, age below 65, was admitted on [DATE]. According to the March 2024 computerized physicians orders (CPO), diagnoses included autistic disorder, dementia and fibromyalgia. The 1/12/24 minimum data set (MDS) assessment revealed the resident's cognitive status was intact with a brief interview for mental status (BIMS) score of 15 out of 15. II. Observation and interview The icyhot was at the bedside on 3/20/24 at 9:45 a.m. The icy hot was at the bedside on 3/21/24 at 10:00 a.m. Registered nurse (RN) #2 said icyhot was considered a medication. She said Resident #26 did not have an order for the icy hot nor did he have an assessment for self administration of the medication. III. Record review The resident did not have an order for icy hot. IV. Staff interview The director of nursing (DON) was interviewed on 3/21/24 at 10:10 a.m. She said icyhot was considered a medication and required a physician's order. She said Resident #26 did not have an order. She said the medication had been removed and the facility would call the provider for an order for an as needed muscle cream. She said she would have training with staff to identify medications and if any were found to turn into nursing when found.

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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 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 31820 Based on record review and interviews, the facility failed to complete a performance review of every nurse aide at least once every 12 months and provide regular in-service education based on the outcome of these reviews for four of four staff reviewed. Specifically, the facility had not completed annual performance reviews and/or provided regular in-service education based on the outcome of the reviews for certified nurse aide (CNA) #2, CNA #3, CNA #4 and CNA #5. Findings include: I. Record review CNA #2 (hired on 5/24/19), CNA #3 (hired on 12/8/10), CNA #4 (hired on 7/22/10) and CNA #5 (hired on 4/29/14) did not have an annual performance review completed. The CNAs did not have an in-service education plan based on the outcome of the review. II. Interview The nursing home administrator (NHA) was interviewed on 3/21/24 at 1:10 p.m. She said she could not locate the performance reviews for CNA #2, CNA #3, CNA #4 and CNA #5. She said she was not aware the performance reviews needed to include a regular in-service plan based on the outcome of these reviews. She said going forward she would ensure the performance reviews were completed annually to ensure best care was being delivered to the residents.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46849 Based on record review and interviews, the facility failed to ensure three (#36, #40 and #49) of five residents were free from unnecessary psychotropic medications out of 23 sample residents. Specifically, the facility failed to: -Implement effective individualized behavior monitoring in the medical record to determine the efficacy of psychoactive medications for Residents #36, #40 and #49; and, -Ensure consents to review the risks versus benefits were in place prior to administration of psychotropic medications for Residents #40 and #49. Findings include: I. Facility policy The Psychopharmacological policy, dated July 2022, was provided by the nursing home administrator (NHA) on 3/25/24 at 11:57 a.m. It read in pertinent part: Drugs in the following categories are considered psychotropic medications and are subject to prescribing, monitoring, and review requirements specific to psychotropic medications: -Anti-psychotics, antidepressants, anti-anxiety medications; and hypnotics. Residents, families and/or the representative are involved in the medication management process. Psychotropic medication management includes indications for use and adequate monitoring for efficacy and adverse consequences. Non-pharmacological approaches are used (unless contraindicated) to minimize the need for medications, permit the lowest possible dose, and allow for discontinuation of medications when possible. II. Resident #36 A. Resident status Resident #36, age under 65, was admitted on [DATE]. According to the March 2024 computerized physician order (CPO), diagnoses included stroke, anxiety disorder and depressive disorder. The 2/4/24 minimum data set (MDS) assessment documented the resident was cognitively intact with a brief interview of mental status (BIMS) score of 15 out of 15. No behaviors were indicated. B. Record review (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The psychosocial care plan, revised 8/3/23, revealed the resident took psychotropic medications (Amitriptyline and Seroquel) related to anxiety and depression. The resident had a psycho-social well being deficit related to anxiety and depression. He had a impaired psychiatric mood related to his stroke. Interventions included offering a non pharmacological behavior intervention prior