STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175473	A. Building B. Wing	07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Nicol Home	303 E Buffalo St Glasco, KS 67445

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** - The Electronic Medical Record (EMR) for R13 documented diagnoses of dementia (progressive mental disorder characterized by failing memory, and confusion) without behavioral disturbance, hypertension (elevated blood pressure), and depression (abnormal emotional state characterized by exaggerated feelings of sadness. The Quarterly Minimum Data Set (MDS), dated [DATE], documented R13 had severely impaired cognition. R13 required substantial assistance for toileting, dressing, and personal hygiene. R13 required supervision with transfers and ambulation. The MDS documented R13 received an antidepressant (medication used to treat mood disorders and relieve symptoms of depression). R13's Care Plan, dated 06/20/24 and initiated on 03/09/20, documented R13 had dementia and would sometimes wander and directed staff to cue, reorient, and supervise as needed. R13's Care Plan lacked interventions for the use of antipsychotic (used to treat psychosis and other mental or emotional conditions) medication and any related Black Box Warning (BBW-a warning from the Food and Drug Administration for serious adverse reactions or special problems that could occur that may lead to death or serious injury). The Physician's Order, dated 07/26/24, directed staff to administer Risperdal (an antipsychotic medication), 0.25 milligrams (mg), by mouth, twice per day for dementia without behavioral disturbance. On 07/30/24 at 10:32 AM, observation revealed Certified Nurse Aide (CNA) M placed a gait belt around R13's wait, and CNA M and CNA P assisted R13 to stand up in front of her walker to ambulate to the bathroom. Staff assisted R13 with personal care, stood her up, and assisted her back to her recliner without resistance with care. On 07/30/24 at 09:00 AM, Certified Nurse Aide O stated R13 had behaviors and was at times resistant to care. On 07/31/24 at 09:20 AM, Licensed Nurse (LN) H stated R13 had advanced dementia; R13 was resistant to care with staff and was recently placed on Risperdal. Licensed Nurse H further stated R13 also received Ativan(antianxiety medication) as needed on her shower days. On 07/31/24 at 12:45 PM Administrative Nurse D stated staff saw that the Risperdal had not flagged on the care plan for a BBW but they had not had the opportunity to document the medications and side effects on the care plan. The facility's Goals and Objectives, Care Plans policy, dated 04/09, documented care plan should (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	incorporate goals and objectives that lead to the resident's highest obtainable level of independence and are defined as the desired outcome for a specific resident problem. Care plan goals and objectives were derived from information contained in the resident's comprehensive assessment. The facility failed to develop a comprehensive care plan for R13's use of an antipsychotic medication. This placed her at risk for impaired care due to uncommunicated care needs. - The Electronic Medical Record (EMR) documented R26 had diagnoses of diabetes mellitus type 2 (DM-when the body cannot use glucose, not enough sepsis made or the body cannot respond to the insulin), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), dementia without behavioral disturbance (progressive mental disorder characterized by failing memory, confusion, and weakness). The Quarterly Minimum Data Set (MDS), dated [DATE], documented R26 had severely impaired cognition and required partial to moderate assistance with toileting, dressing, set-up assistance with mobility, transfers, and supervision with ambulation. The MDS documented R26 required insulin (a hormone that lowers the level of glucose in the blood) daily. R26's Care Plan lacked documentation a diabetes care plan was implemented to provide direction to staff to care for the resident with a diagnosis of diabetes and of R26's insulin pump (an insulin-delivering device). The Physician's Order, dated 08/09/23, directed staff to obtain an accucheck (a test that measured the amount of glucose, or sugar in a blood sample). The Physician's Order, dated 07/02/24, directed staff to document R26's total carbohydrates (compounds that include sugars, starch, and cellulose used in the body for energy) for each meal in the insulin pump so that it would deliver a bolus of insulin based on carbohydrate count at meals. The Physician's Order, dated 07/03/24, directed staff to charge the insulin pump every day for 15 minutes. The Physician's Order, dated 07/03/24, directed staff to check the placement of the insulin pump every shift. The Physician's Order, dated 07/07/24, directed staff to change the insulin pump cartridge and site every 48 hours. The Physician's Order, dated 07/07/24, directed staff to administer Ozempic (an injectable medication that helps manage blood sugar levels), 2 milligrams (mg) sq in the morning every Sunday for DM. The Physician's Order, dated 07/08/24, directed staff to administer Humalog (rapid-acting insulin), 1.7 units every hour via insulin pump for a total of 20.4 units every 12 hours for DM. The Physician's Order, dated 07/08/24, directed staff to administer insulin aspart (a short-acting manmade versus of human insulin), 25 units at lunch if the insulin pump failed. The Physician's Order, dated 07/08/24, directed staff to administer Novolog (a fast-acting insulin), 35 units at breakfast and supper if the insulin pump failed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Physician's Order, dated 07/07/24, directed staff to administer Tresiba (long-acting insulin), 100 units, every 24 hours as needed for blood sugar control and administer 100 units at bedtime if the insulin pump failed. The Physician's Order, dated 07/11/24, directed staff to change the placement of the insulin pump every 10 days in the afternoon. On 07/31/24 at 10:20 AM, observation revealed R26 was lying on her bed with the insulin pump beside her. R26 stated she loved having the pump and that she was happy that she did not get stuck all the time and it was working well for her. On 07/31/24 at 10:20 AM, Licensed Nurse (LN) H stated the insulin pump worked great for R26 and she was doing well with it. LN H further stated that her daughter was one of the nurses on staff and had done a lot of research on insulin pumps and was able to find a doctor who would be in charge of the pump and provided the facility with training and a manual to use if needed. On 07/31/23 at 12:45 PM, Administrative Nurse D stated R26 should have a diabetes care plan and the insulin pump should be addressed on the care plan to provide staff direction for care. The facility's Goals and Objectives, Care Plans policy, dated 04/09, documented care plan should incorporate goals and objectives that lead to the resident's highest obtainable level of independence and are defined as the desired outcome for a specific resident problem. Care plan goals and objectives were derived from information contained in the resident's comprehensive assessment. The facility failed to develop a comprehensive care plan for R26 ' s DM and insulin pump. This placed her at risk for impaired care due to uncommunicated care needs. The facility had a census of 30 residents. The sample included 13 residents. Based on observation, record review, and interview, the facility failed to develop a comprehensive care plan that addressed the individual resident needs for Resident (R)17, R12, R5, R13, and R26. This placed the residents at risk for impaired care due to uncommunicated needs. Findings included: - R17's Electronic Medical Record (EMR) documented diagnoses of muscle weakness, fluency (speech) disorder following nontraumatic subarachnoid hemorrhage (bleeding in the space just outside the brain), atrial fibrillation (rapid, irregular heartbeat), major depressive disorder (major mood disorder which causes persistent feelings of sadness), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), abnormalities of gait and mobility, and dementia (progressive mental disorder characterized by failing memory, confusion) The Quarterly Minimum Data Set, dated 05/17/24, documented R17 had severe cognitive impairment, functional range of motion of one side of the upper and lower extremities, used a wheelchair for mobility, and was dependent on staff with functional abilities. R17 was always incontinent of urine and bowel and at risk for pressure ulcers. R17's Care Plan, dated 06/26/24, documented the resident had a self-care deficit related to confusion and stroke, directing staff to place heel protectors on while in bed or chair. The care plan lacked documentation and instruction for R17's left heel and great toe wounds. