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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey and Complaint #KS00164744. The 2567 was sent electronically on 12/28/21	F 000		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other	F 582		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 12/28/2021

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

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items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.
(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.
(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.
(v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 63 residents. The sample included 16 residents, with three reviewed for "Beneficiary Notices." Based on record review and interview, the facility failed to provide one of the sampled residents, Resident (R) 115 (or their representative) the completed "Notice of Medicare Non-Coverage" (NOMNC) Form 10123 Centers for Medicare and Medicaid Services (CMS), and the completed "Skilled Nursing Facility Advanced Beneficiary Notice of Non Coverage" (SNF ABN) Form 10055 .

Findings included:

- The "Medicare Form 10123" informed the beneficiary that Medicare may not pay for future skilled therapy. The form included detailed

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explanation of non-coverage and explained the appeal process The "Medicare Form 10055" informed the beneficiary that Medicare may not pay for skilled therapy services and provided a cost estimate for continued services. It explained: (1) if Medicare does not pay, the resident would be responsible for payment, but can make an appeal to Medicare, (2) receive therapy listed, but do not bill Medicare, would be responsible for payment for services, or (3) does not want the listed services. A provider must issue advance written notice to enrollees before termination of services in a Skilled Nursing Facility (SNF), Home Health Agency (HHA), or Comprehensive Outpatient Rehabilitation Facility (CORF). If an enrollee files an appeal, then the plan must deliver a detailed explanation of why services should end.

The facility lacked documentation staff provided R115, or her representative, form 10123 which included detailed explanation of non-coverage and explained the appeal process , and form 10055 which included the estimated cost documentation for the services to be able to make an informed choice whether the resident wanted to receive the items or services, knowing she may have to pay out of pocket. The resident's skilled services ended on 12/07/21. The facility did not get signed forms returned to the facility.

On 12/22/21 at 01:30 PM, Administrative Staff A verified R115 was discharged from the facility on 12/07/21 and stated the resident's representative failed/refused to sign the forms before the resident was discharged.

The facility's "Medicare Denial Notice and Advance Benefit Notification (ABN)" policy dated

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12/29/20 recorded the facility would inform each resident before, or at the time of admission. And periodically during the resident's stay of services available in the facility and charges for those services including and charges for services not covered under Medicare by the facility's per diem rate. The facility would provide each resident with a written description of legal rights which includes a description of the manner of protecting personal funds. The policy documented the facility would provide written/oral notification to resident with necessary information to decide whether or not to appeal a decision to terminate Medicare care and services at least three days prior to the planned change in payor status or discharge. When the facility's Medicare Utilization Review Committee will meet weekly to discuss all resident's currently receiving Medicare benefits, the resident's progress toward stated goals, and goals toward discharge from Medicare services. The denial notice would be provided to the resident and/or responsible party no later than three calendar days prior to the planned discharge. Notification of non-coverage for a resident who is not competent will be made to the resident's legal representative (responsible party.) If the facility is unable to personally unable to deliver a denial letter to a person acting on behalf of Medicare resident, the facility representative will telephone the responsible party to advise him/her when the resident's services would no longer be covered. The date of the conversation is the date of receipt of notice. Confirmation of the telephone contact by written notice will be mailed on the same date of the telephone notification by certified mail, return receipt requested, the date the responsible party signs the receipt is the date of receipt. A dated copy of the notice would be placed in the resident's clinical record. If a notice is returned by

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F 582	Continued From page 4 the post office with no indication of a refusal date, the resident's liability starts on the second working day after the facility's mailing date. The facility notification would be provided on facility letter head. The denial notification would contain both CMS Form 10055 and 10123 including all denial notification with state appeal process, contact address and phone numbers and time frame requirements. Residents/responsible party must choose options to continue services or not continue services. Signature line where resident/responsible party must sign and date of receipt of CMS form 10055 and CMS form 10123. The facility failed to obtain signed CMS form 10123 and 10055 by the resident's, or their representative, when discharged from skilled care for R115, which placed the resident, or their representative, at risk to make uninformed decisions about continuation of their skilled care.	F 582		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility;	F 645		

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and
(B) If the individual requires such level of services, whether the individual requires specialized services; or
(ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission-
(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.

