August, 2025 Kansas Survey Findings
Normal Font-Health Survey
Italics= Complaint Survey
Findings in Red=G+ Scope & Severity
Findings in Green from State Regulations
SS=Scope & Severity; LN=Licensed Nurse
TX=treatment; Dx=Diagnosis; Fx=Fracture
CP=Care Plan; CP in pharmacy regulations=Consultant Pharmacist
PU=Pressure Ulcer; ID=identify; Hx=History

FROM McKnights: CMS pushes back iQIES turnover for nursing home surveys - McKnight's Long-Term Care News

KDADS (Kansas Department for Aging and Disability Services) is in the process of transitioning survey documentation from ASPEN (Automated Survey Process Environment) to the newer cloud-based platform iQIES (Internet Quality Improvement and Evaluation System). However, this transition has been delayed.

🖥️ Transition Overview

- ASPEN has long been used by state agencies to manage healthcare provider data and survey documentation.
- iQIES is designed to modernize and consolidate multiple CMS systems, including ASPEN and jRAVEN, into a single platform for survey and certification, patient assessments, and more.
- CMS originally planned to move nursing homes to iQIES in early 2025, but the transition was pushed back to July 14, 2025, due to the need for system upgrades and security improvements.

Reasons for Survey Result Delays

Several factors are contributing to delays in survey results:

- System Transition Disruptions: As with any major software migration, there are bound to be hiccups. Previous transitions (e.g., home health agencies in 2021) experienced data loss and inconsistencies.
- Training and Onboarding: CMS is conducting training sessions for state agencies through April to June 2025 to ensure readiness, which may slow down current survey processing.
- Legacy System Limitations: The outdated QIES environment has security vulnerabilities and high maintenance costs, prompting CMS to prioritize modernization over maintaining full speed in current operations.
- Surveyor Workload and Staffing: Surveyors are adapting to new tools and workflows, which can temporarily reduce efficiency.

NOTE: In future Findings Reports deficiencies will be reported by tag number then highlighted with the month the tag was cited in order to better indicate the numbers of specific deficiencies to indicate trends
April May June July

F550 Resident Rights/Exercise of Rights

NE: SS=D: Failed to provide a dignified care environment for 1 resident during meals placing resident at risk for impaired dignity & quality of life

- Observed staff attempted several times to feed 1 resident while standing over resident during meal on multiple occasions

NE: SS-E: Failed to provide dignified care environment for 6 residents placing residents at risk for impaired dignity & quality of life

- Observed resident in room off DR with pants & briefs pulled down & feeling inside of briefs on multiple occasions; observed resident pushed hand down front of shirt, exposing upper chest; observed resident walked while holding self between legs then pulled down pants & briefs & feeling inside of briefs on multiple occasions
- Observed staff walked up to resident & placed clothing protector w/o asking or speaking to resident then left resident alone
- Observed staff placed 1 resident's meal tray on table in front of resident then other resident began grabbing resident's food off tray then resident abruptly stood up & took tray to room stating "I can't stand this"; resident returned to table once other resident's tray served
- Observed resident received ice cream during activity & upon receiving ice cream, resident immediately pulled away from table by staff & taken to bed w/o staff talking to resident or asking resident if wanted to take ice cream with them

NW: SS=E: Failed to provide 6 residents with resident's right to dignified existence by ensuring residents were well groomed, clean & dressed appropriately for the day placing all 6 residents at risk for impaired dignity & psychosocial impairment

- *Resident with dementia; At 9:30am observed resident in activity room after breakfast in w/c with sling under resident, resident's hair had not been combed & was "mussed", resident with dried yellow & brown food particles on side of w/c that appeared to be days old, resident's blouse wrinkled & no staff in room & no activity for resident to enjoy & resident either looked around room at 5 other residents sitting with resident or slept in w/c; at 10:30, resident sat in same position; staff had placed hymnals to play on iPad but no staff in room interacting with resident & resident slept with head tilted; at 1:30pm CNA rolled resident back & forth in bed by self & resident grabbed CNA's hands & arms to try to stop CNA from rolling resident then staff left room & resident with dark brown food ring around mouth not cleaned from lunch; multiple CNAs stated not enough CNAs working on floor to ensure all resident cares completed, Adm Nurse stated "had been fighting corporate on staffing for awhile"; Adm stated felt staffing was adequate*
- *Resident with dementia; at 9:30am observed resident in activity room with 5 other w/c bound residents with no activity & no staff in room & resident's hair had not been combed & hair sticking up on end, resident w/o bra as CPd & breast & nipple showing thru blouse & w/o makeup & resident with dark brown food particles on sides of w/c that appeared to be days old*
- *Resident with dementia; observed resident in w/c at table & resident with head down, chin on chest, pants stained with food particles, shirt had only 2 buttons buttoned & with large portion of chest & stomach showing & shirt with large, old orange stain on cuff & resident coughed up phlegm on shirt then cited similar findings to previous findings*
- *Cited similar findings for 3 other residents in same unit*