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Skin Progress Note, dated 05/23/24 at 09:58 AM, documented a care plan meeting was held with a family member and they spoke about any skin breakdown which R17 had none. The Skin Progress Note, dated 05/26/24 at 05:15 PM, documented an unstageable area noted outer left foot, Skin-prep (liquid skin barrier) was applied, heel protectors were in place and R17's feet were floated on pillows. The Skin Progress Note, dated 06/09/24 at 01:00 PM documented that R17's great toenail was lifting and had drainage underneath the nail bed. R17's EMR documented physician notification of skin injuries and provided orders for treatment. On 07/01/24 the physician providing routine foot and wound care to the feet documented that staff were unable to feel pulses in either foot; R17's feet were dusky in color. R17 had been taken off of insulin due to a family request as R17 had been on hospice services, and blood sugars had been running higher than the machine could read. The family was educated on diabetic blood sugar control and wound healing and chose to resume insulin orders. The note further documented a non-pressure chronic ulcer to the left foot, with peripheral circulation disorder associated with diabetes mellitus. On 07/30/24 at 09:25 AM, observation revealed Administrative Nurse E provided wound care to R17's left foot. R17 feet had been elevated off the bed with a pillow. R17 wore foam-protective pressure-reducing boots, had a blanket lifter/foot cradle at the foot end of the bed, and a pressure-reducing winged mattress on the bed. R17 had slept through the procedure of wound care without indications of discomfort. On 07/31/24 at 11:57 AM, Certified Nurse Aide (CNA) P reported R17 was dependent on staff for all care, was repositioned every two hours, wore padded boots at all times, and was positioned with her legs on pillows to prevent the feet from laying on the bed. On 07/31/24 at 12:53 PM, Administrative Nurse E verified she had not included the wounds, treatment, and interventions on R17's Care Plan. The facility's Care Plans Goals and Objectives policy, dated 04/2009, documented care plans shall incorporate goals and objectives that lead to the resident's highest obtainable level of independence. Care plan goals and objectives are defined as the desired outcome for specific resident problems. Goals and objectives are entered into the resident's care plan so that all disciplines have access to such information and are able to report whether or not the desired outcome is being achieved. Goals and objectives are reviewed and or revised when there has been a significant change in the resident's condition when the desired outcome has not been achieved, when the resident has been readmitted to the facility, and at least quarterly. The facility failed to develop a comprehensive care plan related to R13's wound care. This placed the resident at risk for impaired care due to uncommunicated care needs. - R12's Electronic Medical Record (EMR) documented diagnoses of hypertension (HTN-elevated blood pressure), major depressive disorder (major mood disorder which causes persistent feelings of sadness), peripheral vascular disease (PVD- slow and progressive circulation disorder causing narrowing, blockage, or spasms in a blood vessel), dementia (progressive mental disorder characterized by failing memory, confusion), anxiety disorder (mental or emotional reaction characterized by apprehension, (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	uncertainty and irrational fear), occlusive and stenosis (narrowing or constricted) of unspecified carotid artery, hypothyroidism (a condition characterized by decreased activity of the thyroid gland), pure hypercholesterolemia (greater than normal amounts of cholesterol in the blood), chronic kidney disease and Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), and dysphagia (swallowing difficulty). The Quarterly Minimum Data Set (MDS), dated [DATE], documented R12 had severe cognitive impairment and wandered daily. R12 required substantial/maximal assistance with dressing and personal hygiene, partial to moderate assistance with toileting hygiene, and supervision/touch assistance with mobility with the use of a walker. R12 had frequent incontinence of urine and bowel and no diagnosis of urinary tract infection (UTI). R12 received an antipsychotic (class of medications used to treat major mental conditions that cause a break from reality), antianxiety (class of medications that calm and relax people), antidepressant (class of medications used to treat mood disorders), antibiotic (class of medication used to treat infections), diuretic (medication to promote the formation and excretion of urine), and opioid (medication used to treat pain). The MDS further documented an antipsychotic was received on a routine basis only but had no gradual dose reduction (GDR), and no physician documentation as clinically contraindicated. R12's Care Plan, dated 06/20/24, documented R12's medications had Black Box Warnings (BBW- highest safety-related warning that medications can have assigned by the Food and Drug Administration) with potential reactions and adverse side effects. This included the use of the following: Ativan (antianxiety) could be associated with an increase in confusion, loss of balance, and cognitive impairment that looks like dementia and increases the risk of falls, broken hips, and legs. R12's Care Plan lacked mention of nonpharmacological approaches to try before the use of as-needed (PRN) Ativan. R12's EMR documented tA Physician's Order dated 05/19/23 for Ativan 0.5 milligrams (mg) every eight hours PRN for agitation. On 07/30/24 at 08:01 AM, R12 was in the dining room, dressed and groomed appropriately for the day. 07/31/24 at 11:57 AM Certified Nurse Aide (CNA) P reported staff provides reassurance when she is anxious, is less tearful, but is easily frustrated, usually redirectable. On 07/31/24 AM Licensed Nurse (LN) H reported staff tried non-pharmacologic interventions for the use of PRN Ativan and stated staff and physician discussed the issue of pain involvement related to behaviors. LN H stated staff had not documented the use of non-pharmacological interventions which should be found in the care plan. On 07/31/24 at 12:53 PM, Administrative Nurse D verified R12 received PRN Ativan which did not have a stop date, and the care plan lacked directions to staff of non-pharmacological interventions prior to use prior to administering PRN Ativan. The facility's Care Plans Goals and Objectives policy, dated 04/2009, documented care plans shall incorporate goals and objectives that lead to the resident's highest obtainable level of independence. Care plan goals and objectives are defined as the desired outcome for specific resident problems. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Goals and objectives are entered into the resident's care plan so that all disciplines have access to such information and are able to report whether or not the desired outcome is being achieved. Goals and objectives are reviewed and or revised when there has been a significant change in the resident's condition when the desired outcome has not been achieved, when the resident has been readmitted to the facility, and at least quarterly. The facility failed to complete a comprehensive care plan related to R12's use of PRN Ativan placing the resident at risk for impaired care due to uncommunicated care needs. - R5's Electronic Medical Record (EMR) documented diagnoses of diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), chronic atrial fibrillation (rapid, irregular heartbeat), major depressive disorder (major mood disorder which causes persistent feelings of sadness), chronic kidney disease and morbid obesity. R5's Quarterly Minimum Data Set (MDS), dated [DATE], documented R5 had intact cognition. R5 required supervision or touching assistance with toileting hygiene and was frequently incontinent of urine and occasionally incontinent of bowel. The MDS recorded R5 had no urinary tract infection (UTI) and received an antidepressant (class of medications used to treat mood disorders), anticoagulant (medication to prevent blood from clotting), and diuretic (a medication to promote the formation and excretion of urine). R5's Care Plan, dated 06/27/24, documented R5 had a self-care deficit due to age and weakness and instructed staff to assist with morning and evening care. The care plan lacked interventions related to the use of antibiotics daily for UTIs. The Physician Order dated 04/19/24 directed staff to administer Macrodantin (an antibiotic) 100 milligrams (mg) at bedtime for chronic UTIs. The Physician Order, dated 05/31/24, directed staff to administer cefdinir 300 mg two times a day for 10 days for UTI. R5's EMR recorded only one UTI for the year during the period of 07/2023 to 07/2024 on 05/32/24. On 07/30/24 at 11:13 AM, observation revealed R5 sat in her room, in her recliner. R5 reported she was able to identify symptoms of UTIs and would report them to staff. She stated she had frequent UTIs in the past, but it was less frequent in the facility. She also reported she did not know what her medication regimen was, and she had confidence the staff was administering them correctly. On 07/31/24 at 10:33 AM, Licensed Nurse (LN) H recognized R5 had ongoing antibiotic use and R5 was able to report to staff signs of UTI. On 07/31/24 at 11:57 AM, Certified Nurse Aide (CNA) P reported R5 toileted herself but did ask for assistance when needed. CNA P reported staff ensure the resident is cleansed properly when assistance is requested. On 07/31/24 at 12:53 PM, Administrative Nurse D verified R5's Care Plan lacked identifying the long-term use of an antibiotic for UTIs and should be addressed with interventions. The facility's Care Plans Goals and Objectives policy, dated 04/2009, documented care plans shall (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	incorporate goals and objectives that lead to the resident's highest obtainable level of independence. Care plan goals and objectives are defined as the desired outcome for specific resident problems. Goals and objectives are entered into the resident's care plan so that all disciplines have access to such information and are able to report whether or not the desired outcome is being achieved. Goals and objectives are reviewed and or revised when there has been a significant change in the resident's condition when the desired outcome has not been achieved, when the resident has been readmitted to the facility, and at least quarterly. The facility failed to develop a comprehensive care plan related to R5's use of daily antibiotic use for a history of UTI placing the resident at risk for impaired care due to uncommunicated care needs.