§483.20(k)(2) Exceptions. For purposes of this section-
(i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.
(ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual-
(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,
(B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and
(C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services.

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§483.20(k)(3) Definition. For purposes of this section-
(i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1).
(ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 63 residents. The sample included 16 residents, with one reviewed for "Pre-Admission Screening and Annual Resident Review" (PASARR). Based on observation, interviews, and record review the facililty failed to ensure a referral was made promptly by the nursing home to the state PASARR program for a Level 2 Resident Review for Resident (R) 63 who had a documented a mental illness (MI) or intellectual disability (ID).

Findings include:

- R63's "Physician Order Sheet" (POS), dated 04/30/21, recorded the diagnoses of Major Depressive Disorder (MDD) (a mental disorder characterized by a persistently depressed mood and long-term loss of pleasure or interest in life), delusional disorder (untrue persistent belief or perception held by a person although evidence shows it was untrue) , cerebrovascular accident (CVA)(sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the

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brain), and wandering.

R63's "Quarterly Minimum Data Set" (MDS), dated 11/30/21, recorded the resident had a Brief Interview for Mental Status (BIMS) score of 14, cognitively intact. The MDS documented the resident had no delusions and no behavior symptoms. The MDS further documented the resident had a wander guard alarm and elopement alarm.

The "Behavior Care Plan," dated 11/24/21, indicated the resident had impaired behavior and could become agitated and demanding to leave the facility and required a wander guard alarm. The "Care Plan" directed staff to intervene as necessary to ensure safety of residents and others and divert attention from stimuli that agitated the resident.

Review of the resident's Electronic Medical Record revealed it lacked evidence a referral was made or a PASRR screen was completed.

On 12/16/21 at 02:30 PM, observation revealed R63 sat in a recliner in his room and read a book. He was dressed and appeared comfortable.

On 12/20/21 at 09:50 AM, Administrative Nurse D verified the resident lacked a PASARR assessment.

The facility's "Preadmission Screening and Annual Resident Review (PASARR)" policy dated 12/29/20 documented the policy would ensure that individuals with mental and intellectual disabilities receive the care and services that they need in the most appropriate setting. The PASARR would be evaluated annually and upon

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F 645	Continued From page 8 asignificant change for those individuals identified. It is the policy of the facility to follow Kansas Department of Aging and Disabilities Level 1 care manual. The facility will participate in or complete the Level 1 CARE Assessment screen for all potential admission regardless of payor source to determine if the individual meets the criteria for mental disorder (SMI/SMD), intellectual disability (ID) or related condition. Based on the Level 1 Care Assessment, if an individual is determined to meet the above criteria, the facility would not admit an individual, the facility will refer the potential admission to the State PASARR Representative for the Level II screening process. Upon completion of the Level II screen the facility would review the screening recommendations and determine the facility's ability to provide the specialized services outlined. Admission decision would be determined and notification to the State PASSAR representative, the potential resident and/or representative will be completed. Upon admission, the facility will include the PASSAR Level ll determination and evaluation report into the resident's assessment, comprehensive care plan and transitions care plan. The facility failed to adequately assess the resident for placement in the facility by completing a PASARR screening, placing R63 at risk for inadequate facility care and treatment.	F 645		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains	F 689		

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as free of accident hazards as is possible; and

§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 63 residents. The sample included 16 residents, with nine reviewed for accidents. Based on observation, record review, and interview, the facility failed to follow toileting and fall interventions as directed in the resident's plan of care care for one sampled resident, Resident (R) 29, who had several falls.