F558 Reasonable Accommodations Needs/Preferences

NE: SS=E: Failed to ensure 4 residents had a way to communicate needs due to call lights being left out of reach; additionally failed to ensure safe transport for 3 residents due to residents being pushed in w/c's w/o foot pedals placing residents at risk for preventable accidents & injuries

- Observed resident in bed with no call light within reach; resident attempted to locate light but was unable to find it when resident's bed pushed against wall & call light on floor under bed
- Observed resident in bed with call light on floor under bed & out of reach for multiple residents on multiple occasions
- Observed staff pushing resident in w/c up hallway & w/c lacked foot pedals & feet touched ground multiple times while being pushed; observed multiple occasions with multiple residents

NE: SS=D: Failed to ensure 1 resident's food preferences were met, due to nursing staff taking dietary items away from tray placing resident at risk for impaired physical, mental & psychosocial wellbeing

- Observed CNA took toast from 1 resident's tray after asking LN if resident should get all bread due to blood glucose readings & LN stated should take ½ bread from resident's tray; CNA took 2 halves of toast from resident's tray; observed LN took bread stick from resident's meal tray stating blood sugar would be too high & resident grabbed with bread grabbed bread off another resident's plate

F580 Notify of Changes (Injury/Decline/Room, etc)

NE: SS=D: Failed to notify 1 resident's physician of changes r/t head injury from staff-assisted cares resulting in delay in acute medical care

- Resident with dementia, acute femur fx, anxiety d/o; total assist with ADLs; NN documented on 1-2-25 indicated staff found resident in bed with blood-soaked Band-Aid & staff reported injury to LN note documented resident did not have injury previous evening & when LN cleaned & assessed wound found 3cm laceration on forehead & LN believed wound might need sutures & notified medical provider & resident sent to ER; EMR w/o progress notes or nursing assessments completed at time of injury; CNA witness stated indicated staff assisting with resident's Hoyer lift transfer before injury occurred & during transfer 1 CNA left room to assist other residents; other CNA's witness statement indicated that after other CNA left room, resident incontinent & during transfer resident punched staff in mouth & CNA saw that resident's head was bleeding so CNA placed Band-Aid on forehead & told other CNA that resident had punched staff in mouth; IDT note documented resident's injury caused when resident struck head on wall outlet next to resident's bed while resident agitated during care

F582 Medicaid/Medicare Coverage/Liability Notice

NE: SS=D: Failed to issue CMS NOMNC form 10123 with required information for 1 resident placing resident at risk for decreased autonomy & impaired decision-making

- EMR documented resident had met therapy goals & would be discharged home; SS staff stated facility did not issue NOMNC to resident who had been discharged from facility with Med A days remaining

F583 Personal Privacy/Confidentiality of Records

NE: SS=D: Failed to ensure staff secured & protected privacy & confidentiality of 1 resident's medical record placing resident at risk for impaired right to confidentiality

- Observed staff left 1 resident's point of care information open & visible on CNA's wall kiosk monitor

F605 Right to Be Free from Chemical Restraints

NE: SS=E: Failed to ensure that 4 residents were free from antipsychotic medication use without an appropriate indication for use or a GDR The facility failed to ensure the physician provided the risk versus benefit statement for the continued use of antipsychotic medications placing 4 residents at risk of unnecessary med administration & related complications

- Resident with psychosis, Alzheimer's disease & dementia with agitation with behaviors; POS for Seroquel for psychosis; Pharmacist (CP) MRR revealed GDR not attempted or recommended since 11-23; reports also lacked CP recommendation for appropriate indication for sue of Seroquel or physician's risk vs benefit for continued use of med
- Resident with dementia, psychosis, insomnia & mood d/o; POS for Rexulti for psychosis, Seroquel for psychosis; CP's MRR lacked recommendation for appropriate indication for use of antipsychotics
- Resident with dementia, Parkinson's, MDD; POS for Aripiprazole for dementia; order lacked approved indication for antipsychotic med use; CP review not completed yet
- Resident with insomnia, dementia; POS for Seroquel for psychosis; EMR lacked evidence of physician-documented rationale for including risks vs benefits of antipsychotic med

