STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175135	A. Building B. Wing	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicalodges Post Acute Care Center	6500 Greeley Avenue Kansas City, KS 66104

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49634 The facility identified a census of 29 residents. The sample included 13 residents. One resident was sampled for reasonable accommodations of needs. Based on observation, record review, and interview, the facility failed to ensure that Resident (R) 4 had foot pedals on her wheelchair while being pushed. This deficient practice left R4 vulnerable to accidents and injuries due to unmet care needs. Findings included: - R4's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), hypertension (HTN-elevated blood pressure), hemiparesis/hemiplegia (weakness and paralysis on one side of the body) following cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain) affecting right dominant side, major depressive disorder (major mood disorder that causes persistent feelings of sadness), vascular dementia (a progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). The Quarterly Minimum Data Set (MDS) dated [DATE] recorded a Brief Interview for Mental Status (BIMS) score of seven which indicated severely impaired cognition. The MDS documented R4 was impaired on one side of her body. The MDS documented R4 needed supervision or touching assistance from staff once seated in her wheelchair. R4's Cognitive Loss Care Area Assessment (CAA) dated 06/06/24 documented R4's BIMS last review was a 12 indicating moderate impairment, and R4's BIMS was currently a seven. R4's Care Plan dated 01/29/24 documented R4 required staff assistance with activities of daily living (ADLs) related to physical limitations. R4's plan of care documented R4 used a wheelchair for transportation and locomotion. R4's plan of care documented she was able to wheel herself about her home in her wheelchair and needed to wear appropriate shoes and non-slip footwear. On 10/22/24 at 08:14 AM Certified Nurse Aide (CNA) O pushed R4 up the 300 hall into the dining room in a wheelchair with no foot pedals. R4's feet repeatedly bounced on the floor, and CNA O repeatedly asked R4 to pick up her feet. (continued on next page)

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

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/24/24 at 08:19 AM CNA N pushed R4 from the commons area into the dining room; R4 had no foot pedals on her wheelchair. On 10/24/24 at 11:58 AM, CNA M stated residents should always have foot pedals if the resident was being pushed by a staff member. On 10/24/24 at 12:14 PM Licensed Nurse (LN) G stated all residents should have foot pedals if being pushed by staff. On 10/24/24 at 12:14 PM Administrative Nurse D stated residents should not be pushed by staff unless they have foot pedals on their wheelchairs. The facility did not provide a policy on accommodation of needs. The facility failed to provide foot pedals for R4's wheelchair. This deficient practice left R4 vulnerable to preventable accidents and injuries due to unmet care needs.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 45668 The facility identified a census of 29 residents. Based on interviews and record review, the facility failed to implement a policy that prohibited hiring employees found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law when the facility failed to conduct background screening on two employees. This deficient practice placed the affected residents at risk for abuse, neglect, misappropriation, or mistreatment. Findings included: - On 10/23/24 at 09:00 AM a review of staffing for license verification, in-service training, and background checks was completed. An employee review of Licensed Nurse (LN) G revealed a hire date of 08/30/23. The facility was unable to provide evidence a criminal background check had been completed by the facility for LN G. An employee review of Housekeeping U revealed a hire date of 06/06/24. The facility was unable to provide evidence a criminal background check had been completed by the facility for her. On 10/23/24 at 10:45 AM Administrative Staff A stated he was not sure why the employees were missing background checks in their files but would make sure all other employee's files were reviewed. On 10/23/24 at 11:45 AM Administrative Staff A provided a receipt dated 10/23/24 for background checks for both LN G and Housekeeping U. The facility's Abuse, Neglect, and Exploitation policy revised 09/2023 indicated the facility will provide staff that are knowledgeable in identifying potential for abuse. The policy indicated the facility will screen all employees to identify previous concerns of abuse, exploitation, and neglect. The policy indicated all employees will have criminal background checks upon hire, transfer, or re-hire. The facility failed to conduct a criminal background check as required for two employees. The employees were allowed access to residents without knowing if they had been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law. This deficient practice placed the affected residents at risk for abuse, neglect, misappropriation, or mistreatment.