Findings included:

- R29's "Admission Minimum Data Set" (MDS), dated 06/10/21, documented the resident had intact cognition and required extensive assistance of one staff for bed mobility, transfers, toileting and limited assistance of one staff for ambulation in room. The MDS further documented the resident, occasionally incontinent of bladder, unsteady gait, had no upper or lower functional impairment, had one non- injury fall since admission, and did not use any alarms.

The "Quarterly MDS," dated 12/11/21, documented the resident had severely impaired cognition and required extensive assistance of one staff for bed mobility, transfers, toileting, and ambulation in room and hallways. The MDS further documented the resident was frequently incontinent of bladder, had unsteady gait, had no upper or lower functional impairment, had two non-injury and one injury fall since the prior assessment, and used a motion detector daily.

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The revised "Fall Care Plan," dated 09/22/21, originally dated 06/15/21, directed staff to offer assistance to the bathroom whenever the resident was awake at night, and to ensure safety while honoring choices and preferences. The update, dated 06/17/21, documented R29 fell taking himself to the bathroom and a motion sensor was initiated when R29 was alone in his room. An update, dated 08/26/21, documented R29 fell while going to the bathroom. Staff were reeducated on R29's two-hour toileting program which was recorded on the "Medication Administration Record" (MAR). An intervention, dated 09/09/21, directed staff to offer toileting more frequently in the afternoon. An intervention, dated 10/29/21, documented staff were provided reeducation regarding the resident's bladder and bowel incontinence.

The "Fall Risk Assessment," dated 06/04/21, 08/08/21, 09/06/21, and 12/13/21, documented the resident at high risk for falls.

The "Physician Orders," dated 08/26/21, directed staff to take R29 to the bathroom at 06:00 AM, 08:00 AM, 10:00 AM, 12:00 PM, 02:00 PM, 04:00 PM, 06:00 PM, 08:00 PM, and 10:00 PM.

The "Nurse's Note," dated 08/26/21 at 01:14 PM, documented the resident was on the floor in the doorway of his bathroom. The resident was incontinent of urine at the time of the fall and his pants and undergarments were changed. The note documented the staff were reeducated of the two hour toileting program.

The "Nurse's Note," dated 09/09/21 at 02:36 PM, documented the resident was on the floor in his room in front of his recliner with his pants at his

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ankles. The resident stated he needed to go to the bathroom. The note further documented the resident's pull-up was wet. The September 2021 MAR lacked documentation R29 was toileted at 02:00 PM.

The "Nurse's Note," dated 09/18/21 at 04:39 PM, documented R29 laid on his back in front of his recliner. The resident stated he was trying to get into bed when he fell. The note further documented the motion sensor was not in place nor activated at the time of the fall. The note documented R29 had bruising and swelling to the back of his head and the physician directed staff to obtain and monitor neurological tests (a test to evaluate a person's nervous system) on the resident.

The "Nurse's Note," dated 10/29/21 at 04:00 PM, documented the resident laid on his left side in the bathroom. The note documented R29 did not hit his head or receive any injury from the fall. The note further documented the resident's motion sensor was near his recliner but had not been turned on.

The "Nurse's Note," dated 12/11/21 at 06:05 AM, documented the resident laid on the floor in front of his bed. The note further documented the resident's brief was wet and fell off of him as he stood up and walked to the bathroom. The note documented the resident had a small abrasion (a scrape) to his left knee which measured 1.8 centimeter (cm) x 0.5 cm. The note directed staff to ensure the motion sensor was in proper placement.

On 12/16/21 at 11:10 AM, observation revealed Certified Nurse Aide (CNA) M put a gait belt on

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R29, stand him up in front of his wheelchair in preparation to walk down the hall with his walker. Further observation revealed R29 ambulated down the hall before he got tired.

On 12/21/21 at 09:15 AM, observation revealed an "X" on R29's floor where the motion sensor was to be placed. Further observation revealed, the motion sensor was on the floor by the end of the bed, not on the "X."

On 12/16/21 at 11:15 AM, CNA M stated R29 had a lot of falls because he liked to get up on his own all the time.