to the behavior medication administration such as offering him fluids/snacks, toileting, one-on-one activities, repositioning, and to re approach him at a later time. Staff were to monitor for signs of mood changes or distress, observe and report any changes in mental status caused by situational stressors. Behavior monitoring initiated 1/18/24 for Amitriptyline (antidepressant) for crying and Seroquel (antipsychotic) for agitation. The March 2024 CPO revealed the following physician orders: Seroquel 50 milligram (MG)- give one tablet a day for other depressive episodes-ordered on 4/3/23; Amitriptyline150 MG- give two tablets a day for other depressive episodes-ordered on 5/4/23; Behavior monitoring for Amitriptyline for crying outbursts-ordered on 8/2/23; Offer non pharmacological behavior interventions prior to behavior medication administration. Non pharmacological behavior interventions that are effective include: offer fluids/snacks, toileting, one-on-one activity, repositioning, and to re approach at a later time-ordered on 8/4/23; and, Behavior monitoring for Seroquel for agitation-ordered on 1/4/24. -A review of the certified nurse aide (CNA) behavior monitoring from 1/1/24 to 3/24/24 failed to reveal any episodes of agitation or tearfulness. A review of the resident's medication administration records (MAR) and treatment administration records (TAR) from 1/1/24 to 3/24/24 revealed: Behaviors indicated related to Amitriptyline as occurring on 1/8/24. -No behaviors were indicated related to Seroquel in January, February, or March 2024. Non pharmacological interventions were tried on 1/1/24, 1/2/24, 1/8/24, 1/14/24, 1/15/24, 1/22/24, 1/23/24, 1/25/24, 1/26/24, 1/28/24, 1/29/24, 2/4/24, 2/5/24, 2/7/24-2/12/24, 2/18/24, 2/20/24 and 2/25/24. -However, the documentation failed to indicate what interventions were tried and what medication the interventions were associated with. -There were no behaviors observed indicated in the resident's progress notes from 1/1/24 to 3/24/24. Non pharmacological interventions indicated in the MAR and TAR were not documented in the progress notes. C. Staff interviews (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	CNA #1 was interviewed on 3/25/24 at 10:22 a.m. She said the CNAs documented behaviors in the point of care (POC) system for CNA charting. If the behavior was not part of the generalized list of behaviors, the CNA would notify the charge nurse verbally for the charge nurse to document. If the social services director (SSD) wanted the staff to monitor for a specific behavior or use a specific intervention, the SSD would verbally let the staff know of the expectation. She said the behaviors the staff were monitoring for Resident #36 were tearfulness and emotional outbursts. The resident struggled with being young and having to live in a nursing home related to his stroke and causing him to become tearful. She was not aware of the non pharmacological interventions for the resident. Registered nurse (RN) #1 was interviewed on 3/25/24 at 11:40 a.m. She said the nurses documented the resident behaviors on the MAR in the resident's chart. The nurse made a progress note indicating the behavior and interventions tried. She said Resident #36 had behaviors of tearfulness. He struggled with adjustment to his deficits and placement. She used distractions when he was tearful by engaging him in stretching when he came to the nurses station. The SSD was interviewed on 3/25/24 at 1:42 p.m. She said the medical records director (MRD) entered the behaviors in an order for the nurses to document on the MARs. The non pharmacological interventions were a separate order entered by the MRD. Behavior tracking was pulled by the director of nursing (DON) for the psychotropic drug review meeting. Behavior tracking reports were used to determine the efficacy of medications and if the medications needed to be continued. If a resident did not display behaviors in a three month period, the medication associated with those behaviors would be reviewed for a dose reduction or to be discontinued. If the resident was taking multiple medications, a behavior tracker would be initiated for each medication. She did not know if there were separate non pharmacological intervention trackers for each medication. The non pharmacological trackers were used to determine if alternative interventions were successful for the resident. She did not know if the DON reviewed the behavior tracking from the CNA charting for the meeting. The SSD did not have a process for auditing if consents were in place for the medications. She said Resident #36 had behaviors of crying outbursts. The resident had a recent divorce after his stroke and randomly cried regarding the loss of his spouse and his independence. The staff were tracking agitation and crying outbursts. The resident would display agitation regarding having to live in a nursing facility. The SSD did not know if the resident had a dose reduction of any of his medications in the last three months. The MRD was interviewed on 3/25/24 at 2:58 p.m. He said residents taking psychotropic medications required a behavior tracker to be initiated on the MAR within a few days of starting the medication. The nurses gave him the behavior information to include on the tracker. The non pharmacological tracking was a separate order. There should be a non pharmacological tracker for each medication. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The DON was interviewed on 3/26/24 at 11:39 a.m. She said the MRD would consult with the nurses regarding which behaviors needed to be included on the behavior tracker. The non pharmacological tracker did not allow the staff to enter what interventions were tried and successful, the nursing staff entered the interventions in the resident's progress notes. She said the staff were to use a non pharmacological intervention when the resident displayed behaviors to determine if the medication was necessary and if a least restrictive approach could be used. The CNAs were to document behaviors in the POC system but the behaviors on the CNA trackers were generalized and not resident specific. The DON said if the resident displayed a behavior not indicated on the tracker, the CNAs reported the behavior and the intervention to the nurse to document in the resident's progress notes. She said the behavior tracking was used to determine the efficacy of the psychotropic medication. If a resident had not displayed behaviors in a three month period, the medication should be reviewed for a dose reduction or to be discontinued. III. Resident #40 A. Resident status Resident #40, age under 65, was admitted on [DATE]. According to the March 2024 CPO, diagnoses included mild cognitive impairment, anxiety, depression, obsessive compulsive disorder and mild intellectual disabilities. The 2/11/24 MDS assessment documented the resident was cognitively intact with a BIMS score of 14 out of 15. No behaviors were indicated. B. Record review The psychosocial care plan, revised 1/12/24, revealed the resident took psychotropic medications related to anxiety and depression. The resident had a psycho-social well being deficit related to anxiety and an intellectual disability. The resident exhibited behaviors of skin picking until the skin bled related to an obsessive compulsive disorder. Interventions included offering a non pharmacological behavior interventions prior to the behavior medication administration such as offering him a calm approach, positive reassurance, one-on-one, a quiet environment, fluids/snacks, diversion activities, re-orientation, and redirection. Behavior monitoring initiated 1/18/24 for Lexapro for crying outbursts and Seroquel for scratching skin. The March 2024 CPO revealed the following physician orders: Quetiapine (Seroquel) 50 MG- give two tablets for anxiety-ordered on 10/3/23; Lexapro (antidepressant) 10 MG- give one a day for depression- ordered on 10/24/23; Offer non pharmacological behavior interventions prior to behavior medication administration. Non pharmacological behavior interventions that are effective include: calm approach, positive reassurance, one-on-one, quiet environment, offering of fluids/snacks, diversion activities, reorientation, and redirection-ordered on 12/3/23; Behavior monitoring for Lexapro (antidepressant) for crying outbursts/losing, forgetting, or misplacing items-ordered on 1/16/24; (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Behavior monitoring for Seroquel for scratching skin until bleeding-ordered on 1/16/24; Lorazepam (Ativan) (antianxiety) 0.5 MG- give one tablet every 6 hours for 14 days PRN for anxiety- ordered on 3/2/24 and discontinued 3/16/24; and, Lorazepam 0.5 MG- give two tablets every 6 hours for 14 days PRN for anxiety-ordered on 3/17/24. -A review of the CNA behavior monitoring from 1/1/24 to 3/24/24 failed to reveal any episodes of frustration, anger at others or scratching and picking at self. A review of the resident's MAR and TAR from 1/1/24 to 3/24/24 revealed: Behaviors indicated related to Seroquel as occurring on 1/22/24, 1/29/24, 1/31/24, 2/25/24 and 3/4/24. Behaviors indicated related to Lorazepam as occurring on 1/2/24, 2/1/24, 2/3/24, 2/7/24, 2/8/24, 2/10/24, 2/14/23, 3/2/24, 3/3/24, 3/4/24, 3/15/24, 3/17/24, 3/21/24, 3/22/24 and 3/23/24. -No behaviors were indicated related to Lexapro in January to March 2024. Non pharmacological interventions were tried to 1/1/24, 1/14/24, 1/15/24, 1/22/24, 1/28/24, 1/29/24, 2/2/24, 2/3/24, 2/5/24, 2/9/24-2/12/24, 2/17/24, 2/19/24, 2/25/24, 3/4/24, 3/9/24, 3/10/24, 3/11/24, 3/18/24-3/21/24 and 3/23/24-3/25/24. -However, the documentation failed to indicate what interventions were tried and what medication the interventions were associated with. Progress notes reviewed from 1/1/24 to 3/24/24 revealed: Behaviors marked as observed on 1/3/24, 1/7/24, 1/8/24, 1/17/24, 1/21/24, 1/22/24, 1/29/24, 1/31/24, 2/7/24-2/10/24, 2/18/24, 2/22/24, 2/25/24, 2/27/24, 2/28/24, 3/1/24, 3/4/24, 3/8/24, 3/15/24, 3/22/24 and 3/24/24. -However, no description of the behaviors were included in the note. Lorazepam PRN given on 3/2/24, 3/3/24, 3/4/24, 3/16/24, 3/17/24, 3/22/24 and 3/24/24. Progress notes documented the PRN was effective. -However, no behaviors or non pharmacological interventions were documented. -No consents that reviewed the risks versus benefits associated with taking the medications were located for the Lorazapem. C. Staff interviews CNA #1 was interviewed on 3/25/24 at 10:22 a.m. She said Resident #40 had behaviors of scratching himself when he became anxious. The resident would perseverate on a concern and it was difficult to redirect him. She said the Lorazeam was effective when he would perseverate. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	RN #1 was interviewed on 3/25/24 at 11:40 a.m. She said the resident used PRN Lorazepam for anxiety and when he would scratch himself. He had a developmental delay and could be challenging to redirect. RN #1 said she did not use non pharmacological interventions with Resident #40 because his behaviors would get out of control. The SSD was interviewed on 3/25/24 at 1:42 p.m. The SSD said the resident took PRN Lorazepam for anxiety and the behavior and non pharmacological interventions needed to be documented to determine if the medication needed to be continued as a PRN or become scheduled. Lorazepam was a medication which required a consent from the resident or the resident's responsible party prior to administration. She gave the consent forms to the MRD to scan into the resident's medication record. The DON was interviewed on 3/26/24 at 11:39 a.m. The DON said the SSD was responsible for obtaining the consents prior to the administration of the medications but the DON did not have a process to check to ensure the consents were in place. When a PRN medication was used, behaviors needed to be documented along with the non pharmacological interventions tried before the administration of the medication. She said the documentation was entered into the resident's progress notes. If a resident was on multiple psychotropic medications then there should be multiple non pharmacological intervention trackers because each medication was given for specific behavior. The DON said if there were not coinciding intervention trackers, the facility would not be able to determine which interventions were effective with which behavior. IV. Resident #49 A. Resident status Resident #49, age 93, was admitted on [DATE]. According to the March 2024 CPO, diagnoses included dementia with behavioral disturbances. The 1/7/24 MDS assessment documented the resident was severely cognitively impaired and unable to complete the assessment. The staff interview revealed the resident had severely impaired decision making. No behaviors were indicated. B. Record review The psychosocial care plan, revised 1/9/24, revealed the resident took psychotropic medications related to mood stabilization and insomnia. The resident had a psycho-social well being deficit related to acute onset of delirium and dementia. Behavior monitoring initiated 1/9/24 for Seroquel for yelling. The March 2024 CPO revealed the following physician orders: Seroquel 25 MG- give one tablet twice a day for dementia with behavioral disturbances-ordered on 1/22/24 and discontinued 3/18/24; Seroquel 50 MG- give one tablet twice a day for dementia with behavioral disturbances-ordered on 3/19/24. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Offer non pharmacological behavior interventions prior to behavior medication administration. Non pharmacological behavior interventions that were effective included: calm approach, positive reassurance, one-on-one, quiet environment, offering of fluids/snacks, diversion activities, reorientation, and redirection- ordered on 12/3/23; and, Behavior monitoring for Seroquel for yelling- ordered on 8/31/23. -A review of the CNA behavior monitoring from 1/1/24 to 3/24/24 failed to reveal any episodes of frustration or anger at others. A review of the resident's MAR and TAR from 1/1/24 to 3/24/24 revealed: Behaviors indicated related to Seroquel as occurring on 1/3/24 and 3/4/24. Non pharmacological interventions were tried on 1/1/24, 1/3/24, 1/8/24, 1/14/24, 1/15/24, 1/28/24, 1/29/24, 2/5/24, 2/10/24, 2/11/24, 2/12/24, 2/19/24, 2/25/24, 3/4/24, 3/9/24, 3/10/24, 3/11/24, 3/18/24-3/21/24 and 3/23/24-3/25/24. Progress notes reviewed from 1/1/24 to 3/24/24 revealed: Behaviors marked as observed on 1/3/24. The resident was yelling out where am I. Staff told her where she was and took the resident to breakfast without complications. Behaviors marked as observed on 3/17/24. The resident was yelling she was hungry and going back and