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 30 residents. The sample included 13 residents. Based on observation, record review, and interview, the facility failed to revise the resident's care plan to reflect the resident's current health needs for Resident (R)3. This placed the resident at risk for impaired care due to uncommunicated care needs. Findings included: - The Electronic Medical Record (EMR) for R3 documented diagnoses of diabetes mellitus type 2 (DM-when the body cannot use glucose, not enough sepsis made, or the body cannot respond to the insulin), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), edema (swelling resulting from an excessive accumulation of fluid in the body tissues) and hypertension (high blood pressure). The Quarterly Minimum Data Set (MDS), dated [DATE], documented R3 had intact cognition. R3 required substantial assistance for transfers, partial assistance for dressing and personal hygiene, and set-up assistance for toileting, mobility, and ambulation. The MDS documented R3 had no skin issues. R3's Care Plan, dated 06/27/24 and initiated on 10/19/22, directed staff to inspect R3's skin during showers for any redness, open areas, scratches, cuts, or bruises, and report any changes to the nurse. The care plan lacked direction to staff on the prevention or treatment of skin tears. The Skin/Wound Note, dated 06/27/24 at 01:34 PM, documented R3 obtained three skin tears to his left forearm from a dog during pet therapy while he gave the dog a treat. The area was cleansed, approximated (edges brought together), and Steri-strips (adhesive wound closures) applied. The note further documented the area was covered with a dressing and wrapped with gauze for protection. The Skin/Wound Note. dated 07/14/24 at 08:37 PM, documented R3 bumped his hand on his drawer and obtained a skin tear above his left thumb. The area was cleansed, and Steri-strips were applied. On 07/29/24 at 10:15 AM, observation revealed a skin tear with multiple Steri-strips on R3's right hand by his thumb. R3 stated he bruised easily and explained he hit his hand on his walker and obtained a skin tear on his right hand. R3 stated he always had bruises or skin tears. On 07/30/29 at 09:00 AM, Certified Nurse Aide (CNA) O stated she was aware of a previous skin tear from a dog and said R3's skin was very fragile. CNA O further stated she was unsure of where R3's current skin tear came from. CNA O said R3 did not wear anything to protect his skin from further injury. On 07/31/24 at 08:46 AM, Administrative Nurse E stated she was unaware of R3's current skin tear and was unable to find any information or a skin assessment related to it. On 07/31/24 at 09:00 AM, Licensed Nurse (LN) H stated residents were assessed in the shower for any skin tears, bruises, or skin changes. LN H stated they had not been made aware of the skin tear on R3's right hand. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/31/24 at 12:45 PM Administrative Nurse D stated a skin assessment should have been completed and placed on R3's care plan for interventions to prevent further skin tears. The facility's Goals and Objectives, Care Plans policy, dated 04/09, documented care plan should incorporate goals and objectives that lead to the resident's highest obtainable level of independence and are defined as the desired outcome for a specific resident problem. Care plans are reviewed and/or revised when there is a significant change in condition when the desired outcome has not been achieved, when readmitted after a hospital stay, and at least quarterly. The facility failed to revise the care plan for R3's skin tears. This placed R3 at risk for impaired care due to uncommunicated care needs.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 30 residents. The sample included 13 residents, with three reviewed for quality of care. Based on observation, record review, and interview, the facility failed to implement interventions to prevent skin tears for Resident (R) 3 and failed to provide general skincare and services for R29, who had multiple sores on his arms. This placed the residents at risk for further skin injury and related complications. Findings included: - The Electronic Medical Record (EMR) for R3 documented diagnoses of diabetes mellitus type 2 (DM-when the body cannot use glucose, not enough sepsis made, or the body cannot respond to the insulin), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), edema (swelling resulting from an excessive accumulation of fluid in the body tissues) and hypertension (high blood pressure). The Quarterly Minimum Data Set (MDS), dated [DATE], documented R3 had intact cognition. R3 required substantial assistance for transfers, partial assistance for dressing and personal hygiene, and set-up assistance for toileting, mobility, and ambulation. The MDS documented R3 had no skin issues. R3's Care Plan, dated 06/27/24 and initiated on 10/19/22, directed staff to inspect R3's skin during showers for any redness, open areas, scratches, cuts, or bruises, and report any changes to the nurse. The care plan lacked direction to staff on the prevention or treatment of skin tears. The Skin/Wound Note, dated 06/27/24 at 01:34 PM, documented R3 obtained three skin tears to his left forearm from a dog during pet therapy while he gave the dog a treat. The area was cleansed, approximated (edges brought together), and Steri-strips (adhesive wound closures) applied. The note further documented the area was covered with a dressing and wrapped with gauze for protection. The Skin/Wound Note. dated 07/14/24 at 08:37 PM, documented R3 bumped his hand on his drawer and obtained a skin tear above his left thumb. The area was cleansed, and Steri-strips were applied. On 07/29/24 at 10:15 AM, observation revealed a skin tear with multiple Steri-strips on R3's right hand by his thumb. R3 stated he bruised easily and explained he hit his hand on his walker and obtained a skin tear on his right hand. R3 stated he always had bruises or skin tears. On 07/30/29 at 09:00 AM, Certified Nurse Aide (CNA) O stated she was aware of a previous skin tear from a dog and said R3's skin was very fragile. CNA O further stated she was unsure of where R3's current skin tear came from. CNA O said R3 did not wear anything to protect his skin from further injury. On 07/31/24 at 08:46 AM, Administrative Nurse E stated she was unaware of R3's current skin tear and was unable to find any information or a skin assessment related to it. On 07/31/24 at 09:00 AM, Licensed Nurse (LN) H stated residents were assessed in the shower for any skin tears, bruises, or skin changes. LN H stated they had not been made aware of the skin tear on R3's right hand. (continued on next page)

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The Nicol Home	303 E Buffalo St Glasco, KS 67445

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/31/24 at 12:45 PM Administrative Nurse D stated a skin assessment should have been completed and placed on R3's care plan for interventions to prevent further skin tears. The facility's Skin Tears-Abrasions and Minor Breaks, Care of policy, dated 09/13, directed staff to record information about the wound in the medical record, complete the in-house investigation of causation, implement interventions, or modify current interventions to prevent further incidents. The policy further documented that staff should complete a Report of Incident/Accident notify the responsible family member and physician and report other information in accordance with facility policy and professional standards of practice. The facility failed to implement interventions including dressing and wound care to prevent and treat skin tears for R3. This placed the resident at risk for further skin injuries. - The Electronic Medical Record (EMR) for R29 documented diagnoses of diabetes mellitus type 2 (DM-when the body cannot use glucose, not enough sepsis is made or the body cannot respond to the insulin), chronic pain, muscle weakness, and hypertension (high blood pressure). The Quarterly Minimum Data Set, (MDS), dated [DATE], documented R29 had intact cognition. R29 required substantial assistance for toileting, dressing, personal hygiene, and supervision for mobility and ambulation. The MDS further documented R29 had no skin issues. R29's Care Plan, dated 06/18/24 and initiated on 08/31/23, directed staff to inspect R29's skin per policy during his showers and to observe for redness, open areas, scratches, cuts, bruises, and report changes to the nurse. The Physician's Orders, dated 11/15/23, directed staff to use A&D ointment with zinc (ointment used as a moisturizer to treat and prevent dry itchy skin and minor skin irritations and protect wounds from moisture and bacteria) for skin preventive care. The Skin Observation Tool, dated 07/25/24, documented R29 had scabs on both forearms and old scabs on his knees. R29's EMR lacked orders or treatments related to R29's skin sores. On 07/29/24 at 08:30 AM, observation revealed R29 had four unopened sores the size of a pencil eraser on his right forearm, one unopened sore between the first and second finger by the knuckle on his left hand, and five unopened sores the size of a pencil eraser on his left forearm. On 07/29/24 at 08:30 AM, R29 stated the sores were from scratching his arms because they itched. R29 said he puts lotion on them during the day. On 07/30/24 at 07:30 AM, Certified Nurse Aide (CNA) O stated she did not know what R29's sores were from but said R29 liked to pick at his skin. On 07/31/24 at 09/20/24, Licensed Nurse (LN) H stated R29's sores were open to the air and he received a daily shower. LN H stated staff applied lotion to his arms after his shower. On 07/31/24 at 12:45 PM, Administrative Nurse D stated staff should offer R29 Geri-sleeves (arm skin protectors) and said she would contact the physician for medicated lotion for his arms. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Skin Tears-Abrasions and Minor Breaks, Care of policy, dated 09/2013 documented to obtain a physician's order as needed, reviewing the care plan, and checking the treatment record. The policy further documented if the resident refused treatment, and explained the risks of refusing and the benefits of accepting alternatives. The facility failed to provide treatment for the sores on R29's arms. , and failed to implement interventions to prevent sores on R29's arms. This placed R29 at risk for ongoing skin sores and related complications.