On 12/21/21 at 09:15 AM, Certified Medication Aide (CMA) R stated the motion sensor was to be placed on the "X" when R29 was in bed to make sure that it alarmed when R29 got out of bed. CMA R further stated staff asked R29 if he needed to go to the bathroom every two hours,usually, and CMA R did not know of any falls related to R29's toileting schedule or the motion sensor not used appropriately.

On 12/21/21 at 09:27 AM, Licensed Nurse (LN) G stated the CNAs tell the CMA or the nurse when R29 was last toileted but the MAR does not reflect the exact time. LN G stated R29 was able to tell staff if he needed to go to the bathroom. LN G could not recall if any of R29's falls were related to the motion sensor not being turned on.

On 12/21/21 at 01:30 PM, Administrative Nurse D verified the motion sensor was not turned on or placed appropriately for some of R29's falls and verified R29's toileting had been a problem so they put it on the MAR. Administrative Nurse D stated the MAR charting would only reflect if the

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 13 resident refused toileting and what time the refusal was. The facility's "Falls" policy, dated 12/11/17, documented all residents would be evaluated for fall risk upon admission, quarterly, and significant change and appropriate interventions would be implemented to decrease the risk for falls. The policy documented, after a new fall, preventative interventions are placed on the care plan update sheet and if the resident continued to fall, only those interventions that were still appropriate would be continued. The facility failed to follow R29's interventions for toileting and motion sensor use to prevent falls, placing the resident at risk for further falls and/or injuries related to falls.	F 689		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions	F 700		

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are appropriate for the resident's size and weight.

§483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 63 residents. The sample included 16 residents, with one reviewed for side rails. Based on observation, record review, and interview, the facility failed to accurately assess Resident (R) 5's side rails for safe use, placing R5 at risk for accident and injury.

Findings included:

- R5's "Quarterly Minimum Data Set" (MDS), dated 09/07/21, recorded the resident had a Brief Interview for Mental Status (BIMS) score of seven, indicating moderately impaired cognition. The MDS documented the resident required extensive assistance of onestaff with bed mobility, transfer and locomotion on and off the unit. The MDS lacked documentation the resident had bedrails.

The "Activities of Daily Living (ADL) Care Plan," dated 12/13/21, indicated one staff assisted the resident with bed mobility. R5 utilized a quarter side rail (a structural support attached to the frame of the bed and intended to prevent a patient from falling and assist with transfers) to assist with repositioning and bed mobility.

The "Side Rail Assessment" dated 12/02/21, recorded the side rail was not a restraint. The assessment documented the side rail had been measured and the gaps between the rails and the

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gap between the side rails were conducive to the resident's safety based on the individual resident. The assessment documented a visual review had been performed and staff assessed the mattress did not shift or slide which would allow an increased gap between the bed and the side rail. The review resulted in no safety issues or concerns.

On 12/15/21 at 04:10 PM, observation revealed the resident lying in bed on her back with her right hand through the bedrail opening, eyes closed and light off in the room. Continued observation revealed a one-third siderail on both the right and left sides of the bed with the upper opening of 25.5 inches x 3.5 inches, and an opening 25.5 inches x 3.5 inches on the bottom of the rail. Continued observation revealed the one-third siderail attached to two metal bars with a width opening of 7.5 inches x 10 inches that were secured to the bed.

On 12/22/21 at 09:30 AM, Administrative Nurse D verified the bedrails should not be on the R5's bed and verified the rails had too large of openings. Administrative Nurse D verified the bed had been brought into the facility from the storage shed when R5 was moved into the room.