F628 Discharge Process

NE: SS=E: Failed to notify the Office of the Long-Term Care Ombudsman (LTCO) of 4 residents' discharge placing residents at risk for uninformed care choices

- Record lacked evidence LTCO notified of hospital transfer for 4 residents

F656 Develop/Implement Comprehensive Care Plan

NE: SS=D: Failed to develop a comprehensive CP for 1 resident for person-centered preferences; also failed to develop comprehensive Cp for 1 resident's respiratory therapy placing residents at risk for impaired care due to uncommunicated care needs

- CP lacked directions to staff of resident's person-centered choices for personal hygiene; observed resident with several days of facial hair on face on multiple occasions; resident stated not trying to grow a beard & would prefer to be shaved on daily basis; staff unaware of where to find if resident preferred to be shaved on daily basis
- CP lacked direction for resident's O2 therapy & use of BiPAP machine at hs; MDS lacked O2 therapy or BiPAP;

F657 Care Plan Timing & Revision

NE: SS=D: Failed to ensure 1 resident was positioned appropriately in Broda chair while being assisted by staff with eating at meals placing resident at risk of swallowing complications & possible aspiration of food

- Resident dependent on ADLs with PEG tube for nutrition along with regular food supplementation with assistance; CP lacked revised interventions that included direction for current nutrition/eating order that included mechanical soft diet with max assist & for resident o be in upright position in w/c; observed resident reclined back in Broda chair wile being assisted with breakfast on multiple occasions; on 1 occasion, staff repositioned resident after realizing resident not in appropriate position

NE: SS=D: Failed to revise CP to include resident-centered functional abilities for 1 resident placing resident at risk for unmet care needs

- Resident with multiple documented behaviors toward staff during assist with ADLs, dressing, transfers & grooming, transfers; CP lacked direction to staff r/t increase in aggressive behaviors with ADLs

NE: SS=D: Failed to revise CP to include resident-centered functional abilities for 2 residents placing residents at risk for unmet care needs

- CP lacked directions to staff for toileting hygiene, transfers, bed mobility, bathing, oral hygiene, dressing & eating for 1 resident
- CP lacked direction for staff on toileting hygiene, transfers, bathing, oral hygiene, dressing & eating for 1 resident

F677 ADL Care Provided for Dependent Residents

NE: SS=D: Failed to ensure 1 resident's footrest was down on w/c & feet had appropriate footwear & further failed to ensure 1 resident provided with assist while eating placing 2 residents at risk for impaired ADLs & unmet care needs

- Observed resident pushed to common area by staff & resident in w/c with no socks on & footrest not pulled down on chair & legs & feet dangling off chair, uncovered
- Observed resident in Broda chair in DR with breakfast on bedside table across lap & no staff sat & offered assist or encouraged resident during breakfast on multiple occasions

NE: SS=D: Failed to provide necessary assistance with personal hygiene for 1 resident placing resident at risk for poor hygiene, decreased self-esteem & impaired dignity

- Cited findings noted in F656 r/t resident's facial hair; Resident with dementia, depression, cognitive communication deficit, lack of coordination; CP lacked direction to staff of resident's person-centered choices for personal hygiene; observed resident with several days of facial hair on face on multiple occasions; resident stated not trying to grow beard & preferred to be shaved daily

NE: SS=D: Failed to provide consistent bathing & grooming for 1 resident placing resident at risk for complications r/t poor hygiene & impaired dignity

- March 2025 shower sheets & bathing record documented resident had not received bath or shower from 3-6-25 thru 3-33-25 (26 days) with 7 refusals; April with 13 days & 15 days between baths with 6 refusals; May with 13 days between baths with 3 refusals;

observed resident with hair uncombed with elastic hair tie & hair tangled & matted; observed resident with same clothes on as previous day & hair uncombed & tangled & matted

NW: SS=E: Failed to provide 6 residents with appropriate ADL care for each resident to maintain a dignified existence and quality of life to maintain the highest practicable physical, mental, and psychosocial wellbeing placing residents at risk for an undignified existence and a decline in their mental and psychosocial well-being