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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** - The Electronic Medical Record (EMR) for R13 documented diagnoses of dementia (a progressive mental disorder characterized by failing memory, and confusion) without behavioral disturbance, weakness, abnormalities of gait and mobility, and repeated falls. The Annual Minimum Data Set (MDS), dated [DATE], documented R13 had severely impaired cognition. R13 required substantial assistance for toileting, dressing, personal hygiene, and transfers. R13 required supervision with ambulation. The MDS documented R13 had no functional impairment and was frequently incontinent of bladder and occasionally incontinent of bowel. R13 had a wander alarm and had one fall since the prior assessment. The Quarterly MDS, dated 05/15/24, documented R13 had severely impaired cognition. R13 required substantial assistance for toileting, dressing, and personal hygiene. R13 required supervision with transfers and ambulation. The MDS documented R13 had no functional impairment and was frequently incontinent of bladder and bowel. R13 had a wander alarm and had two or more falls since the prior assessment. The Morse Fall Scale, dated 02/20/24, 02/21/24, 03/04/24, 03/26/24, 03/30/23, 04/04/24, 05/11/24, 05/21/24, 07/05/24, 07/09/24, and 07/22/24 documented R13 had a high risk for falls. R13's Care Plan, dated 06/20/24 and initiated on 09/17/21, directed staff to assist or ask if R13 needed to use the restroom every two hours. The update, dated 10/09/22, directed staff to continue education for the use of the call lights. The update, dated 08/12/22, directed staff to educate the elder to wait for assistance at night and to not get herself up after a fall. The update dated 09/12/23 directed staff to assist her to the bathroom before and after meals. The update, dated 11/12/23, directed staff to assist R13 as needed to the bathroom. The update, dated 03/26/24, directed staff to take R13 to the bathroom before she laid down in bed, so she doesn't have an accident. The update, dated 02/23/24, directed staff to continue to follow all fall interventions. The update, dated 03/30/24, directed the nurse to reeducate the staff on duty on the importance of periodically checking residents and toileting promptly to prevent falls. The update, dated 07/05/24, documented the reeducation of staff to take R13 to the bathroom after all meals. The update, dated 07/10/24, directed staff to use a wheelchair for longer distances. The Fall Investigation, dated 02/20/24 at 05:55 PM, documented R13 fell in front of her recliner and was unable to tell staff what happened. R13 did not sustain any injury. The Fall Investigation, dated 03/30/24 at 07:41 PM, documented R13 was on the floor between the bed and recliner with her feet extended outward. The investigation further documented R13 did not sustain any injury and staff were educated on the importance of periodically checking on residents more often to make sure they were toileted and changed regularly. The Fall Investigation, dated 04/18/24 at 11:30 AM, documented R13 fell in her room and was unable to tell staff what happened. The investigation further documented R13 was confused, had a gait imbalance, and ambulated without assistance; R13 did not sustain any injury. The Fall Investigation, dated 05/10/24 at 07:23 PM, documented staff observed R13 on the floor in (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the bathroom doorway with no pants on, one shoe on, and her feet extended out towards the bed, with a wet incontinence brief on. The investigation further documented she had not sustained any injury, was unable to tell staff what happened, and the staff was educated on making sure she had proper footwear on and was checked on more periodically to prevent falls. The Fall Investigation, dated 07/05/24 at 10:31 PM, documented R13 on the floor by her bed and was unable to tell staff what happened. R13 was incontinent and did not sustain any injury. The Fall Investigation, dated 03/26/24 at 10:00 PM, documented staff observed R13 on the floor with her back against the bed, feet extended out, blanket over her, in a wet incontinence brief, and no pants. The investigation further documented that staff were educated on the importance of checking on elders periodically and making sure they were not in wet clothing or getting up without assistance. The Fall Investigation, dated 07/09/24 at 05:41 PM, documented R13's knees buckled, and staff lowered her to the ground. The investigation further documented R13 did not sustain any injury. The Fall Investigation, dated 07/10/24 at 11:30 AM, documented R13's knees buckled, and staff lowered her to the ground, The investigation further documented R13 was able to move all extremities per her baseline and did not sustain any injury. On 07/30/24 at 10:32 AM, observation revealed Certified Nurse Aide (CNA) M placed a gait belt around R13's wait, and CNA M and CNA P assisted R13 to stand up in front of her walker to ambulate to the bathroom. Staff assisted R13 with personal care, stood her up, and assisted her back to her recliner. On 07/30/24 at 10:32 AM, CNA M stated R13 had fallen and she was checked on frequently; staff ensured she wore proper footwear. CNA M said R13 had been using a wheelchair more often as her knees were shaky, and staff toileted her more often. CNA M further stated two staff assisted R13 with ambulation but sometimes when she was not weak, they used one staff. CNA M stated when R13 had falls, staff were informed of fall interventions during shift- report or by the leadership team. On 07/31/24 at 09:21 AM, Licensed Nurse (LN) H stated R13 used a wheelchair for longer distances as her knees buckled and staff were to have her call light within reach and make sure she had on proper footwear. On 07/31/24 at 12:45 PM, Administrative Nurse D stated they had not done root cause analysis for R13's falls but did have Resident at Risk meetings to discuss falls and fall interventions. Administrative Nurse D further stated R13 should have a toileting plan to help with fall reduction. The facility's Falls and Fall Risk, Managing policy, dated 03/2018, documented based on previous evaluations and current data, staff would identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. The staff would monitor and document each resident's response to interventions intended to reduce falling or the risks of falling. If interventions have been successful in preventing falls, staff would continue the interventions or consider whether these were still needed if the problem was resolved. If the resident continued to fall, staff would re-evaluate the situation and whether it was appropriate to continue or change the current intervention. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility failed to identify the root cause of R13's falls and implement meaningful person-centered interventions to prevent further falls. This placed R13 at risk for further falls and injury. The facility had a census of 30 residents. The sample included 13 residents of which eight residents were reviewed for falls. Based on observation, record review, and interview, the facility failed to identify and implement interventions to prevent Resident (R) 25 and R13 from falling which placed the residents at risk for further falls and injuries. Findings included: - R25's Electronic Medical Record (EMR) included diagnoses of unspecified falls, altered mental status, weakness, unsteadiness, abnormality of gait and mobility, major depressive disorder (major mood disorder that causes persistent feelings of sadness), and heart failure. The Quarterly Minimum Data Set (MDS), dated [DATE], documented R25 had severe cognitive impairment and wandering behavior which occurred one to three days during a seven-day observation period. R25 had no functional range of motion impairment and used a walker and wheelchair for mobility, R25 required partial to moderate assistance with dressing, putting on and taking off footwear, and toileting hygiene. The MDS further documented R25 required setup or clean-up assistance with bed mobility, transfers, and walking 10 to 150 feet. R25 had not fallen since the prior assessment. R25's Care Plan, dated 06/11/24, documented R25 was at high risk for falls due to confusion, gait, and balance problems. The care plan directed staff to anticipate and meet R25's needs, be sure the call light was within reach, and encourage use for assistance. Staff were to respond promptly and ensure a safe environment with even floors, free of spills and clutter. The care plan further directed staff to review information on past falls and attempt to determine the cause of falls and record possible root causes. R25's care plan lacked documentation of falls or immediate actions placed to prevent the resident from falling. The Progress Notes recorded the following falls: On 06/07/24 at 09:25 AM, R25 was found in her room on the floor in front of the bed. She stated she was getting up from the wheelchair to bed to lie down, did not make it, and slid out of bed. On 06/07/24 at 10:19 AM, R25 was found on the floor in front of her recliner. R25 stated she was fearful of falling and put herself on the floor. The facility's investigation form recorded the immediate action was to bring the resident to the living room to be more closely monitored. On 06/08/24 at 04:06 PM, staff called the nurse to R25's room due to finding the resident on the floor beside the bed with her wheelchair beside her. R25 reported she slipped. The facility's investigation form documented the immediate action was to bring R25 closer to staff for close monitoring. On 06/14/24 at 09:45 AM, R25 was found on the floor of her bathroom, with her wheelchair behind her. The facility's investigation form lacked documentation of an immediate action. On 06/23/24 at 01:27 PM, R25 was found on the floor in her room, sitting by the door and/or hallway. R25 reported she was in her recliner and went to get into her wheelchair and did not lock the brakes, so she went onto her knees and crawled to the doorway. The facility's investigation documented the immediate action taken was to assist R25 into her wheelchair as requested. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/30/24 at 11:30 AM, observation revealed R25 in the dining room in her wheelchair for church service. On 07/31/24 at 10:33 AM, Licensed Nurse (LN) H reported staff assessed the resident for injuries following the falls and documented findings in the EMR. LN H reported all nursing staff could add intervention to prevent further falls if identified. LN H stated care plan oversight was done by the leadership team. On 07/31/24 at 11:57 AM, Certified Nurse Aide (CNA) P reported fall intervention for R25 consisted of assisting the resident with care and toileting if the resident allowed it; staff tried to keep an eye on her whereabouts. CNA P reported fall information was passed on during shift change reports. On 07/31/24 at 12:53 PM, Administrative Nurse D verified that R25's falls had not been recorded in the care plans, nor had interventions been implemented. Administrative Nurse D verified the facility had not done a root cause analysis to determine the reasons for falling. The facility's Managing Falls and Fall Risk policy, dated 03/2018, documented based on previous evaluation and current data, the staff will identify interventions related to the resident's specific risks and causes to prevent the resident from falling and to try to minimize complications from falling. The staff, with the input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factors of falls for each resident at risk or with a history of falls. If falling recurs despite interventions, staff will implement additional or different interventions, or indicate why the current approaches remain relevant. If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions. If underlying causes cannot be readily identified or corrected, staff will try various relevant interventions based on an assessment of the nature or category of falling, until falling reduces or stops or until a reason is identified for its continuation. The staff and physician will monitor and document the individual's response to interventions intended to reduce falling or the consequences of falling. The facility failed to identify and implement interventions to prevent R25 from falling which placed the resident at risk for further falls and injuries.