forth to her room. No non-pharmacological interventions were documented. -No consents to review the risks versus benefirs of the medication were located for Seroquel. C. Staff interviews CNA #1 was interviewed on 3/25/24 at 10:22 a.m. She said Resident #49 had advanced dementia and had behaviors of yelling out. She frequently yelled out for food even after eating due to her short term memory deficits. She could be redirected with food or to an activity. RN #1 was interviewed on 3/25/24 at 11:40 a.m. She said the resident had behaviors of yelling out for food and propelling herself in and out of her room. If the staff provided her with food or candy, the resident could be redirected. The SSD was interviewed on 3/25/24 at 1:42 p.m. She said the resident yelled out when she wanted food or wanted to lie down. The resident was taking Seroquel for her yelling out. The resident yelled out when she was anxious. The behavior tracker should specify what yelling out behavior was being tracked regarding the Seroquel. The SSD said sometimes a resident might be yelling out for an unmet need and an unmet need was not a behavior requiring medication. The staff should anticipate unmet needs to prevent yelling out. Seroquel was a medication which required a consent from the resident or the resident's responsible party prior to administration. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The DON was interviewed on 3/26/24 at 11:39 a.m. She said if a resident's behavior tracker only indicated a behavior such as yelling out, the tracker failed to specify if the yelling was for an unmet need or an uncontrollable behavior. If a resident communicated by yelling, this would not be a behavior to administer an antipsychotic medication for.

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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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48114 Based on interviews and record review, the facility failed to assist a resident in obtaining routine or emergency dental services, as needed for one (#54) of three residents reviewed for dental care out of 23 sample residents. Specifically, the facility failed to ensure dental services were offered to Resident #54. Findings include: I. Facility policy and procedures The Dental Services policy, revised December 2016, was received by the nursing home administrator (NHA) on 3/25/24 at 11:56 a.m. It revealed in pertinent part, Routine and emergency dental services are available to meet the resident's oral health services in accordance with the resident's assessment and plan of care. Routine and 24 hour emergency dental services are provided to our residents through: -A contract agreement with a licensed dentist that comes to the facility monthly; -Referral to the resident's personal dentist; -Referral to community dentists; or -Referral to other health care organizations that provide dental services. All dental services provided are recorded in the resident's medical record. A copy of the resident's dental record is provided to any facility to which the resident is transferred. II. Resident #54 A. Resident status Resident #54, age 66, was admitted on [DATE]. According to the March 2024 computerized physician orders (CPO), the diagnoses included type II diabetes mellitus. The 2/11/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 13 out of 15. She required partial/moderate assistance with showering/bathing self, upper body dressing, lower body dressing, putting on and taking off footwear, personal hygiene, lying to sitting on side of bed, sitting to standing, chair/bed to chair transfer, toileting transfer and tub/shower transfer. It indicated the resident had no broken or loose teeth, loose or cracked teeth and no difficulty with mouth pain or discomfort. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	B. Resident interview Resident #54 was interviewed on 3/20/24 at 2:11 p.m. Resident #54 said she had not seen the dentist since she arrived on 11/3/23. She said she would like to see the dentist as she reported to the surveyor having tooth pain. C. Record review Review of the admission packet under dental services Resident #54 marked to have an initial dental consult dental examination upon admitted d 11/3/23. Review of computerized physician orders revealed dentist and podiatrist as needed with consent dated 11/9/23. -Review of care plan revealed no care plan for person-centered dental service needs. -Review of progress notes from 11/03/23 until 3/26/24 revealed no documentation concerning the initiation or completion of dental care. III. Staff interview The social service director (SSD) was interviewed on 3/25/24 at 1:32 p.m. She said she was not responsible for arranging the appointments for ancillary services. She said the medical records director (MRD) was responsible for arranging medical and ancillary appointments. She said the residents or family members