- *Cited findings noted in F550 r/t unkempt hair, soiled w/c's, soiled clothing; inappropriate clothing, lack of face cleaning after meals, assist with snacks that were wheeled into unit but no one passed or assisted residents; lack of repositioning provided & lack of assistance with eating and lack of activity programming for 6 residents; CNAs and Adm nurse confirmed lack of staffing to provide cares for residents; referenced F725 Sufficient Nursing Staff*

F679 Activities Meet Interest/Needs Each Resident

NW: SS=E: Failed to provide 6 residents with a resident-centered activities program that incorporated the residents' interests, hobbies, and cultural preferences to maintain or improve the residents' physical, mental, and psychosocial well-being placing 6 residents at risk for decline in meaningful interaction, meaningful activities, and psychosocial well-being

- *Cited findings noted in F550 & F677 r/t lack of activity programming in area with 6 residents with dementia; observed 6 residents sitting in activity room with no activities or music from iPad with no staff present & no residents participating in programming; AD/SSD stated allowed 3-1/2 hours/day for each position & when gone had replacement staff member covering activities; AD/SSD stated Catholic residents would not want to meet with local pastor & had not tried to get anyone but local pastor; Adm Nurse admitted activities provided to residents were "old, redundant, and activity calendar was rarely changed to meet residents' activity needs"; observed all 6 residents sitting in activity room w/o activity programming other than occasion hymns played on iPad*

F684 Quality of Care

NE: SS=D: Failed to follow a physician's order to apply TED hose in mornings for edema placing resident at risk for increased edema, pain, and skin-related difficulties

- POS for TED stockings off bilateral LE at hs & on every day shift; observed resident on multiple occasions w/o TED stockings on feet

F686 Treatment/Services to Prevent/Heal Pressure Ulcer (PU)

NE: SS=D: Failed to ensure pressure-reducing devices were in place for 2 residents who were at risk for development of PUs placing 2 residents at risk for complications r/t skin breakdown

- Resident with risk for skin impairment r/t incontinence & dx; CP documented staff would encourage resident to offload BLE while in bed; POS for PRAFO; observed resident in Broda chair in DR & no PRAFO boots in place as ordered on multiple occasions
- Resident at risk for skin impairment r/t incontinence & impaired mobility; CP documented resident used foam mattress & heels to be floated in bed; resident with tx to heel r/t impairment; observed resident in bed & heels not floated & boots under hand sink & not on resident

NE: SS=D: Failed to ensure pressure for 2 residents' offloading boots were applied to their heels to prevent pressure ulcers placing 2 residents at increased risk for pressure ulcer development

- POS for low air loss mattress, check functionality & setting, setting at auto firm mode & on #3 every shift for wounds; heel protectors on at all times when in bed; observed resident with no heel protectors on multiple occasions
- POS for heel suspension boots at all time when in bed q evening & night shift; rt heel to encourage non-weight bearing as much as possible except for therapy & transfers as needed for wound healing; observed resident on multiple occasions with suspension boot in chair next to bed & no extra pillow on bed or in chair

F688 Increase/Prevent Decrease in ROM/Mobility

NE: SS=D: Failed to ensure 1 resident's resting splint and 1 resident's cockup splint were applied for contractures & dysphagia placing resident at risk for discomfort and decreased range of motion

- CP documented restorative program r/t hand splints PRN & rolls as alternative & dates from 4-17-25 thru 4-29-25 marked with "x"; record under Restorative Monthly Progress Notes documented last progress note dated 11-19-24; POS with OT recommendations r/t hand splints bilaterally with rolls as alternative; observed resident with right hand closed & held next to resident's chest & left hand closed & laid on leg & resident w/o resting splints on hands or bilateral hand rolls on multiple occasions
- EMR documented resident with contracture & resident with max assist with ADLs; CP instructed staff to assist resident with cockup splint for wrist; observed resident with hands closed with left hand & wrist curled to chest & hand closed & w/o cockup splint on hand on multiple occasions

NE: SS=D: Failed to ensure 1 resident's braces to both knees were applied placing resident at risk for discomfort and decreased range of motion

- Observed resident in Broda chair w/o ordered braces to both knees on multiple occasions