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 30 residents. The sample included 13 residents. Based on observation, record review, and interview, the facility failed to provide Resident (R) 2 with the appropriate treatment and services to attain the highest practicable mental and psychosocial well-being. This placed the resident at risk for unmet mental health care needs. Findings included: - R2's Electronic Medical Record (EMR) documented diagnoses of chronic kidney disease, polyosteoarthritis (many sites of inflammation of a joint characterized by pain, swelling, redness, and limitation of movement), weakness, and displaced fracture (broken bone) of the humerus (upper arm bone). The Quarterly Minimum Data Set (MDS), dated [DATE], documented R2 had severe cognitive impairment without delirium (sudden severe confusion, disorientation, and restlessness), psychosis (any major mental disorder characterized by a gross impairment perception), or behaviors. R2 required setup or clean-up assistance and had frequent incontinence of urine and occasional incontinence of bowel. R2 received an antipsychotic (class of medications used to treat major mental conditions that cause a break from reality), antidepressant (class of medications used to treat mood disorders), diuretic (medication to promote the formation and excretion of urine), and opioid (medication to treat pain). The MDS further documented an antipsychotic was received on a routine basis only, had no gradual dose reduction (GDR) attempt, and no physician documentation of GDR as clinically contraindicated. R2's Care Plan, dated 06/06/24, documented R2 was dependent on staff for meeting emotional, intellectual, physical, and social needs due to immobility. The plan lacked resident-specific interventions based on the resident's preferred activities or to address her difficulty adjusting to the facility and loss of independence. The Progress Note dated 10/15/24 at 11:36 PM, documented R2 was tearful and stated her leg hurt, R2 accepted pain medication. The Progress Note dated 10/18/24 at 08:00 AM, documented R2 would not acknowledge therapy or nursing staff though staff assisted her in sitting up and taking her medication. She then sat in her recliner without verbalizing to or with the staff providing care. The Progress Note dated 10/21/24 at 01:17 PM, documented R2 refused to leave her room all day, would not be weighed, refused breakfast and medications, and ignored staff when they tried to talk to her. R2 was up in her room independently getting things out of her closet and going to the bathroom. The Progress Note, Dated 10/21/24 at 06:09 PM, documented R2 refused assistance to get ready for supper stating she would do it herself. The nurse on duty went and helped. R2 stated she didn't know she lived in a prison and was upset. The nurse spent 50 minutes talking with R2 when she shared with staff she was upset because she could not go back to her apartment where she enjoyed sitting on her porch to watch the sun go down and look at the flowers she had planted on her patio. She felt she had gotten worse and not better due to increased pain. R2 was very repetitive and hung up on things in the past that she was unable to let go of and move forward. R2 stated she cries every time she goes (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to the dining room and does not want others to see her that way The Progress Note dated 10/23/23 at 09:56 AM documented R2 was assisted to the dining room and was upset and tearful, reporting Please let me die. The note further documents a call was placed to the physician requesting something for R2's anxiety. The Progress Note, dated 10/24/24 at 09:15 AM documented R2 was screaming and crying, stating no one cared about her and she was having pain and requesting to see the physician. Staff offered pain medication, heat, and ice packs but refused interventions related to pain reporting they did not help. The Physician Order, dated 10/25/23, directed staff to administer quetiapine 25 milligrams (mg) twice a day for anxiety. The Physician Order, dated 10/30/23, directed staff to administer trazodone 50 mg at bedtime for depression. The Progress Note dated 10/24/23 at 05:55 PM, documented a physician visit with R2 due to pain and increased tearfulness, and orders were received to obtain an x-ray of the left hip and lumbar spine, start morphine (opioid) PRN for pain for two days only. The progress note further documented R2 was upset and thought nobody cared about her and was very tearful. The Physician Order, dated 10/25/23, directed staff to administer quetiapine 25 milligrams (mg) twice a day for anxiety. The Physician Order, dated 10/30/23, directed staff to administer trazodone 50 mg at bedtime for depression. R2's clinical record lacked evidence of nonpharmacological interventions implemented or action taken to address R2's verbalizations of loss, embarrassment, sadness, and feelings of wanting to die. On 07/31/24 at 10:33 AM Licensed Nurse (LN) H, reported R2's mood had been good, and she had a history of tearfulness and anxiousness. LN H reported that R2 had been coming out of her room more lately. LN H also stated R2's mood seemed to be related to pain and the physician had made changes to her medication and this had helped. On 07/31/24 at 11:33 AM, Certified Nurse Aide (CNA) P reported R2 was less tearful and anxious. On 07/31/24 at 12:50 PM, Social Service X stated she had not spent time with the resident regarding her anxiety and depression. On 07/31/24 at 12:53 PM, Administrative Nurse D verified the lack of social service involvement or mental health support provided to R2 prior to starting medications to treat her mental health. The facility did not provide a policy for behavioral or mental health services. The facility failed to provide R2 with the appropriate mental health support and services before administering psychotropic medication to attain the highest practicable mental and psychosocial well-being. This placed the resident at risk for unmet mental health 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** The facility had a census of 30 residents. The sample included 13 residents. Based on observation, record review, and observation, the facility failed to ensure the Consultant Pharmacist (CP) identified and reported Resident (R) 12 and 13's as needed (PRN) antianxiety medication without a stop date and the lack of an approved indication, or the required documentation, for the use of an antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) medications for R12 and R2. This placed the residents at risk for inappropriate and/or unnecessary medication. Findings included: - R12's Electronic Medical Record (EMR) documented diagnoses of hypertension (HTN-elevated blood pressure), major depressive disorder (major mood disorder which causes persistent feelings of sadness), peripheral vascular disease (PVD- slow and progressive circulation disorder causing narrowing, blockage, or spasms in a blood vessel), dementia (progressive mental disorder characterized by failing memory, confusion), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), occlusive and stenosis (narrowing or constricted) of unspecified carotid artery, hypothyroidism (a condition characterized by decreased activity of the thyroid gland), pure hypercholesterolemia (greater than normal amounts of cholesterol in the blood), chronic kidney disease and Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), and dysphagia (swallowing difficulty). The Quarterly Minimum Data Set (MDS), dated [DATE], documented R12 had severe cognitive impairment and wandered daily. R12 required substantial/maximal assistance with dressing and personal hygiene, partial to moderate assistance with toileting hygiene, and supervision/touch assistance with mobility with the use of a walker. R12 had frequent incontinence of urine and bowel and no diagnosis of urinary tract infection (UTI). R12 received an antipsychotic (class of medications used to treat major mental conditions that cause a break from reality), antianxiety (class of medications that calm and relax people), antidepressant (class of medications used to treat mood disorders), antibiotic (class of medication used to treat infections), diuretic (medication to promote the formation and excretion of urine), and opioid (medication used to treat pain). The MDS further documented an antipsychotic was received on a routine basis only but had no gradual dose reduction (GDR), and no physician documentation as clinically contraindicated. R12's Care Plan, dated 06/20/24, documented R12's medications had Black Box Warnings (BBW- highest safety-related warning that medications can have assigned by the Food and Drug Administration) with potential reactions and adverse side effects. This included the use of the following: Venlafaxine (antidepressant) could lead to worsening of suicidal thoughts and behaviors Ativan (antianxiety) could be associated with an increase in confusion, loss of balance, and cognitive impairment that looks like dementia and increases the risk of falls, broken hips, and legs. Olanzapine (antipsychotic) is not approved for the treatment of patients with dementia-related psychosis and has an increased risk of death. R12's EMR documented the following physician orders: (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	02/16/24 venlafaxine 50 milligrams (mg) two times a day for depression. 05/19/23 Ativan 0.5 mg every eight hours PRN for agitation (no stop date). 03/31/23 Olanzapine two times a day for behaviors. R12's Medication Administration Record (MAR) revealed the use of as-needed (PRN) Ativan three times in March 2024, six times in April 2024, eight times in May and June 2024, and four times in July 2024. On 05/14/24 at 10:38 AM, Progress Note documented R12 had increased behaviors requiring the use of PRN Ativan, and a verbal order was received for a urine analysis. The CP reviewed R12's medical record monthly and documented R12's medication reviewed and no recommendations with the exception of 02/19/24 which identified venlafaxine required an attempt for GDR twice a year, and then yearly thereafter. The physician's response was stable. The CP reviews lacked recommendations for the of olanzapine without an approved indication and did not identify the lack of a stop date or specified duration for the use of PRN Ativan. On 07/30/24 at 08:01 AM, R12 was in the dining room, dressed and groomed appropriately for the day. On 07/31/24 at 12:53 PM, Administrative Nurse D verified the CP did not identify and report the unapproved indication of anxiety for the use of quetiapine. The facility's Pharmacy Services-Role of the Provider Pharmacy policy, dated 04/2019, documented the provider pharmacy to provide services that comply with applicable facility policies and procedures, accepted professional standards of practice, and laws and regulations, including (but not limited to) help the facility comply with its legal and regulatory requirements related to medication and medication management, maintain a medication profile for each resident that includes all pertinent information including that which is required by law and regulations. Screen new medication orders for key parameters, including appropriate indications, proper dose, and duration, correct route of administration, potential for adverse consequences including medication interactions, and possible duplication therapy. The facility failed to ensure the CP identified and reported R12's unapproved indication or lack of required physician documentation for the ongoing use of antipsychotic medication. This placed R12 at risk for inappropriate use of antipsychotic medications. - R2's Electronic Medical Record (EMR) documented diagnoses of chronic kidney disease, polyosteoarthritis (many sites of inflammation of a joint characterized by pain, swelling, redness, and limitation of movement), weakness, and displaced fracture (broken bone) of the humerus (upper arm bone). The Quarterly Minimum Data Set (MDS), dated [DATE], documented R2 had severe cognitive impairment without delirium (sudden severe confusion, disorientation, and restlessness), psychosis (any major mental disorder characterized by a gross impairment perception), or behaviors. R2 required setup or clean-up assistance and had frequent incontinence of urine and occasional incontinence of bowel. R2 received an antipsychotic (class of medications used to treat major mental conditions that cause a (continued on next page)