The facility's "Bed Inspection" policy, dated 12/29/20 recorded the facility would conduct regular inspections of all bed frames, mattresses, and bed rails, as part of a regular maintenance program to identify areas of potential entrapment or other safety hazards. The facility would comply with approaches to risk identification and prevention of entrapment or other related safety hazards. This would serve as key component of care plan development including appropriate

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F 700	Continued From page 16 assessment of safety risk of each resident, implementation of appropriate interventions to reduce identified risk, monitoring for effectiveness of planned interventions and modifying interventions as indicated. It is the policy of the facility to prevent entrapment and other safety hazards associated with resident bed rails, bed frames, mattresses, and other bed mobility devices. The facility leadership are responsible for providing employees appropriate information, education, and training pertaining to entrapment and other safety hazards associated with resident bed rails, frames, mattresses and other bed mobility enhancing devices with potential entrapment risk. The policy documented any open space between the perimeter of the rail can present a risk of head entrapment FDA recommends space less than 4 and ¾ inches. Facility maintenance staff will conduct bed inspections in accordance with providing a "safe, clean, comfortable and homelike environment." The facility failed to accurately assess siderail and identify safety risks, placing R5 at risk for accident and injury.	F 700		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic	F 758		

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F 758	Continued From page 17 Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: The facility had a census of 63 residents. The	F 758		

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sample included 16 residents with five reviewed for unnecessary medications. Based on observation, record review, and interview, the facility failed to ensure appropriate diagnoses for the use of antipsychotic medications (class of medications used to treat any major mental disorder characterized by a gross impairment in reality testing and other mental illness conditions) for three sampled residents, Residents (R) 9, R29 and R14. This placed the residents at increased risk for inappropriate treatment and risk for adverse outcomes associated with antipsychotic medications

Findings included:

- R9's "Physician Order Sheet" (POS), dated 11/02/21, documented diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure) and depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness).

The "Quarterly Minimum Data Set" (MDS), dated 12/11/21, documented R9 had severely impaired cognition, and required extensive assistance of one staff for bed mobility, transfers, dressing, toileting, and hygiene. The MDS further documented R9 had continuous disorganized thinking and received antipsychotic medications all seven days of the look back period.

The "Psychotropic [alters mood or thought] Drug Use Care Plan," dated 09/22/21, directed staff to consult with pharmacy and physician to consider dosage reduction when clinically appropriate, address psychotropic medication changes and psychiatric signs and symptoms with the team

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weekly, monitor for side effects, and address mood affect and anxiety from antipsychotics.

The "Medication Side Effects Care Plan," dated 09/22/21, documented Seroquel (antipsychotic medication) was associated with increased mortality (death) in older adults and these agents were not approved for treatment of behavioral symptoms in older adults with dementia related psychosis and to use only when benefit outweighed risk.

The "Physician Orders," dated 08/06/21, directed staff to administer Seroquel, 12.5 milligrams (mg), by mouth, at bedtime for the diagnosis of depression.

On 12/20/21 at 02:00 PM, observation revealed the resident sat by the nurse's station in his wheelchair, waved and smiled.

On 12/21/21 at 09:15 AM, Licensed Nurse (LN) G stated a member of the management team send the physician any recommendations from the pharmacist. LN g was not sure what happened after that.

On 12/20/21 at 01:30 PM, Administrative Nurse D stated the facilty staff knew depression was not an appropriate diagnosis for the Seroquel medication and sent documentation from the pharmacist to the physician requesting to change the diagnosis.

The facility's "Medication Monitoring" policy, dated 07/27/12, documented each elder was provided only those medications that are clinically indicated in the dose and for the duration to meet his/her assessed needs. The effects of medications on

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elders are monitored to assess the effectiveness of the medication therapy and to minimize the occurrence of adverse events. The LN or Certified Medication Aide (CMA) administering medications evaluated the elder continuously for effectiveness and adverse effects of medications as indicated on the medication care plan.

The facility failed to ensure an appropriate diagnosis for R9's antipsychotic medication, placing the resident at risk for adverse side effects.

- R29's "Physician Order Sheet" (POS), dated 12/08/21, documented diagnoses of dementia with behavioral disturbance (progressive mental disorder characterized by failing memory and confusion), depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), and hallucinations (sensing things while awake that appear to be real, but the mind created).