F689 Free of Accident Hazards/Supervision/Device

NE: K (Abated to E): Failed to ensure a safe care environment related to environmental hazards. On 04/21/25 at 07:15 AM, an inspection of the facility's open kitchenette area off the main entry revealed the kitchenette's oven/stove top power shut-off was not activated. An

inspection of the electric oven/stove top revealed working stove top burners and oven, and the counter to the left of the oven revealed a working bread toaster. On 04/21/25 at 07:30 AM, an inspection of the 200-hallway revealed an unlocked maintenance closet which contained 15 bottles of disinfectant cleaner. On 04/21/25, an inspection of the secured memory care unit revealed cognitively impaired resident going through an unlocked cabinet next to the television area, which contained a half-gallon jug of bleach and disinfectant spray. The facility failed to secure potentially hazardous materials and equipment, placing 11 cognitively impaired/independently mobile residents on the main unit & 4 cognitively impaired/independently mobile residents on the memory care unit in immediate jeopardy. The facility additionally failed to implement effective fall interventions for 1 resident placing resident at risk for falls and accidents

- Cited findings noted in findings' statements
- Plan of Removal:
    - Power shutoff switch activate & cabinet locked
    - Maintenance office locked & keypad reprogrammed to entry door for maintenance office
    - Pop-up toaster unplugged & moved to cabinet
    - Chemicals removed from closet in memory care unit
    - Maintenance staff completed full facility safety rounds
    - Education provide to staff about safe chemical use & storage
- Resident with dementia with dependent on staff assist for LE dressing & bathing; resident with multiple falls & continued with fall risk; resident with documented non-injury falls on 2-22-25, 2-28-25, 4-2-24 & no investigation with root cause analysis provided; intervention for 2 falls was medication review & no reviews provided; observed room lacked sign to remind resident to wear appropriate footwear; observed resident pushed in w/c as feet drug along floor & w/c lacked birth tape on w/c brakes as CP'd

NE: SS=E: Failed to promote a safe care environment free from accidents & hazards for 3 residents placing residents at risk for preventable falls and injuries

- Resident with total assist with ADLs with Hoyer transfers; NN documented resident suffered laceration of scalp during staff-assisted transfer from w/c to bed & resident sent to ER for eval & treat of head injury; incident report lacked root cause analysis or description of how injury occurred; no witness statements provided with incident investigation; EMR lacked progress notes or assessments completed at time of resident's injury; CNA involved in incident terminated due to failure to comply with company standards
- Resident with fall risk; event report documented resident found on floor; resident bleeding on side of eyebrow; bed found in highest position; resident sent to ER; resident with multiple further falls; EMR lacked bed control device assessment to ensure resident safe to operate bed
- Observed resident with fall risk in Broda chair with call light out of reach on multiple occasions;

F690 Bowel/Bladder Incontinence, Catheter, UTI

NE: SS=D: Failed to ensure staff provided appropriate treatment and services to prevent potential UTI for 1 resident when staff failed to ensure resident's catheter bag was drained each shift and as needed placing resident at risk of complications, infection, and further urinary problems

- Resident with retention of urine with indwelling catheter; CP lacked staff direction for frequency of emptying catheter bag; POS for 18 French to straight drainage; record urine output every shift; observed resident with catheter bag visibly full or urine & tubing full of urine on multiple occasions; staff reported bag & tubing should be emptied at least q shift & PRN & bag & tubing should not be overfilled with urine that could back up into bladder & cause pain or infection

F692 Nutrition/Hydration Status Maintenance

NE: SS=D: Failed to ensure 1 resident was positioned appropriately in Broda while being assisted by staff with eating at meals placing resident at risk of swallowing complications and possible aspiration

- Observed resident reclined back in Broda chair while being assisted to eat on multiple occasions on multiple occasions

F695 Respiratory/Tracheostomy Care & Suctioning

NE: SS=D: Failed to ensure 1 resident's CPAP was stored in sanitary manner placing resident at risk of increased risk for respiratory infection & complications

- Observed resident in bed & CPAP mask & tubing laid on floor between bed & wall & not stored in sanitary manner

NE: SS=D: Failed to ensure there was a physician indication fo O2 administration for 1 resident & failed to ensure O2 tubing was stored in sanitary manner to & contamination placing resident at increased risk for respiratory infection & complications