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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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	break from reality), antidepressant (class of medications used to treat mood disorders), diuretic (medication to promote the formation and excretion of urine), and opioid (medication to treat pain). The MDS further documented an antipsychotic was received on a routine basis only, had no gradual dose reduction (GDR) attempt, and no physician documentation of GDR as clinically contraindicated. R2's Care Plan, dated 06/06/24, documented R2 was dependent on staff for meeting emotional, intellectual, physical, and social needs due to immobility and lacked the use of quetiapine (antipsychotic) and Black Box Warning (BBW- highest safety-related warning that medications can have assigned by the Food and Drug Administration) or mood state with non-pharmacological interventions. The Physician Order, dated 10/25/23, directed staff to administer quetiapine 25 milligrams (mg) twice a day for anxiety. The Consultant Pharmacist (CP) medication review on 04/17/24 documented that R2 received quetiapine twice a day and recommended attempting a gradual dose reduction twice within the first year, then yearly. The CP requested the physician to evaluate the current therapy and document accordingly. The CP recommendation did not identify the inappropriate indication associated with the use of quetiapine. On 04/18/24, the CP documented the physician requested no changes and would consider GDR next year. The documentation lacked the reason for continued use without a GDR. The Progress Note dated 10/24/23 at 05:55 PM, documented a physician visit with R2 due to pain and increased tearfulness, and orders were received to obtain an x-ray of the left hip and lumbar spine, start morphine (opioid) PRN for pain for two days only. The progress note further documented R2 was upset and thought nobody cared about her and was very tearful. R2's clinical record lacked evidence of documented nonpharmacological interventions attempted and failed or the risks versus benefits of continued use without GDR. On 07/31/24 at 12:53 PM, Administrative Nurse D verified the CP did not identify and report the unapproved indication of anxiety for the use of quetiapine. The facility's Pharmacy Services-Role of the Provider Pharmacy policy, dated 04/2019, documented the provider pharmacy to provide services that comply with applicable facility policies and procedures, accepted professional standards of practice, and laws and regulations, including (but not limited to) help the facility comply with its legal and regulatory requirements related to medication and medication management, maintain a medication profile for each resident that includes all pertinent information including that which is required by law and regulations. Screen new medication orders for key parameters, including appropriate indications, proper dose, and duration, correct route of administration, potential for adverse consequences including medication interactions, and possible duplication therapy. The facility failed to ensure the CP identified and reported R2's unapproved indication or lack of required physician documentation for the ongoing use of antipsychotic medication. This placed R2 at risk for inappropriate use of antipsychotic medications. - The Electronic Medical Record (EMR) for R13 documented diagnoses of dementia (progressive mental disorder characterized by failing memory, and confusion) without behavioral disturbance, (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hypertension (elevated blood pressure), and depression (abnormal emotional state characterized by exaggerated feelings of sadness. The Quarterly Minimum Data Set (MDS), dated [DATE], documented R13 had severely impaired cognition. R13 required substantial assistance for toileting, dressing, and personal hygiene. R13 required supervision with transfers and ambulation. The MDS documented R13 received an antidepressant (medication used to treat mood disorders and relieve symptoms of depression). R13's Care Plan, dated 06/20/24 and initiated on 03/09/20, documented R13 had dementia and would sometimes wander and directed staff to cue, reorient, and supervise as needed. The care plan directed staff to administer medications as ordered document for side effects and effectiveness and report any signs of depression or anxiety. The Physician's Order, dated 05/30/24, directed staff to administer Ativan (an antianxiety medication), 1 milligram, by mouth, four times per day, as needed for agitation. The order lacked a stop date. The CP's Medication Regimen Review, dated 06/19/24 and 07/10/24, failed to address the as-needed Ativan. On 07/30/24 at 10:32 AM, observation revealed Certified Nurse Aide (CNA) M placed a gait belt around R13's wait, and CNA M and CNA P assisted R13 to stand up in front of her walker to ambulate to the bathroom. Staff assisted R13 with personal care, stood her up, and assisted her back to her recliner without resistance with care. On 07/30/24 at 09:00 AM, Certified Nurse Aide O stated R13 had behaviors and was at times resistant to care. On 07/31/24 at 09:20 AM, Licensed Nurse (LN) H stated R13 had advanced dementia, would be resistant to care with staff, and was recently placed on Risperdal. Licensed Nurse H further stated R13 also received Ativan as needed on her shower days. On 07/31/24 at 12:45 PM Administrative Nurse D stated she was unaware that the Ativan required a 14-day stop date and said she had not been notified by the pharmacist. The facility's Pharmacy Services-Role of the Provider Pharmacy policy, dated 04/19, documented the Pharmacist would help the facility comply with its legal and regulatory requirements related to medications and medication management. The Pharmacist would establish a reliable way to identify the facility in a timely fashion of issues and concerns related to medications and prescriptions. The CP failed to identify and report the lack of a stop date for R13's PRN Ativan. This placed the resident at risk for inappropriate use of psychotropic medication.

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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** The facility had a census of 30 residents. The sample included 13 residents, with seven reviewed for unnecessary medications. Based on observation, record review, and interview, the facility failed to ensure an appropriate indication, or a documented physician rationale, which included the unsuccessful attempts for nonpharmacological symptom management and risk versus benefit for continued use for Resident (R)4, R13, R2, and R12s' antipsychotic (a medication used to treat any major mental disorder characterized by a gross impairment testing) medication and failed to ensure a 14-day stop date or specified duration for R13 and R12's ongoing as needed (PRN) antianxiety (a class of medications that calm and relax people with excessive anxiety, nervousness, or tension). This placed the residents at risk for unintended effects related to psychotropic (alters mood or thought) drug medications. Findings included: - The Electronic Medical Record (EMR) for R4 documented diagnoses of dementia (a progressive mental disorder characterized by failing memory, and confusion) without behavioral disturbance, anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness, and hopelessness). The Quarterly Minimum Data Set (MDS), dated [DATE], documented R4 had moderately impaired cognition and was dependent upon staff for toileting, dressing, and transfers. R4 required substantial assistance from staff for personal hygiene and mobility, and R4 did not ambulate. The MDS documented R4 had periods of feeling down about herself, had no behaviors, and received antidepressants (medication used to treat mood disorders and relieve symptoms of depression) daily. R4's Care Plan, dated 05/10/24, initiated on 08/18/22, directed staff to administer medications as ordered by the physician and monitor for side effects, consult with the pharmacy to consider dosage reduction and monitor for target behaviors. The Physician's Order, dated 06/21/24, directed staff to administer Rexulti (atypical antipsychotic medication), 0.25 milligram (mg), by mouth, in the evening for dementia. The medication was discontinued on 07/10/24. The Physician's Order, dated 07/10/24, directed staff to administer Rexulti, 0.5 mg, by mouth, in the evening for dementia. R4's EMR lacked a documented physician rationale which included unsuccessful attempts for nonpharmacological symptom management and risk versus benefits for the continued Rexulti use. On 07/30/24 at 09:15 AM, observation revealed R4 in the doorway of her room. R4 was very pleasant and stated she was very happy with her care. On 07/30/24 at 09:00 AM, Certified Nurse Aide (CNA) O stated R4 did not have the typical behaviors but did obsess about a male resident in the facility that she was friends with and always wanted to be with. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/31/24 at 09:20 AM. Licensed Nurse (LN) H stated R4 would get upset if she wanted to watch the news out in the living room area and other residents were watching something else but said she had never been aggressive with other residents. On 07/31/24 at 12:45 PM, Administrative Nurse D stated the family requested she be placed on the medication due to the obsessive calls to her family. Administrative Nurse D further stated the Consultant Pharmacist recommended a reduction in the medication due to the obsessive phone calls to family were less frequent and that the medication was not appropriate for residents with dementia, so the physician did decrease the dose. The facility's Antipsychotic Use policy, dated 07/22, documented that residents would not receive medications that were not clinically indicated to treat a specific condition and would be prescribed at the lowest possible dosage, for the shortest period of time and are subject to gradual dose reduction and re-review. Diagnosis of a specific condition for which antipsychotic medications are necessary to treat will be based on a comprehensive assessment of the resident. Residents would be informed of the recommendations, risks, benefits, purpose, and potential adverse consequences of the medication use. The facility failed to ensure R4 did not receive antipsychotic medication without an appropriate indication or required documentation for its use. This placed R4 at risk for adverse side effects. - The Electronic Medical Record (EMR) for R13 documented diagnoses of dementia (progressive mental disorder characterized by failing memory, and confusion) without behavioral disturbance, hypertension (elevated blood pressure), and depression (abnormal emotional state characterized by exaggerated feelings of sadness. The Quarterly Minimum Data Set (MDS), dated [DATE], documented R13 had severely impaired cognition. R13 required substantial assistance for toileting, dressing, and personal hygiene. R13 required supervision with transfers and ambulation. The MDS documented R13 received an antidepressant (medication used to treat mood disorders and relieve symptoms of depression). R13's Care Plan, dated 06/20/24 and initiated on 03/09/20, documented R13 had dementia and would sometimes wander and directed staff to cue, reorient, and supervise as needed. The care plan directed staff to administer medications as ordered, document for side effects and effectiveness, and report any signs of depression or anxiety. The Physician's Order, dated 05/30/24, directed staff to administer Ativan (an antianxiety medication), 1 milligram, by mouth, four times per day, as needed for agitation. The order lacked a stop date. The Physician's Order, dated 07/26/24, directed staff to administer Risperdal (an antipsychotic medication), 0.25 milligrams (mg), by mouth, twice per day for dementia without behavioral disturbance. R13's EMR lacked a documented physician rationale which included unsuccessful attempts for nonpharmacological symptom management and risk versus benefits for the continued Risperdal use. On 07/30/24 at 10:32 AM, observation revealed Certified Nurse Aide (CNA) M placed a gait belt around R13's wait, and CNA M and CNA P assisted R13 to stand up in front of her walker to ambulate to the bathroom. Staff assisted R13 with personal care, stood her up, and assisted her back to her (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	recliner without resistance with care. On 07/30/24 at 09:00 AM, Certified Nurse Aide O stated R13 had behaviors and was at times resistant to care. On 07/31/24 at 09:20 AM, Licensed Nurse (LN) H stated R13 had advanced dementia, was resistant to care with staff, and was recently placed on Risperdal. Licensed Nurse H further stated R13 also received Ativan as needed on her shower days. On 07/31/24 at 12:45 PM Administrative Nurse D stated she was unaware that the Ativan required a 14-day stop date and of the inappropriate indication for Risperdol. Administrative Nurse D