STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175220	A. Building B. Wing	10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Onaga Operator, LLC	500 Western Street Onaga, KS 66521

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32360 The facility had a census of 25 residents. The sample included 13 residents, with four reviewed for hospitalization . Based on observation, record review, and interview, the facility failed to provide written notice for a facility-initiated transfer for Resident (R) 16, R24, R4, and R26 or their representatives when they were transferred to the hospital. The facility also failed to notify the Office of the Long-Term Care Ombudsman (LTCO-a public official who works to resolve resident issues in nursing facilities) of R16, R24, R4, and R26's discharge. This placed the residents at risk for uninformed care choices and impaired rights. Findings included: - R16's Electronic Medical Record (EMR) documented R16 had diagnoses of atrial fibrillation (rapid, irregular heartbeat), diastolic heart failure (the left heart ventricle doesn't relax properly between heartbeats), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and pleural effusion (abnormal accumulation of fluid in the lungs). The Quarterly Minimum Data Set (MDS), dated [DATE], documented R16 had moderately impaired cognition and was dependent upon staff for lower body dressing, toileting, and showers. R16 required substantial assistance with personal hygiene, upper body dressing, and transfers. R16 required supervision with ambulation. The Significant Change MDS, dated [DATE], documented R16 had moderately impaired cognition and required substantial assistance from staff for showers, lower body dressing, personal hygiene, transfers, and ambulation was not attempted. R16 required set-up assistance with eating. R16's Care Plan, dated 09/17/24 and initiated on 01/27/21, directed staff to administer medications as ordered, monitor for signs and symptoms of respiratory distress, monitor for edema (swelling), and administer oxygen continuously via nasal cannula (a medical device that provides supplemental oxygen) as ordered. R16's Progress Notes, dated 08/28/24 at 03:39 AM documented R16 was transferred to the hospital. R16's clinical record lacked evidence the resident or representative was provided written notice, or the ombudsman was notified of the hospital transfer. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 09/30/24 at 10:49 AM, observation revealed R16 sat in her recliner in her room. Her eyes were closed and she had her oxygen on. On 10/01/24 at 10:00 AM, Administrative Nurse D verified the LTCO had not been notified when R16 went to the hospital on the above date and verified no written notice was provided to R16 or her representative. Administrative Nurse D stated the social service designee was responsible for notifying the LTCO. On 10/02/24 at 01:41 PM, Social Service X verified she had not provided R16 or her representative with written notice when R16 was transferred to the hospital and stated she was unaware she was supposed to. The facility's Transfer and/or Discharge policy, dated 10/22, documented the resident and/or representative would be provided with a notice in writing, the reason for the transfer or discharge, and a copy would be sent to the State Long Term Care Ombudsman. The facility failed to provide R16 or her representative written notice regarding R16's facility-initiated transfer to the hospital and also failed to notify the LTCO. This placed R16 at risk of uninformed care choices and impaired rights. - R24's Electronic Medical Record (EMR) documented diagnoses of fracture (cracked or broken) of the patella (kneecap), unsteadiness on feet, fracture of the femur (the bone of the thigh or upper hind limb articulating at the hip and the knee). The Quarterly Minimum Data Set (MDS), dated [DATE], documented R24 had severely impaired cognition. R24 required extensive assistance of one staff for dressing, and supervision with bed mobility, toileting, and transfers. R24 had no upper or lower extremity impairment. The Quarterly MDS, dated [DATE], documented R24 had severely impaired cognition. She required partial assistance with toileting and ambulation, and set-up assistance with eating, mobility, and personal hygiene. R24 had lower functional impairment on one side. R24's Care Plan, dated 09/24/24 and initiated on 01/09/23, documented R24 lacked safety awareness and had a history of falls. The update, dated 12/30/22, directed staff to educate the resident and family about safety reminders and what to do if a fall occurs. The plan directed staff to determine the possible root cause of the falls and alter or remove any potential causes of the falls if possible. R24's Progress Notes, dated 12/03/24 at 03:50 PM, documented R24 was transferred to the hospital. R24's clinical record lacked evidence the resident or representative was provided written notice, or the ombudsman was notified of the hospital transfer. On 10/01/24 at 11:18 AM, observation revealed Certified Nurse Aide (CNA) N placed a gait belt around the resident's waist. R24 stood up, pivoted, and sat down in the wheelchair. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/02/24 at 01:41 PM, Social Service X verified she had not provided R24 or her representative with written notice when R24 was transferred to the hospital and stated she was unaware she was supposed to. The facility's Transfer and/or Discharge policy, dated 10/22, documented the resident and/or representative would be provided with a notice in writing, the reason for the transfer or discharge, and a copy would be sent to the State Long Term Care Ombudsman. The facility failed to provide R24 or her representative written notice regarding R24's facility-initiated transfer to the hospital and failed to notify the LTCO. This placed R24 at risk of uninformed care choices and impaired rights. 32358 - R4's Electronic Medical Record (EMR) documented that R4 had diagnoses of chest pain and bradycardia (heart rate less than 60 beats per minute). R4's Quarterly Minimum Data Set (MDS), 06/23/24, documented R4 had a Brief Interview of Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS documented the resident had chest pain. R4's Care Plan, revised 09/24/24, documented R4 occasionally complained of chest pain. R4 had a loop recorder (a small device implanted underneath the skin of your chest that records your heart's rate and rhythm) in her mid-chest area. The care plan instructed staff to keep the area clean and dry until healed, observe for any signs or symptoms of infection, administer R4 oxygen as ordered by the physician, and impress upon the resident the importance of letting staff know when her chest pain first began, monitor vital signs during reported chest pain episodes (at least every five minutes), and monitor and document R4's lung fields; report to the physician any abnormal findings. The care plan instructed staff to document the description of R4's chest pain. The Progress Note, dated 01/18/24 at 11:35 AM documented R4 had been admitted to hospital on 01/17/24. The Progress Note, dated 02/01/2024 at 08:46 PM documented R4 had been admitted to the hospital. A review of R4's clinical record lacked evidence the resident or representative was provided written notice when she was transferred to the hospital or of notification to the LTCO of R4's discharge. On 09/30/24 at 02:58 PM, observation revealed R4 sat in a recliner in her room with her feet up on a footrest, reading a book. On 10/01/24 at 10:00 AM, Administrative Nurse D verified that the staff had not provided R4 or her representative with written notice of the transfer/discharge and did not notify the LTCO when R4 was admitted to the hospital. Administrative Nurse D stated Social Service X was responsible for the notifications. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/02/24 at 01:41 PM, Social Service X verified she had not provided R4 or her representative nor the LTCO with written notice when R4 was admitted to the hospital. Social Service X said she was unaware she was supposed to. The facility's Transfer and /or Discharge, Including Against Medical Advice (AMA) Policy, revised 10/22, documented that if a resident was transferred emergent to a hospital, the resident or representative would be provided, in writing and language they understood, the reason for the transfer or discharge and the facility would send a copy of the notice to the state LTCO. The facility failed to provide R4 or his representative written notice regarding R4's facility-initiated transfer to the hospital and further failed to notify the LTCO. This placed the resident and/or her representative at risk of uninformed care choices and impaired rights. - R26's Electronic Medical Record (EMR) documented that R26 had a diagnosis of constipation. R26's Medicare Five-Day Minimum Data Set (MDS), dated [DATE], documented that R26 had a Brief Interview of Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS documented that R26 was independent with most activities of daily living (ADLs). R26's Care Plan, revised 10/01/24, documented R26 required one staff assistance with toileting at times; when he was up in a wheelchair, he was continent of bowel and bladder, and when in bed he was incontinent at times. The Progress Note, dated 07/11/24 at 09:10 PM documented that R26 was admitted to the hospital. R26's clinical record lacked evidence the resident or representative was provided a written notice when he was transferred to the hospital or notification to the LTCO of R26's discharge. On 09/30/24 at 03:07 PM, observation revealed R26 sat on the edge of his bed with his eyes open. On 10/01/24 at 10:00 AM, Administrative Nurse D verified that the staff had not provided R26 or his representative nor the LTCO with written notice when R26 was admitted to the hospital. Administrative Nurse D stated Social Service X was responsible for notifying them. On 10/02/24 at 01:41 PM, Social Service X verified she had not provided R26 or