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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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49634 The facility identified a census of 29 residents. The sample included 13 residents with one sampled for activities of daily living (ADL). Based on observations, interviews, and record review, the facility failed to ensure Resident (R) 18 received supportive care and services to promote and maintain his quality of life when the facility did not implement strategies to allow and promote R18, who had a primary language other than English to communicate his wants, needs, or feelings and promote socialization. This deficient practice placed the resident at risk for decreased quality of life, isolation, and impaired dignity. Findings included: - R18's Electronic Medical Record (EMR) from the Diagnoses tab documented cerebral infarction (stroke-sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), hypertension (HTN-elevated blood pressure), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), cognitive-communication deficit, hemiplegia (paralysis of one side of the body), vascular dementia (a progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain), expressive language disorder, and protein-calorie malnutrition. R18's Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of six which indicated severely impaired cognition. The MDS documented R18 needed minimal to partial assistance from staff for toileting, hygiene, and bathing. The MDS documented R18 often had social isolation. The Cognitive Loss/Dementia Care Area Assessment (CAA) dated 01/04/22 documented that a TV program in R18's native language was established, and music was provided by R18's family. R18 had an improvement in his BIMS score from the previous assessment. The Communication CAA dated 01/04/24 documented R18 does not speak a lot of English and was able to use a few words and gestures. Staff repeated information when communication was difficult. Staff restated things or used gestures. R18's communication was unchanged at this time. R18's Care Plan reviewed 10/16/23 documented R18 could not share emotions and communicate related to impaired verbal communication related to speaking [non-English language]. R18's plan of care documented R18 was able to communicate thoughts, feelings, and preferences through an interpreter. R18's Care Plan directed staff to turn on R18's radio or his TV which had the native language subtitles when R18 was in his room. On 10/22/24 at 08:46 AM R18 sat at the dining room table eating his breakfast. Staff placed R18's divided tray in front of him, but staff did not communicate with R18 during the meal. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/22/24 at 12:15 PM R18 sat in his wheelchair in his room, with his head down. Staff did not turn R18's TV or his radio. On 10/22/24 at 02:10 PM staff pushed R18 out of his room into the commons area. The TV in the commons area was on a Western channel and in English. There were no subtitles in R18's native language. R18 put his head down. On 10/23/24 at 09:17 AM staff pushed R18 into the commons area. The TV in the commons area was on a Western channel, not in R18's preferred language, and with no subtitles. On 10/24/24 at 09:17 AM staff took R18 to his room. Staff did not turn on the TV or turn on the radio in R18's preferred language. R18 sat in his room, awake but with his head down. On 10/24/24 at 11:26 AM Certified Nurse Aide (CNA) M stated R18 pointed at things or gestured. CNA M stated R18 liked to watch TV in his room in his native language. She stated staff had a communication book; the book had pictures to help understand R18's wants. CNA M stated they also had access to an interpreter, and there was always someone in the facility who knew R18. On 10/24/24 at 12:05 PM Licensed Nurse (LN) G stated there was always staff in the facility that had worked in the facility a long time, that knew R18 well. He stated staff were able to understand a lot of what R18 was saying by pointing and gestures. On 10/24/24 at 12:14 Administrative Nurse D stated R18 can understand a lot of what the staff were saying. She stated the facility has an interpreter available 24 hours a day. Administrative Nurse D stated the facility could also call R18's family. The facility did not provide a policy related to maintaining communication and other ADLs. The facility failed to implement strategies to facilitate person-centered communication and socialization for R18. This placed the resident at risk for decreased quality of life and isolation.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45668 The facility identified a census of 29 residents. The sample included 13 residents with two reviewed for pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, because of pressure, or pressure in combination with shear and/or friction). Based on interviews, observations, and record reviews, the facility failed to ensure Resident (R)24's low air-loss mattress was set to the appropriate weight settings per her physician's order and current weight. This deficient practice placed R24 at risk for complications related to skin breakdown and pressure ulcers. Findings included: - The Medical Diagnosis section within R24's Electronic Medical Records (EMR) noted diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), dysphagia (difficulty swallowing), insomnia (difficulty sleeping), encephalopathy (a broad term for any brain disease that alters brain function or structure), and peripheral