stated she would work with the physician on the Risperdal. The facility's Antipsychotic Use policy, dated 07/22, documented that residents would not receive medications that were not clinically indicated to treat a specific condition and would be prescribed at the lowest possible dosage, for the shortest period of time and are subject to gradual dose reduction and re-review. Diagnosis of a specific condition for which antipsychotic medications are necessary to treat will be based on a comprehensive assessment of the resident. Residents would be informed of the recommendations, risks, benefits, purpose, and potential adverse consequences of the medication use. Residents who received as-needed psychotropic medication would not be renewed beyond 14 days unless the healthcare practitioner had evaluated the resident for the appropriateness of that medication and documented the rationale for continued use. The facility failed to ensure R13 did not receive antipsychotic medication without an appropriate indication or the required documentation for its use and failed to ensure R13's Ativan had a 14-day stop date or specified duration. This placed the resident at risk for adverse side effects. - R12's Electronic Medical Record (EMR) documented diagnoses of hypertension (HTN-elevated blood pressure), major depressive disorder (major mood disorder which causes persistent feelings of sadness), peripheral vascular disease (PVD- slow and progressive circulation disorder causing narrowing, blockage, or spasms in a blood vessel), dementia (progressive mental disorder characterized by failing memory, confusion), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), occlusive and stenosis (narrowing or constricted) of unspecified carotid artery, hypothyroidism (a condition characterized by decreased activity of the thyroid gland), pure hypercholesterolemia (greater than normal amounts of cholesterol in the blood), chronic kidney disease and Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), and dysphagia (swallowing difficulty). The Quarterly Minimum Data Set (MDS), dated [DATE], documented R12 had severe cognitive impairment and wandered daily. R12 required substantial/maximal assistance with dressing and personal hygiene, partial to moderate assistance with toileting hygiene, and supervision/touch assistance with mobility with the use of a walker. R12 had frequent incontinence of urine and bowel and no diagnosis of urinary tract infection (UTI). R12 received an antipsychotic (class of medications used to treat major mental conditions that cause a break from reality), antianxiety (class of medications that calm and relax people), antidepressant (class of medications used to treat mood disorders), antibiotic (class of medication used to treat infections), diuretic (medication to promote the formation and excretion of urine), and opioid (medication used to treat pain). The MDS further documented an antipsychotic was received on a routine basis only but had no gradual dose reduction (GDR), and no physician documentation as clinically contraindicated. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R12's Care Plan, dated 06/20/24, documented R12's medications had Black Box Warnings (BBW- highest safety-related warning that medications can have assigned by the Food and Drug Administration) with potential reactions and adverse side effects. This included the use of the following: Venlafaxine (antidepressant) could lead to worsening of suicidal thoughts and behaviors Ativan (antianxiety) could be associated with an increase in confusion, loss of balance, and cognitive impairment that looks like dementia and increases the risk of falls, broken hips, and legs. Olanzapine (antipsychotic) is not approved for the treatment of patients with dementia-related psychosis and has an increased risk of death. R12's EMR documented the following physician orders: 02/16/24 venlafaxine 50 milligrams (mg) two times a day for depression. 05/19/23 Ativan 0.5 mg every eight hours PRN for agitation (no stop date). 03/31/23 Olanzapine two times a day for behaviors. R12's Medication Administration Record (MAR) revealed the use of as-needed (PRN) Ativan three times in March 2024, six times in April 2024, eight times in May and June 2024, and four times in July 2024. On 05/14/24 at 10:38 AM, Progress Note documented R12 had increased behaviors requiring the use of PRN Ativan, and a verbal order was received for a urine analysis. On 07/30/24 at 08:01 AM, R12 was in the dining room, dressed and groomed appropriately for the day. On 07/31/24 at 12:53 PM, Administrative Nurse D verified that R12 received an antipsychotic without an approved indication and the required physician documentation. Administrative Nurse D verified R12's PRN Ativan did not have a stop date, and there was no documentation of non-pharmacological interventions prior to use. The facility's Psychotropic Medication Use policy, dated 07/2022, documented that residents will not receive medication that is not clinically indicated to treat a specific condition. Consideration of the use of any psychotropic medication is based on a comprehensive review of the resident. This includes evaluation of the resident's signs and symptoms in order to identify underlying causes. 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. Residents on psychotropic medications receive gradual dose reductions (coupled with non-pharmacological interventions) unless clinically contraindicated, in an effort to discontinue these medications. Psychotropic medications are not prescribed or given on a PRN basis unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record. PRN orders for psychotropic medications are limited to 14 days. For psychotropic medications that are NOT antipsychotics, if the prescriber or attending physician believes it is appropriate to extend the PRN order beyond 14 days, he or she will document the rationale for extending the use and include the duration for the PRN order. When determining whether to initiate, modify, or discontinue medication therapy, the (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	IDT conducts an evaluation of the resident. The facility failed to ensure R12 did not receive antipsychotic medication without appropriate indications for or required documentation for its use and failed to ensure R12's PRN Ativan had a 14-day stop date or specific duration. This placed the resident at risk for adverse side effects. - R2's Electronic Medical Record (EMR) documented diagnoses of chronic kidney disease, polyosteoarthritis (many sites of inflammation of a joint characterized by pain, swelling, redness, and limitation of movement), weakness, and displaced fracture (broken bone) of the humerus (upper arm bone). The Quarterly Minimum Data Set (MDS), dated [DATE], documented R2 had severe cognitive impairment without delirium (sudden severe confusion, disorientation, and restlessness), psychosis (any major mental disorder characterized by a gross impairment perception), or behaviors. R2 required setup or clean-up assistance and had frequent incontinence of urine and occasional incontinence of bowel. R2 received an antipsychotic (class of medications used to treat major mental conditions that cause a break from reality), antidepressant (class of medications used to treat mood disorders), diuretic (medication to promote the formation and excretion of urine), and opioid (medication to treat pain). The MDS further documented an antipsychotic was received on a routine basis only, had no gradual dose reduction (GDR) attempt, and no physician documentation of GDR as clinically contraindicated. R2's Care Plan, dated 06/06/24, documented R2 was dependent on staff for meeting emotional, intellectual, physical, and social needs due to immobility and lacked the use of quetiapine (antipsychotic) and Black Box Warning (BBW- highest safety-related warning that medications can have assigned by the Food and Drug Administration) or mood state with non-pharmacological interventions. The Physician Order, dated 10/25/23, directed staff to administer quetiapine 25 milligrams (mg) twice a day for anxiety. The Consultant Pharmacist (CP) medication review on 04/17/24 documented that R2 received quetiapine twice a day and recommended attempting a gradual dose reduction twice within the first year, then yearly. The CP requested the physician to evaluate the current therapy and document accordingly. The CP recommendation did not identify the inappropriate indication associated with the use of quetiapine. On 04/18/24, the CP documented the physician requested no changes and would consider GDR next year. The documentation lacked the reason for continued use without a GDR. The Progress Note dated 10/24/23 at 05:55 PM, documented a physician visit with R2 due to pain and increased tearfulness, and orders were received to obtain an x-ray of the left hip and lumbar spine, start morphine (opioid) PRN for pain for two days only. The progress note further documented R2 was upset and thought nobody cared about her and was very tearful. R2's clinical record lacked evidence of documented nonpharmacological interventions attempted and failed or the risks versus benefits of continued use without GDR. On 07/31/24 at 10:33 AM Licensed Nurse (LN) H, reported R2's mood had been good, and she had a history of tearfulness and anxiousness. LN H reported that R2 had been coming out of her room more lately. LN H also stated R2's mood seemed to be related to pain and the physician had made changes to her medication and this had helped. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/31/24 at 11:33 AM, Certified Nurse Aide (CNA) P reported R2 was less tearful and anxious. On 07/31/24 at 12:53 PM, Administrative Nurse D verified the antipsychotic was started without documentation of nonpharmacological interventions attempted prior and verified the physician had not provided a rationale for the continued use or lack of GDR. The facility's Psychotropic Medication Use policy, dated 07/2022, documented that residents will not receive medication that is not clinically indicated to treat a specific condition. Consideration of the use of any psychotropic medication is based on a comprehensive review of the resident. This includes evaluation of the resident's signs and symptoms in order to identify underlying causes. 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. Residents on psychotropic medications receive gradual dose reductions (coupled with non-pharmacological interventions) unless clinically contraindicated, in an effort to discontinue these medications. The facility failed to ensure R2 did not receive antipsychotic medication without appropriate indications or the required documentation for its use and failed to provide a rationale for the lack of a GDR. This placed the resident at risk for adverse side effects related to psychotropic medication use.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. The facility had a census of 30 residents. The sample included 13 residents. Based on the interview and record review, the facility failed to submit complete and accurate information to the federal regulatory agency through Payroll Based Journaling (PBJ) when the facility failed to submit accurate staffing hour date for all direct care personnel as required. This placed the residents at risk for unidentified issues with inadequate staffing. Findings included: - The PBJ report provided by the Centers for Medicare & Medicaid Services (CMS) for Fiscal Year (FY) 2024 Quarter 2 documented the metric for Registered Nurse (RN) hours and Licensed Nurse (LN) Coverage 24hours/Day was suppressed for the facility and quarter. The PBJ report for FY 2023 Quarter 4 documented 13 dates the facility did not have LN coverage. A review of the nursing schedule and timesheet payroll for FY 2023 Quarter 4 and FY 2024 Quarter 2 revealed LN and RN coverage. On 07/31/24 at 08:05 AM, Administrative Staff A reported he was responsible for submitting the PBJ information and verified he had an inaccurate submission for FY 2023 Quarter 4. Administrative Staff A verified he did not make the submission deadline for FY Quarter 2. The facility's Reporting Direct Care Staffing Information(Payroll-Based Journal) policy, dated 08/2022, documented direct care staffing information is reported electronically to CMS through the Payroll-Based Journal system. Direct care staffing information is submitted on the schedule specified by CMS, but no less frequently than quarterly. Staffing information is collected daily and reported for each fiscal quarter no later than 45 days after the end of the reporting quarter. The facility failed to submit accurate information to CMS PBJ. This placed the residents at risk for unidentified issues with inadequate staffing.