her representative with written notice and had not notified the LTCO when R26 was admitted to the hospital. Social Service X stated she was unaware she was supposed to. The facility's Transfer and /or Discharge, Including Against Medical Advice (AMA) Policy, revised 10/22, documented that if a resident was transferred emergent to a hospital, the resident or representative would be provided, in writing and language they understood, the reason for the transfer or discharge and the facility would send a copy of the notice to the state LTCO. The facility failed to provide R26 or his representative written notice regarding R26's facility-initiated transfer to the hospital and further failed to notify the LTCO. This placed the resident and/or her representative at risk of uninformed care choices and impaired rights.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32358 The facility had a census of 25 residents. The sample included 13 residents. Based on observation, record review, and interview, the facility failed to develop a comprehensive care plan with instruction to staff on providing interventions for the prevention of constipation (difficulty passing stools) for one resident, Resident (R) 26, who had a history of constipation and had been admitted to hospital for constipation. This placed R26 at risk for impaired care due to uncommunicated care needs. Findings included: - R26's Electronic Medical Record (EMR) documented that R26 had a diagnosis of constipation. R26's Quarterly Minimum Data Set (MDS), dated [DATE], documented that R26 had a Brief Interview of Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS documented the resident was independent with most activities of daily living (ADLs). The MDS documented R26 was frequently incontinent of bowel. R26's Care Plan, revised 10/01/24, documented that R26 required one staff assistance with toileting at times; when he was up in a wheelchair, he was continent of bowel and bladder, and when in bed he was incontinent at times. The care plan lacked a section regarding interventions to avoid constipation. The Progress Note, dated 07/06/24 at 09:34 AM, documented that R26 had difficulty having a bowel movement (BM) and had a long history of constipation. The note documented R26 requested he be administered Colace (stool softener). The Progress Note, dated 07/11/24 at 02:45 PM, documented R26 did not participate in therapy that day because he had severe constipation. The note documented R26 endorsed extreme straining when attempting to have a BM and had small bright blood from the rectum. Staff administered a Fleets enema (procedure of inserting liquid directly into the rectum to induce a BM). The Progress Note, dated 07/13/2024 at 11:55 AM, documented R26 was admitted to the hospital for constipation and hypotension (low blood pressure). On 09/30/24 at 03:07 PM, observation revealed R26 sat on the edge of the bed with eyes open. On 10/02/24 at 10:18 AM, Administrative Nurse E verified R26's Care Plan lacked information with interventions for staff to implement for R26 to help him avoid constipation. On 10/02/24 at 11:45 AM, Administrative Nurse D verified R26's Care Plan lacked information with interventions for staff to implement for R26 to help him avoid constipation. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Comprehensive Care Plans Policy, revised 08/24, documented the facility would provide a comprehensive centered care plan that included measurable objectives and time frames to meet the resident's medical, nursing, mental, cultural, and psychological (the most basic things that everyone needs to survive) needs would be developed for each resident. The facility failed to develop a comprehensive care plan for R26 with instructions to staff on interventions to provide him to avoid constipation. This placed R26 at risk for impaired care due to uncommunicated care needs.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32360 The facility had a census of 25 residents. The sample included 13 residents, with six reviewed for unnecessary medications. Based on observation, record review, and interview, the facility failed to ensure the Consultant Pharmacist (CP) identified and reported the inappropriate indication for Seroquel (an antipsychotic medication) for Resident (R)19 and failed to identify and report the lack of a stop date for R19, R7 and R23's as needed (PRN) lorazepam (an antianxiety medication). This placed the residents at risk for unnecessary psychotropic medication side effects. Findings included: - R19's Electronic Medical Record (EMR) had diagnoses of dementia with other behavioral disturbances (a progressive mental disorder characterized by failing memory, confusion), anxiety (cognitive or emotional reaction characterized by apprehension uncertainty, and irrational fear), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and bipolar disorder (a major mental illness that causes people to have episodes of severe high and low moods). The Admission Minimum Data Set (MDS), dated [DATE], documented R19 had severely impaired cognition. R19 was dependent upon staff for eating, toileting, mobility, and transfers, and required substantial assistance for personal hygiene. R19 had inattention, disorganized thinking that fluctuates, verbal behaviors, and rejection of care daily. The MDS documented that R19 received antipsychotics, antidepressants (a class of medications used to treat mood disorders), and anti-anxiety medications. The Quarterly MDS, dated [DATE], documented R19 had severely impaired cognition and was dependent upon staff for toileting, mobility, showers, dressing, personal hygiene, and transfers. R19 had inattention, disorganized thinking that fluctuates, verbal behaviors, and rejection of care daily. The MDS documented that R19 received antipsychotic, antidepressant, antianxiety, and opioid (a class of controlled drugs used to treat pain) medication. R19's Care Plan, dated 08/25/24 and initiated on 04/01/24, directed staff to administer medications as ordered, monitor and document side effects, and monitor occurrences for target behaviors. The plan directed staff to ask one question at a time and wait for his response, contact his spouse for all medical changes, and minimize distractions while speaking to him. The Physician's Order, dated 03/28/24, directed staff to administer Seroquel (an antipsychotic medication), 125 milligrams (mg), once daily, for hallucinations. The Physician's Order, dated 06/01/24, directed staff to administer lorazepam (an antianxiety medication), 0.25 milliliters (ml), by mouth, every hour, as needed for anxiety. The order lacked a stop date. R19's EMR lacked a documented physical rationale which included unsuccessful attempts for nonpharmacological symptom management and risk versus benefit for the continued Seroquel. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Drug Regimen Review, dated 5/06/24, 07/04/24, 08/06/24, and 09/10/24 failed to address the as-needed lorazepam. The drug regimen review for 06/06/24 documented R19 was on as-needed lorazepam and had no stop date with a response from the physician that R19 was on hospice care services (medical care for people with an anticipated life expectancy of 6 months or less). The EMR lacked further documentation regarding a stop date for R19's as-needed lorazepam. On 10/01/24 at 08:05 AM, observation revealed R19 sat at the dining table with staff present and he would periodically yell out Nurse, Nurse. On 10/01/24 at 09:45 AM, the Certified Nurse Aide (CNA) stated R19 typically yelled out whether staff was with him or not and she notified the nurse when he did that. On 10/02/24 at 11:21 AM, Licensed Nurse (LN) G stated R19 did holler out and received PRN medication as well as he was offered whether to get up out of bed, a snack, or toileting. LN G further stated she was aware of the 14-day stop date for the PRN lorazepam but R19's physician would not put a stop date on the order. On 10/02/24 at 11:44 AM, Administrative Nurse D stated R19's physician would not put a stop date on the PRN lorazepam and was aware it was required but was unaware of the need for risk versus benefit or the indications for the use of an antipsychotic medication with a dementia diagnosis. Administrative Nurse D further stated the Consultant Pharmacist had not documented the lack of the stop date in the monthly reviews. Upon request a policy for Drug Regimen Review was not provided by the facility, The facility failed to ensure the Consultant Pharmacist identified and reported the lack of a documented physician rationale which included the multiple unsuccessful attempts for nonpharmacological symptom management and risk versus benefits for the continued use of antipsychotic medication and failed to identify and report the continued use of as needed lorazepam without a stop-date. This placed the resident at risk for unnecessary psychotropic medication side effects. - The Electronic Medical Record (EMR) for R7's documented diagnoses of depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness, and hopelessness), adjustment disorder with mixed anxiety (an extreme emotional or behavioral reaction within three months of a stressful or monumental life event), and pain. The Admission Minimum Data Set (MDS), dated [DATE], documented R7 had moderately impaired cognition and was dependent upon staff for eating, mobility, transfers, toileting, and showers. R7 had two to six days of depressed mood and received antidepressant (a class of medications used to treat mood disorders), opioid (a class of controlled drugs used to treat pain), antibiotic (a medicine that inhibits the growth of or destroys microorganisms), and anticoagulant (a class of medications sued to prevent the blood from clotting) medication for seven days. R7's Care Plan, dated 07/30/24 and initiated on 07/07/24, directed staff to allow R7 to voice her fears and concerns, administer medications as ordered, and monitor for side effects and behaviors. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Physician's Order, dated 07/19/24, directed staff to administer lorazepam (an antianxiety medication), 0.25 cubic centimeter (cc), every hour PRN for anxiety and restlessness. The order lacked a stop date. The Drug Regimen Review, dated 07/04/24, 08/06/24, and 09/10/24 failed to address the PRN lorazepam. On 10/01/24 at 08:30 AM, observation revealed R7 in her bed. She received her medication as ordered and without any issues. On 10/01/24 at 09:45 AM, Certified Nurse Aide (CNA) M stated R7 did not have any behaviors but used to; she mainly stayed in her room. On 10/02/24 at 11:21 AM, Licensed Nurse (LN) G stated R7 had periods of delusions (a false belief or judgment about external reality) but otherwise she had no behaviors. LN G further stated she was aware of the 14-day stop date for the PRN lorazepam but R7's physician would not put a stop date on the order. On 10/02/24 at 11:44 AM, Administrative Nurse D stated R7's physician would not put a stop date on the PRN lorazepam and was aware it was required. Administrative Nurse D further stated the Consultant Pharmacist had not documented the lack of the stop date in the monthly reviews. Upon request a policy for Drug Regimen Review was not provided by the facility, The facility failed to ensure the Consultant Pharmacist identified and reported the lack of a stop date for R7's PRN lorazepam. This placed the resident at risk for inappropriate use of as-needed antianxiety medication. 32358 - R23's Electronic Medical Record (EMR) documented R23 had a diagnosis of anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). R23's Significant Change Minimum Data Set (MDS), dated [DATE], documented R23 had short and long-term memory problems and severely impaired cognition. The MDS documented that R23 received an antianxiety (a class of medications that calm and relax people) medication during the observation period. R23's Care Plan, revised 09/23/24, instructed staff to provide physical and verbal cues to alleviate anxiety; give positive feedback, assist in verbalization of the source of agitation, and assist in setting goals for more pleasant behavior. The plan directed staff to encourage seeking out of staff members when agitated. The care plan instructed staff to intervene before R23's agitation escalated, guide him away from the source of distress, and engage R23 calmly in conversation or activity. The Physician Order, dated 02/04/23 at 09:57 PM instructed staff to administer Ativan (lorazepam-medication used to treat anxiety) oral concentrate two milligrams (mg)/milliliter (ml) give 0.25 ml orally every hour PRN or give 0.5 ml orally every hour PRN or give 0.75 ml orally every hour PRN or give one ml orally every hour as needed for anxiety with a stop date of indefinitely. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Consultant Pharmacist (CP) Regimen Review from 05/01/24 to 09/30/24 lacked evidence the CP identified and reported that R23's PRN Ativan order lacked a stop date or specified duration with a documented physician rationale for the extended use. On 07/10/24 at 10:00 AM, Administrative Nurse D verified the CP had not alerted the facility of the lack of a stop date for R23's PRN Ativan. Upon request, the facility did not provide a policy regarding CP regimen review. The facility failed to ensure the CP identified and reported R23's PRN Ativan lacked a stop date or specified duration. This placed the resident at risk for unnecessary medication side effects.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32360 The facility had a census of 25 residents. The sample included 13 residents, with six reviewed for unnecessary medications. Based on observations, record review, and interview, the facility failed to ensure an appropriate indication, or a documented physician rationale, which included unsuccessful attempts for nonpharmacological symptom management and risk versus benefit for the continued use of Resident (R) 19's antipsychotic (a medication used to treat any major mental disorder characterized by a gross impairment testing) and failed to ensure a 14-day stop date or specified duration for R19, R7 and R23s' ongoing as needed (PRN) antianxiety (a class of medications that calm an relax people with excessive anxiety, nervousness, or tension). This placed the residents at risk for unintended effects related to psychotropic (alters mood or thought) medications. Findings included: - R19's Electronic Medical Record (EMR) had diagnoses of dementia with other behavioral disturbances (a progressive mental disorder characterized by failing memory, confusion), anxiety (cognitive or emotional reaction characterized by apprehension uncertainty, and irrational fear), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and bipolar disorder (a major mental illness that causes people to have episodes of severe high and low moods). The Admission Minimum Data Set (MDS), dated [DATE], documented R19 had severely impaired cognition. R19 was dependent upon staff for eating, toileting, mobility, and transfers, and required