The "Quarterly Minimum Data Set' (MDS), dated 10/15/21, documented R29 had impaired cognition, and required extensive assistance of one staff for bed mobility, transfers, dressing, toileting, personal hygiene and eating. The MDS further documented R29 had inattention, disorganized thinking, hallucinations and received antipsychotic, and antidepressant (medication used to treat mood disorders and relieve symptoms of depression) medications all seven days of the look back period.

The "Psychotropic [alters mood or thought] Drug Use Care Plan," dated 10/20/21, directed staff to consult with pharmacy and physician to consider dosage reduction when clinically appropriate, to

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address psychotropic medication changes and psychiatric signs and symptoms with the team weekly, monitor for side effects, and address mood affect and anxiety from antipsychotics.

The "Medication Side Effect Care Plan," dated 10/20/21, documented the pharmacist monthly review referred to the medication administration record and POS for current listing of all medications, corresponding diagnoses, risk versus benefit, and side effects for the use of Risperdal (antipsychotic) medication.

The "Physician Order," dated 11/18/20, directed staff to administer Risperdal, 0.5 milligrams (mg), by mouth, at bedtime, for the diagnosis of hallucinations.

On 12/20/21 at 02:00 PM, observation revealed the resident seated in his recliner with his eyes closed.

On 12/21/21 at 09:15 AM, Licensed Nurse (LN) G stated someone from the management team send the physician any recommendations from the pharmacist. LN G was not sure what happened after that.

On 12/20/21 at 01:30 PM, Administrative Nurse D stated hallucinations was not an appropriate diagnosis for the Risperdal medication and requested the physician change the diagnosis.

The facility's "Medication Monitoring" policy, dated 07/27/12, documented each elder was provided only those medications that are clinically indicated in the dose and for the duration to meet his/her assessed needs. The effects of medications on elders are monitored to assess the effectiveness

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of the medication therapy and to minimize the occurrence of adverse events. The LN or Certified Medication Aide (CMA) administering medications evaluated the elder continuously for effectiveness and adverse effects of medications as indicated on the medication care plan.

The facility failed to ensure an appropriate diagnosis for R29's Risperdal, placing the resident at risk for adverse side effects.

- Resident (R) 14's "Physician Order Sheet" (POS), dated 11/22/21, recorded the diagnoses of Major Depressive Disorder (MDD-a mental disorder characterized by a persistently depressed mood and long-term loss of pleasure or interest in life).

The "Quarterly Minimum Data Set" (MDS), dated 09/13/21, recorded the resident had a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. The MDS recorded R14 required one staff assist with bed mobility and transfers and recorded R14 received antipsychotic medication on a daily basis.

The "Antipsychotic Care Plan," dated 09/24/21, directed staff to monitor the resident for side effects of the medication. The "Care Plan" recorded R14 received Seroquel (an antipsychotic medication) for depression and to contact the physician and consulting pharmacist to consider gradual dose reduction when clinically appropriate.

The "Physician Order," dated 10/28/21, directed the staff to administer Seroquel, 50 milligrams (mg) by mouth twice daily.

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F 758	Continued From page 23 On 12/15/21 at 12:20 PM, observation revealed R14 stood in her doorway, awaiting staff to deliver lunch. The resident had a flat affect. On 12/20/21 at 01:00 PM, Administrative Nurse D verified R14's diagnosis of depression for the use of the Seroquel was not an appropriate diagnosis. The facility's "Medication Monitoring" policy, dated 07/27/12 documented each elder is provided only the medications that are clinically indicated, including the dose and duration to meet his/her assessed needs. The policy recorded the effects of medications on elders are monitored to assess the effectiveness of the medication therapy and to minimize the occurrence of adverse events and the nurse or medication aide administering medications evaluated the elder continuously for effectiveness and adverse effects of medications as indicated on the medication care plan. The facility failed to have an appropriate diagnosis for the use of the antipsychotic medication for R14 placing the resident at risk for adverse side effects.	F 758		