- MDS lacked documentation that resident was on O2 therapy & had order for BiPAP on multiple MDSs; CP lacked direction for O2 therapy & use of BiPAP; POS for BiPAP while asleep or in bed; CPAP; check O2 saturation q shift & titrate O2 to keep stats above 90% every shift for CHF exacerbation; order lacked dosing instructions for O2; observed resident with O2 tubing in nares; observed O2 tubing laid on DR table unbagged

Pain Management

SE: SS=G: Failed to assess for pain & take action to manage severe pain for 1 resident. Additionally, facility failed to communicate resident's pain between nurses, doctors, & other healthcare providers; as a result of the deficient practice, resident had severe pain with ineffective pain relief for 6 days placing resident at risk for discomfort and further decline in overall well-being

- *Resident with OA, hemiparesis/hemiplegia & chronic pain; pain CAA did not trigger on MDS; resident with BIMS of 0, dependent with ADLs; POS for Acetaminophen q hs; & PRN for pain; hydrocodone/acetaminophen PRN pain; hydrocodone/acetaminophen BID for arthritis pain; NN documented resident cried out in pain in DR as arm behind resident in w/c & resident hollered out loudly in pain when arm touched; note documented resident with edema on elbow; staff notified physician & received order for x-ray of humerus & elbow; progress note documented x-ray results negative; NN documented resident received shower & recorded yellow bruises on chest area; NN documented resident with uncontrolled crying & poor oral intake but lacked mention of any actions taken or follow up assessment for ongoing pain on multiple occasions; Orders Administration Note documented scheduled hydrocodone/acetaminophen ran out & pharmacy unable to provide code to remove med from emergency kit due to need for new signed prescription from physician & request for new script placed in MD book to notify physician; NN documented staff notified provider via phone r/t resident's need for new script; NN documented x-ray results showed acute mildly displaced fx of surgical neck of proximal lt humerus, new to prior x-ray results; resident went 6 days w/o adequate pain management for acute fx of humerus*

F725 Sufficient Nursing Staff

NW: SS=F: Failed to provide sufficient nurse staffing with the appropriate skill sets and competencies to treat 5 residents with respect, dignity, and care for each resident in a manner and in an environment that promoted maintenance or enhancement of his or her quality of life to maintain the highest practicable physical, mental, and psychosocial wellbeing. (Refer to F677)

- *Cited findings noted in F550, F677, & F679 r/t lack of sufficient staff to provide ADLs and activity programming for residents with dementia; multiple staff reported lack of enough staff to provide cares & activity programming & that activity programming was "old, redundant, and activity calendar was rarely changed to meet residents' activity needs"*

F726 Competent Nursing Staff

NE: SS=D: Failed to ensure staff possessed the appropriate skills & knowledge to safely provide direct care & nursing services r/t 1 resident's care needs resulting in preventable injuries & delayed medical treatment

- Review of CNA personnel file involved in resident injury during transfer revealed final notice counseling r/t injury-related accident that occurred; termination form indicated CNA terminated due to failure to comply with company standards r/t CNA position

F730 Nurse Aide Performance Review-12 hr/yr In-Service

NE: SS=F: Failed to ensure 5/5 CNA staff reviewed had yearly performance evals completed placing residents at risk for inadequate care

- 5 CNA's files with no yearly performance evaluation in record

F732 Posted Nurse Staffing Information

NE: SS=C: Failed to maintain posted daily nurse staffing data for required 18 months

- Review of posted staffing sheets from 10-20-23 thru 4-20-25 revealed 31 days missing sheets

F744 Treatment/Service for Dementia

NE: SS=D: Failed to ensure staff provided necessary person-centered activities & interventions to address 1 resident's dementia placing resident at risk of ineffective treatment & decreased quality of care

- Resident with dementia, MDD, Parkinson's disease, bipolar d/o; resided on memory care unit; CP lacked person-centered activities & services to direct staff for dementia care needs; observed resident in bed, hollering inaudible words n native Cantonese language & no staff present in room; staff reported tried to perform activities but resident "not able to participate"; CP lacked dementia focus

NE: SS=E: Failed to provide consistent dementia-related care services for 6 residents to promote the resident's highest practicable level of well-being placing residents at risk for decreased quality of life, isolation, and impaired dignity