substantial assistance for personal hygiene. R19 had inattention, disorganized thinking that fluctuates, verbal behaviors, and rejection of care daily. The MDS documented that R19 received antipsychotics, antidepressants (a class of medications used to treat mood disorders), and anti-anxiety medications. The Quarterly MDS, dated [DATE], documented R19 had severely impaired cognition and was dependent upon staff for toileting, mobility, showers, dressing, personal hygiene, and transfers. R19 had inattention, disorganized thinking that fluctuates, verbal behaviors, and rejection of care daily. The MDS documented that R19 received antipsychotic, antidepressant, antianxiety, and opioid (a class of controlled drugs used to treat pain) medication. R19's Care Plan, dated 08/25/24 and initiated on 04/01/24, directed staff to administer medications as ordered, monitor and document side effects, and monitor occurrences for target behaviors. The plan directed staff to ask one question at a time and wait for his response, contact his spouse for all medical changes, and minimize distractions while speaking to him. The Physician's Order, dated 03/28/24, directed staff to administer Seroquel (an antipsychotic medication), 125 milligrams (mg), once daily, for hallucinations. The Physician's Order, dated 06/01/24, directed staff to administer lorazepam (an antianxiety medication), 0.25 milliliters (ml), by mouth, every hour, as needed for anxiety. The order lacked a stop date. (continued on next page)

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	175220	A. Building B. Wing	10/02/2024

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R19's EMR lacked a documented physical rationale which included unsuccessful attempts for nonpharmacological symptom management and risk versus benefit for the continued Seroquel. On 10/01/24 at 08:05 AM, observation revealed R19 sat at the dining table with staff present and he would periodically yell out Nurse, Nurse. On 10/01/24 at 09:45 AM, the Certified Nurse Aide (CNA) M stated R19 typically yelled out whether staff was with him or not and she notified the nurse when he did that. On 10/02/24 at 11:21 AM, Licensed Nurse (LN) G stated R19 did holler out and received PRN medication as well as he was offered whether to get up out of bed, a snack, or toileting. LN G further stated she was aware of the 14-day stop date for the PRN lorazepam but R19's physician would not put a stop date on the order. On 10/02/24 at 11:44 AM, Administrative Nurse D stated R19's physician would not put a stop date on the PRN lorazepam and was aware it was required but was unaware of the need for risk versus benefit or the indications for the use of an antipsychotic medication with a dementia diagnosis. Administrative Nurse D further stated the Consultant Pharmacist had not documented the lack of the stop date in the monthly reviews. The facility's Psychotropic Drug Use policy, dated 04/24, documented that residents would only receive antipsychotic and psychotropic medications when necessary to treat specific conditions for which they are indicated and effective and would not be used for discipline or convenience of the staff. Limit PRN orders for antidepressants hypnotics, and antianxiety medications to 14 days. This may be extended beyond the 14 days through documentation in the medical record by the practitioner as to why this should occur. The facility failed to ensure R19's lorazepam had a 14-day stop date or specified duration and failed to ensure R19 did not receive antipsychotic medication without an appropriate indication or required documentation for its use. This placed the resident at risk for adverse side effects. - The Electronic Medical Record (EMR) for R7's documented diagnoses of depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness, and hopelessness), adjustment disorder with mixed anxiety (an extreme emotional or behavioral reaction within three months of a stressful or monumental life event), and pain. The Admission Minimum Data Set (MDS), dated [DATE], documented R7 had moderately impaired cognition and was dependent upon staff for eating, mobility, transfers, toileting, and showers. R7 had two to six days of depressed mood and received antidepressant (a class of medications used to treat mood disorders), opioid (a class of controlled drugs used to treat pain), antibiotic (a medicine that inhibits the growth of or destroys microorganisms), and anticoagulant (a class of medications sued to prevent the blood from clotting) medication for seven days. R7's Care Plan, dated 07/30/24 and initiated on 07/07/24, directed staff to allow R7 to voice her fears and concerns, administer medications as ordered, and monitor for side effects and behaviors. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Physician's Order, dated 07/19/24, directed staff to administer lorazepam (an antianxiety medication), 0.25 cubic centimeter (cc), every hour, prn, for anxiety and restlessness. The order lacked a stop date. On 10/01/24 at 08:30 AM, observation revealed R7 in her bed. She received her medication as ordered and without any issues. On 10/01/24 at 09:45 AM, Certified Nurse Aide (CNA) M stated R7 did not have any behaviors but used to; she mainly stayed in her room. On 10/02/24 at 11:21 AM, Licensed Nurse (LN) G stated R7 had periods of delusions (a false belief or judgment about external reality) but otherwise she had no behaviors. LN G further stated she was aware of the 14-day stop date for the PRN lorazepam but R7's physician would not put a stop date on the order. On 10/02/24 at 11:44 AM, Administrative Nurse D stated R7's physician would not put a stop date on the PRN lorazepam and was aware it was required. Administrative Nurse D further stated the Consultant Pharmacist had not documented the lack of the stop date in the monthly reviews. The facility's Psychotropic Drug Use policy, dated 04/24, documented that residents would only receive antipsychotic and psychotropic medications when necessary to treat specific conditions for which they are indicated and effective and would not be used for discipline or convenience of the staff. Limit prn orders for antidepressants hypnotics, and antianxiety medications to 14 days. This may be extended beyond the 14 days through documentation in the medical record by the practitioner as to why this should occur. The facility failed to ensure R7's lorazepam had a 14-day stop date or specified duration. This placed the resident at risk for adverse side effects. 32358 - R23's Electronic Medical Record (EMR) documented that R23 had a diagnosis of anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). R23's Significant Change Minimum Data Set (MDS), dated [DATE], documented R23 had short and long-term memory problems and severely impaired cognition. The MDS documented that R23 received an antianxiety (a class of medications that calm and relax people) medication during the observation period. R23's Care Plan, revised 09/23/24, instructed staff to provide physical and verbal cues to alleviate anxiety; give positive feedback, assist in verbalization of the source of agitation, and assist in setting goals for more pleasant behavior. The plan directed staff to encourage seeking out of staff members when agitated. The care plan instructed staff to intervene before R23's agitation escalated, guide him away from the source of distress, and engage R23 calmly in conversation or activity. The Physician Order, dated 02/04/23 at 09:57 PM instructed staff to administer Ativan (lorazepam-medication used to treat anxiety) oral concentrate two milligrams (mg)/milliliter (ml) give 0.25 ml orally every hour PRN or give 0.5 ml orally every hour PRN or give 0.75 ml orally every hour PRN or give one ml orally every hour as needed for anxiety with a stop date of indefinitely. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/10/24 at 10:00 AM, Administrative Nurse D verified the R23's PRN Ativan did not have a stop date and it should have one. Administrative Nurse D stated the facility staff were having a hard time getting the physician to place a stop date. The facility's Psychotropic Drug Use Policy, revised 04/24, documented the facility would limit PRN orders for antianxiety drugs to 14 days through documentation in the medical record by the practitioner as to why this should occur. The facility failed to ensure R23's physician order for PRN Ativan had a stop date. This placed the resident at risk for unnecessary psychotropic medications.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 32358 The facility had a census of 25 residents. The sample included 13 residents. Based on observation, record review, and interview, the facility failed to employ a full-time certified dietary manager for the 25 residents who resided in the facility and received meals from the facility kitchen. This placed the residents at risk for inadequate nutrition. Findings included: - On 10/01/24 at 10:30 AM, a review of the noon meal consisted of meatloaf, garlic mashed potatoes, dinner roll, lemon pudding, and California medley vegetables. On 10/01/24 at 11:30 AM, observation revealed Dietary Staff BB in the kitchen overseeing the preparation of the noon meal. On 09/30/24 at 08:39 AM, Dietary Staff BB verified he was not a certified dietary manager. Dietary Staff BB stated he had started taking the classes. On 10/02/24 at 11:00 PM, Administrative Nurse D verified Dietary Staff BB had no dietary manager certification. The facility's Food Service Staffing Policy, revised 10/23, documented a qualified dietitian would help oversee clinical nutritional services to the residents. If a destination was not full time the facility would employ another qualified nutritional professional to serve as the dietary manager. This person must meet one of the following qualifications: a. certified dietary manager b. certified food service manager cl had a similar certification in food service management from a national certifying body d. had an associate's or higher degree in food services management or hospitality if the course study included food service or restaurant management from an accredited institution of higher learning. E. had two or more years of experience in the position of dietary manager in a nursing facility setting and had completed a course of study in food safety and management topics integral to managing dietary operations including, but not limited to foodborne illness, sanitation procedures, and food purchasing, receiving and met the states established standards if applicable. The facility failed to employ a full-time certified dietary manager for 25 residents who resided in the facility and received meals from the kitchen. This placed the residents at risk of not receiving adequate nutrition.