could let her know if they needed to be seen for dental services and she said she would notify the MRD. The SSD said Resident #54 had not been seen by the dentist since her admission on 11/3/23. She said she did not know why the resident was not seen by the dentist. The MRD was interviewed on 3/25/24 at 2:58 p.m. He said he was responsible for medical and ancillary appointments. He said when a resident arrived to the facility that they should have been scheduled for ancillary services as soon as possible. He said within the first week they arrived an appointment should have been made. He said the facility had a mobile dentist who started coming to the facility. He said he thought Resident #54 was seen by the dentist. He said the mobile dentist had been to the facility on ce and provided services in February 2024. He said the mobile dentist had been scheduled to come to the facility at least once a month. The director of nursing (DON) was interviewed on 3/26/24 at 11:29 a.m. She said the MRD was responsible for scheduling medical and ancillary appointments. She said the facility recently got a new dentist and they were seeing all the residents. She said residents should be seen by the dentist as often as requested. She said the facility started having a mobile dentist come in. She said the last time the mobile dentist came to the facility was two months ago. She said the mobile dentist was going to start seeing all the residents who did not have a regular dentist. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON said she did not know if Resident #54 had been seen by the dentist. She said if the resident had not been seen by the dentist was problematic and would need to check into what happened.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31820 Based on record review and staff interviews, the facility failed to develop and implement policies and procedures related to pneumococcal immunizations for one (#17) of three residents reviewed for vaccinations of 23 sample residents. Specifically, the facility failed to ensure Resident #17 was offered the secondary pneumococcal immunization. Findings include: I. Professional reference The Centers for Disease Control and Prevention (CDC), Pneumococcal Vaccine Recommendations website, revised 9/21/23, retrieved on 3/27/24 from https://www.cdc.gov/vaccines/vpd/pneumo/hcp/recommendations.html read in pertinent part, CDC recommends routine administration of pneumococcal conjugate vaccine (PCV15 or PCV20) for all adults [AGE] years or older who have never received any pneumococcal conjugate vaccine or whose previous vaccination history is unknown: If PCV15 is used, this should be followed by a dose of PPSV23 one year later. The minimum interval is 8 weeks and can be considered in adults with an immunocompromising condition, cochlear implant, or cerebrospinal fluid leak. According to the CDC Recommended Immunization Schedule for Adults Aged [AGE] years or Older, United States, 2023, retrieved on 3/27/23 from https://www.cdc.gov/vaccines/schedules/downloads/adult/adult-combined-schedule.pdf. It read, in pertinent part, The pneumococcal vaccine was to be administered to immunocompetent adults aged [AGE] years or older one dose of 13-valent pneumococcal conjugate vaccine (PCV13), if not previously administered, followed by one dose of 23-valent pneumococcal polysaccharide vaccine (PPSV23) at least one year after PCV13; if PPSV23 was previously administered but not PCV13, administer PCV13 at least one year after PPSV 23. For special situations (see-www.cdc.gov/mmwr/preview/mmwrhtml/mm6140a4. htm): individuals aged 19-[AGE] years with chronic medical conditions (chronic heart excluding hypertension, lung, or liver disease, diabetes), alcoholism, or cigarette smoking: give 1 dose PPSV23. II. Resident #17 A. Resident status Resident #17, over the age of 65, was admitted on [DATE] and readmitted on 7/ 21/19. According to the March 2024 computerized physician orders (CPO), diagnoses included nontraumatic intracerebral hemorrhage (brain bleed). (continued on next page)

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 2/11/24 MDS assessment indicated the resident was not up to date on her pneumococcal vaccination but did not specify a reason. B. Record review The resident had received the Prevnar 23 vaccine on 9/7/16. -The facility did not have evidence of an offer or refusal of the pneumococcal vaccine. III. Staff interviews The minimum data set (MDS) coordinator was interviewed on 3/21/24 at 12:55 a.m. She said she was the person who kept track of the vaccines. She said she did not know the facility had to offer the vaccine annually even if the resident refused. She said she would contact the family to see if they wanted Resident #17 to receive the second pneumococcal vaccine. The director of nursing (DON) was interviewed on 3/21/24 at 1:10 p.m. She said the facility needed to follow CDC guidelines.