- Resident with dementia; observed resident wandering into other resident rooms & exited room with other resident belongings; resident into verbal altercation with other resident about belongings resident had taken out of room resulting in resident punching other resident in arm & grabbing shirt & LN separated residents other residents returned to room & resident followed other resident
- Observed 2 residents walking down hallway holding hands then went into a 3rd resident's room where looked through other resident's belongings & took a stuffed bear from dresser; LN stated resident not allowed to enter other resident rooms or take property
- Resident with dementia; observed resident in DR & other resident sat at table; when staff placed other resident's tray on table in front of resident, resident began grabbing other resident's food off tray & other resident abruptly stood up & took tray to room stating "I can't stand this"
- Observed resident in Broda chair in DR awaiting activity of ice cream; upon receiving ice cream no interaction or further activity for resident

- Observed dementia resident at DR table with another resident; resident took other resident's ice cream & started eating it; CNA moved resident to another table; CNA stated area for dining & watching TV very small on secured unit & sometimes staff not always able to do activities due to resident behaviors & resident's lack of staying focused
- Resident with dementia-related aggressive behaviors of hitting, pinching, hitting at staff, biting resulting in injury to resident; resident with multiple documented behaviors

NE: SS=D: Failed to address 1 resident's dementia care needs, when resident continued to go through staff members' belongings that were kept at the nurse's station placing resident at risk for decreased quality of life and accidents

- Resident with dementia with behaviors & received antipsychotic & antianxiety meds; POS for Seroquel for schizoaffective d/o, Oxcarbazepine for mood disturbance, Mirtazapine for depression, Ativan for anxiety; NN documented resident with increased wandering & attempts at taking staff members' belongings on multiple occasions

F756 Drug Regimen Review, Report Irregular, Act On

NE: SS=D: Failed to ensure the Consultant Pharmacist (CP) identified & reported when 3 residents' antipsychotic medication lacked a CMS-approved indication for use placing residents at risk of unnecessary medication administration & related complications

- Resident with dementia; POS for Olanzapine for mood d/o; order lacked appropriate CMS indication for use for resident dx'd with dementia; review of MR from 1-24 thru 3-25 revealed lack of CP ID'ing & reporting inappropriate indication for use of Olanzapine
- Resident with dementia; POS for Seroquel via G-tube for agitation; order lacked appropriate CMS-approved indication for use; MRRs 1-24 thru 3-25 lacked ID'ing & reporting of inappropriate indication for use of Seroquel
- Resident with dementia, depression; POS for Quetiapine for agitation; MMR on 3-4-25 indicated Seroquel had non-approved indication with recommendation for dx change or reassess indications; Seroquel indication changed to depression; EMR w/o physician-documented rationale for indicated use of Seroquel for dementia-related agitation or depression; observed resident agitated & yelling at care staff but was redirectable

NE: SS=E: Failed to ensure that the Consultant pharmacist (CP) identified and reported 2 resident's antipsychotic medication use w/o an appropriate indication for use. The facility failed to ensure the CP recommended a GDR for 2 residents' antipsychotic medication. The facility also failed to ensure the physician provided the risk vs benefit for the continued use of 1 resident's antipsychotic medications placing 2 residents at risk of unnecessary medication administration & related complications

- Cited findings noted in F605 r/t antipsychotic use with inappropriate indications & lack of GDR

F757 Drug Regimen is Free from Unnecessary Drugs

NE: SS=D: Failed to ensure that 2 resident's physician-ordered parameters were obtained & monitored prior to administration of beta-blocker antihypertensive meds; failed to ensure 1 resident's Diclofenac Gel order included required dosage amount placing 2 residents at risk of unnecessary medication administration & related complications

- POS for Metoprolol with holding parameters; MAR revealed resident's BP & pulse not obtained & recorded prior to administration on 30/30 opportunities in previous month & 14/14 in current month prior to administration of Metoprolol
- POS for Diclofenac gel 1% & order lacked dosage amount to apply

NE: SS=D: Failed to hold BP med per the physician-ordered parameters for 1 resident placing resident at risk for physical decline and other related complications

- POS for Midodrine for hypotension with holding parameters; MAR revealed 17 opportunities of med administration outside holding parameters

F758 Free from Unnecessary Psychotropic Meds/PRN Use

NE: SS=D: Failed to ensure the physician provided an appropriate CMS indication for use of 2 residents' prescribed antipsychotic medication. The facility failed to ensure the physician provided the risk versus benefit for the continued use of antipsychotic medications placing residents at risk of unnecessary medication administration and related complications

- Cited findings noted in F756 r/t residents with dementia on antipsychotic meds w/o CMS-approved medications