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 32358 The facility had a census of 25 residents. The sample included 13 residents. Based on observation, record review, and interview the facility failed to provide a nourishing, well-balanced diet for one resident who received a pureed diet. This placed the resident at risk for impaired nutrition. Findings included: - On 10/01/24 at 11:50 AM Dietary Staff (DS) CC reported the facility had one resident who received a pureed diet. DS CC placed one 4-ounce (oz) slice of meatloaf in a blender with 2.5 teaspoons (tsp.) of beef broth and blended to the consistency of mashed potatoes. DS CC transferred the meatloaf to a bowl using a spatula. DS CC retrieved a new small blender container and placed two 4-oz scoops of mixed vegetables into the blender, added 2.5 tsp. of liquid from the mixed vegetables, and blended to the consistency of mashed potatoes, then transferred the mixed vegetables into a small bowl. DS CC stated the resident would receive mashed potatoes and lemon pudding. When asked how the resident would receive his bread, DS CC stated she does not prepare pureed bread for the resident. On 10/01/24 at 12:30 PM, DS BB stated normally staff tried to fill in the pureed food item from the grain group with another item. DS CC went on to say it had been an active day, and staff thought that the resident would not eat the pureed bread due to it being soggy, so it was not prepared and offered. The facility's Therapeutic Diets Policy, revised 10/2023, documented those residents on therapeutic diets would not receive extra or reduced portions or modifications that are not part of the diet unless approved by the physician in conjunction with the clinical dietician. The facility failed to provide a nourishing, well-balanced diet to one resident who received a pureed diet. This placed the resident at risk for impaired nutrition.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 32358 The facility had a census of 25 residents. The sample included 13 residents. Based on observation, record review, and interview the facility failed to ensure a sanitary environment to help prevent the development and transmission of communicable diseases and infections when staff failed to implement laundry practices to eliminate infectious pathogens. This placed the residents at risk of obtaining an infection or communicable disease. Findings included: - On 10/02/24 at 10:27 AM, observation in the laundry room lacked evidence the staff monitored the washing machine water temperatures. On 10/02/24 at 10:27 AM, Housekeeping Staff (HS) U stated the facility had high-temperature washing machines, and the laundry staff did not check or record the hot water temperatures of the washing machines. She said maintenance was responsible for ensuring the hot water temperature for the washing machines was high enough. HS U stated residents on Enhanced Barrier Precautions (EBP-infection control interventions designed to reduce transmission of resistant organisms which employ targeted gown and glove use during high contact care) clothing and bedding were washed with the other residents' laundry as well. On 10/02/24 at 11:45 AM, Administrative Nurse D stated laundry or maintenance staff should be checking and recording the hot water temperatures for all laundry daily. On 10/02/24 at 10:30 AM, Maintenance Staff (MS) V stated he did not check the washing machine's hot water temperatures, he only checked hot water in areas in which he was monitoring for waterborne pathogens. The facility's Laundry and Bedding, Soiled Policy, revised 09/2023, instructed staff to handle all laundry as contaminated, and place and transport contaminated laundry in a bag or container at the location where it is used. The policy documented the recommendations for laundry cycles are per manufacturer guidelines and the following: hot water should be at 160 degrees Fahrenheit(F) for 25 minutes, low-temperature washing machines' hot water temperature should be 71-77 degrees F plus 125 parts per million (PPM) chlorine bleach rinse. The facility failed to provide a sanitary environment when staff failed to ensure washing machine temperatures were maintained in order to kill infectious pathogens. This placed the resident at risk of obtaining an infection or communicable disease.