vascular disease (PVD- slow and progressive circulation disorder causing narrowing, blockage, or spasms in a blood vessel). R24's Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of zero indicating severe cognitive impairment. The MDS indicated she had bilateral upper and lower extremity impairments. The MDS indicated she required substantial to maximal assistance from staff for dressing, bed mobility, transfers, bathing, and toileting. The MDS indicated she was at risk for pressure ulcers with a history of Stage 3 (full-thickness pressure injury extending through the skin into the tissue below) pressure ulcers. The MDS indicated she had pressure-reducing devices for her wheelchair and bed. The MDS indicated she weighed 154 pounds (lbs.). R24's Functional Abilities Care Area Assessment (CAA) completed 01/31/24 indicated she required substantial to maximal assistance with her activities of daily living (ADLs). The CAA instructed staff to give verbal cues to and allow her to participate in the care process. R24's Pressure Injuries CAA completed 01/31/24 indicated she was at risk for pressure injuries and skin breakdown related to her previously healed pressure injuries, incontinence, and limited mobility. The CAA instructed staff to provide wound and incontinence care, repositioning, and a low air-loss mattress for her bed. R24 Care Plan initiated 03/14/23 indicated she was at risk for falls, pressure injuries, and a decline in her ADLs related to her medical diagnoses and limited mobility. The plan indicated she required extensive assistance from staff for bed mobility, transfers, dressing, bathing, toileting, and ambulation in her wheelchair. The plan noted she had a pre-existing Stage 3 pressure ulcer located on her sacrum (large triangular bone/area between the two hip bones). The plan indicated staff were to complete preventative wound care to her sacrum. The plan indicated her low air-loss mattress was to be set on the less than (<) 250 lbs. mark. R24's EMR under Physician's Orders revealed an order for her low air-loss mattress dated 04/11/24. The order instructed staff to set her mattress's weight at <250 lbs. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the manual of low air-loss mattress manufacturers' operation (Drive Model #14048) indicated that the mattress system was intended to reduce the incidence of pressure ulcers while optimizing comfort. The manual indicated the mattress pump's pressure levels and firmness were preset based on the weight range and comfort settings. The manual indicated an optimal bed system assessment should be conducted on each patient by a qualified clinician or medical provider to ensure maximum safety. On 10/22/24 at 10:17 AM R24 watched television in her bed. Her bed was in a low position and had bilateral grab bars at the head of her bed. She had a bariatric (associated with obesity) low air-loss mattress system. Her mattress control panel was set to 500 lbs. On 10/24/24 at 08:55 AM R24's low air-loss mattress control panel weight was set to 550 lbs. Licensed Nurse (LN) G entered the room and confirmed the bed should be set per the resident's weight. He verified the bed was set to 550 lbs. but did not know why the setting was so high. He stated staff were to check the settings each shift. On 10/24/24 at 12:15 PM Administrative Nurse D stated the mattresses should be by the resident's current weight and inspected each time staff enter the room. She stated someone may have bumped R24's control panel to cause the weight pressure to increase. The facility was unable to provide a policy related to the prevention of pressure ulcers as requested on 10/24/24. The facility failed to ensure R24's low air-loss mattress was set to the appropriate weight settings per her physician's order and current weight. This deficient practice placed R24 at risk for complications related to skin breakdown and pressure ulcers.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 45668 The facility identified a census of 29 residents. The sample included 13 with two reviewed for accidents. Based on observation, record review, and interview the facility failed to secure potentially hazardous cleaning chemicals in a safe, locked area, and out of reach of seven cognitively impaired, independently mobile residents. This placed the affected residents at risk for preventable accidents and injuries. Findings Included: - On 10/22/24 at 07:04 AM an inspection of the 100-hall revealed the restorative room was left unlocked and unsupervised. An inspection of the sink area of the room revealed several types of multiple-purpose cleaners in an unlocked cabinet underneath the sink. The bottles contained the warning, Keep out of reach of children, hazardous to humans can cause eye irritation, harmful if swallowed. On 10/22/24 at 07:14 AM Certified Nurse's Aide (CNA) stated the chemicals under the sink should be secured under the sink or the door should be closed. She stated chemicals should not be within reach of the residents. On 10/24/24 at 12:15 PM Administrative Nurse D stated potentially hazardous cleaning products should be locked up in closets and inaccessible to the residents. The facility's Accidents and Fall Management policy revised 12/2017 indicated each resident will be assessed based on each resident's individual identified risks. The policy noted staff will ensure a safe care environment to include transfer equipment, spills, clutter, and potential room hazards. The facility failed to secure potentially hazardous cleaning chemicals in a safe, locked area, and out of reach of seven cognitively impaired independently mobile residents. This placed the affected residents at risk for preventable accidents and injuries.