STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185224	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bowling Green Nursing and Rehabilitation Center	1561 Newton Ave Bowling Green, KY 42104

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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition Based on interview, record review, and review of the Centers for Medicare & Medicaid Services Long-Term Care Facility Resident Assessment Instrument [RAI] 3.0 User's Manual, the facility failed to ensure a significant change in status assessment (SCSA) Minimum Data Set (MDS) assessment was completed for one of two sampled resident (Resident (R) 4) reviewed for hospice. R4 was admitted to hospice care on 09/16/2024; however, a SCSA MDS had not been completed. The findings include: The Centers for Medicare & Medicaid Services Long-Term Care Facility Resident Assessment Instrument [RAI] 3.0 User's Manual, dated 10//2024, specified, 03. Significant Change in Status Assessment (SCSA) The SCSA is a comprehensive assessment for a resident that must be completed when the IDT [interdisciplinary team] has determined that a resident meets the significant change guidelines for either major improvement or decline. Per the manual, An SCSA is required to be performed when a terminally ill resident enrolls in a hospice program or changes hospice providers and remains a resident at the nursing home. The ARD [assessment reference date] must be within 14 days from the effective date of the hospice election. Review of R4's medical record on the admission Face Sheet revealed the facility admitted the resident on 06/02/2017. According to the admission Face Sheet, the resident had a medical history that included diagnoses of adult failure to thrive, anorexia, cerebral infarction, unspecified dementia, and intellectual disabilities. Review of R4's physician orders revealed an undated order that indicated the resident was on hospice. Review of R4's care plan, titled Advance Directive, established 04/06/2021, revealed an intervention with a start date of 09/16/2024, that indicated the resident was placed on hospice care. Further review of R4's medical record revealed no evidence to indicate a SCSA MDS assessment had been completed since the resident was admitted to hospice care on 09/16/2024. During an interview on 11/06/2024 at 9:01 AM, the MDS Coordinator stated she was not aware of the rule regarding the completion of a SCSA MDS following a resident being placed on hospice. The MDS Coordinator confirmed that a SCSA MDS was not completed when R4 was placed on hospice. (continued on next page)

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

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/07/2024 at 9:02 AM, the Director of Nursing (DON) stated her expectation was for staff to follow the state and federal guidelines for completing assessments timely. The DON stated she was not aware a SCSA MDS should have been completed when a resident was placed on hospice. During an interview on 11/07/2024 at 9:16 AM, the Administrator stated her expectation was for assessments to be completed per the RAI guidelines. The Administrator stated she was aware a SCSA MDS needed to be completed when R4 was placed on hospice; however, she was unaware the MDS Coordinator did not know about this rule.

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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. Based on interview, record review, and facility policy review, the facility failed to take action after receiving a pharmacy recommendation for one of five sampled residents (Resident (R) 6) reviewed for unnecessary medications. The findings include: A facility policy titled, Behavior and Psychoactive Medication Protocol, with a review date of 11/2020, revealed Purpose: The facility strives to enhance the Quality of Life and Quality of Care of residents experiencing behavior and receiving psychoactive medications through the Behavior and Psychoactive Medication review process. Each resident shall receive individualized care and services to attain or maintain their highest practicable physical, mental, and psychosocial well-being. Protocol: * The facility IDT [interdisciplinary team] works with the physician to determine the appropriate diagnosis associated with the resident's symptoms so the underlying causes of symptoms are recognized and treated appropriately. * Physician orders and pharmacist reviews clinically support the diagnosis and reason for the medication, including and evaluation of risk versus benefit of the medication to be shared with resident and/or responsible party. A review of R6's medical record which included the admission Face Sheet revealed the facility admitted the resident on 08/15/2024. According to the admission Face Sheet, the resident's medical history included diagnoses of Alzheimer's disease and dementia. Review of an admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/21/2024, revealed R6 had a Brief Interview for Mental Status (BIMS) of 4, which indicated the resident has severe cognitive impairment. The MDS indicated the resident received antipsychotic medication on a routine basis. Review of R6's care plan, titled Psychotropic Drug Use, established 08/24/2024, revealed the resident was at risk for complications as evidenced by the use of psychotropic medications and a history of falls related to a diagnosis of dementia. Review of R6's Medication Orders, revealed an order for risperidone (an antipsychotic medication) oral tablet 0.25 milligrams one tablet by mouth on the day shift between 2:00 PM and 5:00 PM. Review of R6's pharmacy recommendation report dated 08/16/2024, revealed a recommendation to Please clarify/document the approved diagnosis to justify use of Risperdal [risperidone] and update order in EMR [electronic medical record]. There was no outcome listed. Continued review of the pharmacy recommendation report for R6 dated 08/27/2024, revealed a recommendation to Please clarify/document the approved diagnosis to justify use of Risperdal and update order in EMR. The outcome was listed as No response 09/24/2024. Further review of the pharmacy recommendations report for R6 dated 10/28/2024, revealed a recommendation to Please clarify/document the approved diagnosis to justify use of Risperdal and update order in EMR. There was no outcome listed. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 11/05/2024 at 2:44 PM, Pharmacist 7 stated the facility had not responded to the recommendations to add an approved diagnosis to the risperidone for R6, which was why she recommended it again at the end of October 2024. Pharmacist 7 stated she did not know why there had been no response to her identified irregularity, but stated sometimes recommendations fell through the cracks. During a telephone interview on 11/06/2024 at 12:39 PM, R6's primary physician stated if he had not responded to the pharmacy recommendation for R6, it must have been a miscommunication. During an interview on 11/07/024 at 9:03 AM, the Director of Nursing stated she expected staff to respond to irregularities identified in the medication regiment review.