F760 Residents are Free of Significant Med Errors

NE: SS=D: Failed to prevent a medication administration error for 1 resident whose BP was out of the physician's ordered parameters, & resident received BP medication placing resident at risk for physical decline and other related complications

- Cited findings noted in F757 r/t administration of Midodrine outside physician-ordered parameters

F761 Label/Store Drugs & Biologicals

NE: SS=E: Failed to label 11 residents' insulin flex pens & vials with opened date & when expired placing affected residents at risk for ineffective meds

- Observed med cart with insulin flex pen not labeled or date with open or expiration date for 11 residents

F812 Food Procurement, Store/Prepare/Serve-Sanitary

NE: SS=F: Failed to follow sanitary dietary standards r/t food & equipment storage placing residents at risk r/t foodborne illnesses & food safety concerns

- Observed uncovered food, open to air; unlabeled & undated food items in freezer & fridge; plate & utensil storage with stacked bowls in plastic bin facing upward
- Kitchenette with stains & old food debris inside fridge & microwave & freezer with open,
- Food cart with clean plates stored facing upward

F838 Facility Assessment

NE: SS=F: Failed to conduct a thorough facility-wide assessment to determine the resources necessary to care for residents competently during both day-to-day operations and emergencies with potential to affect all residents residing in the facility

- Assessment failed to ID specific staffing needs by shifts for weekends & staffing needed for specialized memory care unit; PBJ report revealed excessively low weekend staffing triggered for all 4 quarters

F849 Hospice Services

NE: SS=D: Failed to ensure a coordinated plan of care, which coordinated care & services provided by the facility with the care & services provided by hospice, was developed and available for 2 residents placing residents at risk for inappropriate end-of-life care

- CP lacked direction to staff for collaboration of care & services with hospice provider which included services, frequency of visits, meds & equipment provided by hospice
- CP lacked hospice provider's contact information, services, meds, & equipment provided by hospice & how often hospice staff would make visits

F851 Payroll Based Journal

NE: SS=F: Failed to submit complete & accurate staffing information to PBJ placing residents at risk for impaired care due to unidentified staffing issues

- PBJ for all 4 quarters indicated facility triggered for low weekend staffing; Adm nurse stated weekend staffing was not low; Adm stated information based on payroll hours

F865 QAPI Program/Plan, Disclosure/Good Faith Attempts

NE: SS=F: Failed to maintain effective QAA program to address quality deficiencies prior to survey placing residents at risk for ineffective care

- Referenced: F550, F558, F583, F657, F677, F686, F688, F689, F692, F695, F730, F732, F744, F756, F758, F812, F838, F851, F880, F947

F880 Infection Prevention & Control

NE: SS=E: Failed to ensure trash was not left on floor & linens, dishes, trash bags & gloves were not left on radiator or handrail; failed to ensure 2 residents' nasal cannula O2 tubing was stored in sanitary manner & failed to ensure 1 resident's CPAP mask stored in sanitary manner & further failed to ensure Hoyer was sanitized after resident use placing residents at risk for infectious diseases

- Observed gloves, trash bags on handrail; trash bag filled with briefs & wipes laid on floor at top of hallway close to common area; towel & plate with plastic spoon & cup on register at end of hallway; 2 residents' nasal O2 tubing wrapped around stationary canisters in room & cannulas not stored in sanitary manner; CPAP not stored in sanitary manner; staff moved Hoyer lift from 1 resident to another resident room w/o cleaning lift

NE: SS=E: Failed to adhere to infection control for enhanced barrier precautions (EBP) for 1 resident who had a diabetic neuropathy ulcer on on right great toe & right second toe placing resident at risk for possible exposure to infection

- Observed LN entered room for 1 resident to perform wound care; LN washed hands, donned gloves but no gown; when finished, discarded gloves in trash can in room; no PPE available in room or instructions for use of PPE when providing cares

F883 Influenza & Pneumococcal Immunizations

NE: SS=E; Failed to obtain consent or declinations for the PCV20 vaccination for 5 residents placing residents at increased risk for complications related to pneumonia

- Record of 5 residents revealed PCV20 was offered or declined & lacked documentation of historical administration or physician-documented contraindication

F947 Required In-Service Training for Nurse Aides

NE: SS=F: Failed to ensure 5/5 CNAs reviewed had required 12 hours of in-service education placing residents at risk for decreased quality of life &/or inadequate care

- 5 CNA records revealed staff had not completed required in-services in past 12 months