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49634 The facility identified a census of 29 residents. The sample included 13 residents with one resident reviewed for hemodialysis (a procedure using a machine to remove excess water, solutes, and toxins from the blood in people whose kidneys can no longer perform these functions naturally). Based on observation, record review, and interviews, the facility failed to ensure consistent communication between the facility and Resident (R) 15's dialysis center. This deficient practice placed R15 at risk of potential adverse outcomes and physical complications related to dialysis. Findings included: - R15's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), obesity, dialysis (a procedure where impurities or wastes are removed from the blood), hypertension (HTN-elevated blood pressure), and abnormalities of the gait and mobility. The Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS documented R15 had impairment on one side of his body. The MDS documented R15 was independent for toileting, eating, and bathing. The MDS documented R15 required dialysis during the observation period. R15 Nutritional Status Care Area Assessment (CAA) dated 07/30/24 documented R15 was alert and oriented. He was able to make his own food choices, often declined meals and alternate menus, and purchased snacks. R15's weight was followed by his physician and dialysis. R15's Care Plan dated 07/20/19 documented that R15 received dialysis and had a shunt (tube or device implanted in the body to redirect a body fluid from one cavity to another) in his left arm. Staff were to monitor the dialysis shunt daily and change dressing as ordered by the dialysis center, and physician. R15's EMR under the Orders tab revealed the following physician's order: Monitor the dialysis site every shift for bleeding, infection, thrill (a fine vibration felt that reflects the blood flow by a dialysis resident's shunt), and bruit (blowing or swishing sound heard when blood flows through a shunt), every shift related to dialysis dated 09/14/21. A review of R15's clinical record including the facility dialysis communication forms lacked evidence of post-hemodialysis assessment for the dialysis dates of 04/10/24, 05/15/24, 06/14/24, 06/26/24, 08/21/24, 08/23/24, and 09/18/24. On 10/23/24 at 09:10 AM R15 stood at the nurse's station waiting for the bus, for an out-of-facility appointment. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/24/24 at 12:05 PM Licensed Nurse (LN) G stated it was the nurse's responsibility to ensure a communication sheet was sent to dialysis with the resident and to ensure a signed communication sheet was returned with the resident. On 10/24/24 at 12:14 PM Administrative Nurse D said the facility expects to get all dialysis communications sheets returned with the resident. She stated if the communication sheet was not returned or not signed when the sheet was returned, the nurse should call the dialysis center and fax the sheet to the dialysis center for any orders and a signature. The facility's Dialysis Management Guideline policy dated 04/15 documented the facility was to have an agreement, or arrangement with the dialysis center. The facility was to maintain communication and coordinate care with the dialysis center before and after dialysis, including transportation services. Dialysis care and services are to be included in the resident's plan of care. The resident's dialysis access site was to be assessed on a routine basis. Emergency care and contracts are to be maintained in the resident's clinical record. The resident's nutritional status and needs are to be reviewed on a routine basis by a registered dietitian. Social and mental health services are to be available for residents receiving dialysis. The facility failed to ensure consistent communication between the facility and R15's dialysis center. This deficient practice placed R15 at risk of potential adverse outcomes and physical complications related to dialysis.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45668 The facility identified a census of 29 residents. The sample included 13 residents with two residents reviewed for accidents. Based on observation, record review, and interviews, the facility failed to ensure that Resident (R)24's bed rails were removed as indicated per her most current side rail assessment. The facility additionally failed to ensure that R5, R12, and R17 had safety assessments for the use of side rails that acknowledged the risks from their low air-loss mattresses, risk for entrapment, consent for the use of the side rails, and failed to ensure the resident and/or responsible party were advised of the risks and/or benefits of the use of the side rails. This placed the residents at risk for uninformed decisions and impaired safety related to the risks associated with the use of side rails. Findings Included: - The Medical Diagnosis section within R24's Electronic Medical Records (EMR) noted diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), dysphagia (difficulty swallowing), insomnia (difficulty sleeping), encephalopathy (a broad term for any brain disease that alters brain function or structure), and peripheral vascular disease (PVD- slow and progressive circulation disorder causing narrowing, blockage, or spasms in a blood