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	175473	A. Building B. Wing	07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Nicol Home	303 E Buffalo St Glasco, KS 67445

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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 30 residents. The sample included 13 residents. Based on observation, interview, and record review, the facility failed to implement antibiotic use protocols to avoid unnecessary and/or inappropriate antibiotic use to reduce the risk of adverse events, including antibiotic resistance, when the facility failed to monitor effectiveness and evaluate appropriateness for the extended administration of prophylactic antibiotics for Resident (R) 5 and R12. This placed the resident at risk for complications related to antibiotic use including the development of antibiotic-resistant organisms. Findings included: - R5's Electronic Medical Record (EMR) documented diagnoses of diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), chronic atrial fibrillation (rapid, irregular heartbeat), major depressive disorder (major mood disorder which causes persistent feelings of sadness), chronic kidney disease and morbid obesity. R5's Quarterly Minimum Data Set (MDS), dated [DATE], documented R5 had intact cognition. R5 required supervision or touching assistance with toileting hygiene and was frequently incontinent of urine and occasionally incontinent of bowel. The MDS recorded R5 had no urinary tract infection (UTI) and received an antidepressant (class of medications used to treat mood disorders), anticoagulant (medication to prevent blood from clotting), a diuretic (a medication to promote the formation and excretion of urine) and an antibiotic (class of medications used to treat infections). R5's Care Plan, dated 06/27/24, documented R5 had a self-care deficit due to age and weakness and instructed staff to assist with morning and evening care, the care plan lacked the use of antibiotic use daily for UTI. The Physician Order dated 04/19/24 directed staff to administer Macrodantin (an antibiotic) 100 milligrams (mg) at bedtime for chronic UTIs. The Physician Order, dated 05/31/24, directed staff to administer cefdinir 300 mg two times a day for 10 days for UTI. R5's EMR recorded one UTI for the year during the period of 07/2023 to 07/2024 on 05/32/24 which was treated with cefdinir. R12's EMR lacked a physician rationale and benefits statement regarding the ongoing use of antibiotics or the concurrent use with other antibiotics for the same issue. On 07/30/24 at 11:13 AM, observation revealed R5 sat in her room, in her recliner. R5 reported she was able to identify symptoms of UTIs and would report them to staff. She stated she had frequent UTIs in the past, but it was less frequent in the facility. She also reported she did not know what her medication regimen was, and she had confidence the staff was administering them correctly. On 07/31/24 at 10:33 AM, Licensed Nurse (LN) H recognized R5 had ongoing antibiotic use and R5 was able to report to staff signs of UTI. On 07/31/24 at 11:57 AM, Certified Nurse Aide (CNA) P reported R5 toileted herself but did ask for (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assistance when needed. CNA P reported staff ensure the resident is cleansed properly when assistance is requested. On 07/31/24 at 12:53 PM, Administrative Nurse D verified the CP should have identified and reported the ongoing antibiotic use without signs and symptoms of infections. The facility's Antibiotic Stewardship policy, dated 12/2016, documented antibiotics will be prescribed and administered to residents under the guidance of the facility's Antibiotic Stewardship Programs. The purpose of our Antibiotic Stewardship Program is to monitor the use of antibiotics in our residents. Orientation, training, and education of staff will emphasize the importance of antibiotic stewardship and will include how inappropriate use of antibiotics affects individual residents and the overall community. Training and education will include an emphasis on the relationship between antibiotic use and gastrointestinal disorders, opportunistic infections, medication interactions, and the elevation of drug-resistant pathogens. The facility failed to identify and address the ongoing use of antibiotics for R5 which placed the resident at risk for adverse effects and antibiotic resistance. - R12's Electronic Medical Record (EMR) documented diagnoses of hypertension (HTN-elevated blood pressure), major depressive disorder (major mood disorder which causes persistent feelings of sadness), peripheral vascular disease (PVD- slow and progressive circulation disorder causing narrowing, blockage, or spasms in a blood vessel), dementia (progressive mental disorder characterized by failing memory, confusion), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), occlusive and stenosis (narrowing or constricted) of unspecified carotid artery, hypothyroidism (a condition characterized by decreased activity of the thyroid gland), pure hypercholesterolemia (greater than normal amounts of cholesterol in the blood), chronic kidney disease and Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), and dysphagia (swallowing difficulty). The Quarterly Minimum Data Set (MDS), dated [DATE], documented R12 had severe cognitive impairment and wandered daily. R12 required substantial/maximal assistance with dressing and personal hygiene, partial to moderate assistance with toileting hygiene, and supervision/touch assistance with mobility with the use of a walker. R12 had frequent incontinence of urine and bowel and no diagnosis of urinary tract infection (UTI). R12 received an antipsychotic (class of medications used to treat major mental conditions that cause a break from reality), antianxiety (class of medications that calm and relax people), antidepressant (class of medications used to treat mood disorders), antibiotic (class of medication used to treat infections), diuretic (medication to promote the formation and excretion of urine), and opioid (medication used to treat pain). The MDS further documented an antipsychotic was received on a routine basis only but had no gradual dose reduction (GDR), and no physician documentation as clinically contraindicated. R12's Care Plan, dated 06/20/24, documented R12's medications had Black Box Warnings (BBW- highest safety-related warning that medications can have assigned by the Food and Drug Administration)with potential reactions and adverse side effects. R12's Care Plan lacked mention of nitrofurantoin (antibiotic) which could lead to resistive infective organisms. R12's EMR documented a Physician's Order dated 06/23/22 for nitrofurantoin (antibiotic) 80 milligrams in the morning for urinary health. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R12's EMR recorded two urine analyses completed on 03/05/24 and 05/15/24 which resulted in no active infection or reason for cultures. R12's EMR lacked a physician rationale and benefits statement regarding the ongoing use of antibiotics without symptoms or infection present. On 05/14/24 at 10:38 AM, Progress Note documented R12 had increased behaviors requiring the use of PRN Ativan, and a verbal order was received for a urine analysis. On 07/30/24 at 08:01 AM, R12 was in the dining room, dressed and groomed appropriately for the day. On 07/31/24 at 12:53 PM, Administrative Nurse D confirmed R12 had ongoing antibiotic use without signs and symptoms of infections. The facility's Antibiotic Stewardship policy, dated 12/2016, documented antibiotics will be prescribed and administered to residents under the guidance of the facility's Antibiotic Stewardship Programs. The purpose of our Antibiotic Stewardship Program is to monitor the use of antibiotics in our residents. Orientation, training, and education of staff will emphasize the importance of antibiotic stewardship and will include how inappropriate use of antibiotics affects individual residents and the overall community. Training and education will include an emphasis on the relationship between antibiotic use and gastrointestinal disorders, opportunistic infections, medication interactions, and the elevation of drug-resistant pathogens. The facility failed to identify and address the ongoing use of antibiotics for R12 which placed the resident at risk for adverse effects and antibiotic resistance.