vessel). R24's Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of zero indicating severe cognitive impairment. The MDS indicated she had a history of delusions (untrue persistent beliefs or perceptions held by a person although evidence shows it was untrue). The MDS indicated she had bilateral upper and lower extremity impairments. The MDS indicated she required substantial to maximal assistance from staff for dressing, bed mobility, transfers, bathing, and toileting. The MDs indicated she had no falls since her admission. The MDS indicated she was at risk for pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction) with a history of Stage 3 (full-thickness pressure injury extending through the skin into the tissue below) pressure ulcer. The MDS indicated she had pressure-reducing devices for her wheelchair and bed. The MDS indicated she had no bed rails. R24's Functional Abilities Care Area Assessment (CAA) completed 01/31/24 indicated she required substantial to maximal assistance with her activities of daily living (ADLs). The CAA instructed staff to give verbal cues to and allow her to participate in the care process. R24 Care Plan initiated 03/14/23 indicated she was at risk for falls, pressure injuries, and a decline in her ADLs related to her medical diagnoses and limited mobility. The plan indicated she required extensive assistance from staff for bed mobility, transfers, dressing, bathing, toileting, and ambulation in her wheelchair. The plan noted she was at risk for pressure injuries and had a low air-loss mattress on her bed. The plan noted she had assist bars installed on her bed. The plan indicated she used them for repositioning. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R24's EMR revealed a Clinical Health Review completed on 08/16/24 noting an assessment was completed for side rails and restraints. The assessment indicated R24 was able to get into and out of bed with or without assistance. The assessment indicated she had impaired memory, cognition, or decision-making functioning. The assessment indicated side rails, grab bars, or transfer bars will not be utilized at this time due to the assessment findings. The evaluation did not acknowledge the use of R24's low air-loss mattress. A review of the low air-loss mattress manufacturer's operation (Drive Model #14048 Series) manual indicated the usage of bed rails with the air mattress system should be assessed based on the risk of entrapment. R24's EMR lacked a safety assessment for the use of her bed cane which addressed the risk of entrapment between the device and the mattress, a consent for the use, and failed to ensure the resident and/or responsible party were advised of the risks and/or benefits of the use of the bed canes. The facility was unable to provide this documentation as requested on 10/24/24. On 10/22/24 at 10:17 AM R24 watched television in her bed. Her bed was in a low position and had bilateral side rails at the head of her bed. She had a bariatric (associated with obesity) low air-loss mattress system. On 10/24/24 at 08:55 AM Licensed Nurse (LN) G entered the room and confirmed that R24 had grab bars (side rails) to assist with repositioning and transfers. He stated staff should check the side rails to ensure no gaps or entrapment hazards were created by the bed or bars. He stated he was not sure if the side rail assessments included the risks associated with the low air-loss mattresses. On 10/24/24 at 12:15 PM Administrative Nurse D stated the side rails assessments were part of the clinical assessment completed quarterly. She stated the assessment should include risks associated with the railing, bed, and environment. The facility did not provide a bed rail policy. The facility failed to ensure that R24's bed rails were removed as indicated per her most current side rail assessment and further failed to ensure safety assessments acknowledged the risks when used with a low air loss mattress. This placed the R24 at risk for impaired safety related to the risks associated with the use of side rails. - The Medical Diagnosis section within R5's Electronic Medical Records (EMR) noted diagnoses of Alzheimer's Disease (progressive mental deterioration characterized by confusion and memory failure), dysphagia (difficulty swallowing), seizures (violent involuntary series of contractions of a group of muscles), epilepsy (brain disorder characterized by repeated seizures), left-sided hemiparesis (muscular weakness of one half of the body) and major depressive disorder (major mood disorder). R5's Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of eight indicating moderate cognitive impairment. The MDS indicated he had bilateral upper and lower extremity impairments. The MDS indicated he required substantial to maximal assistance from staff for dressing, bed mobility, transfers, bathing, and toileting. The MDS indicated he had no falls since his admission. The MDS indicated he had no bed rails. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R5's Functional Abilities Care Area Assessment (CAA) completed 10/20/23 indicated he required substantial to maximal assistance from staff for all his activities of daily living (ADLs). The CAA noted staff was to support R5 with all transfers and needs due to his decline. R5's Care Plan initiated on 10/15/15 indicated he required assistance with his ADLs related to his physical limitations and medical diagnoses. The plan noted he required assistance from two staff for bed mobility, transfers, dressing, grooming, and toileting. The plan noted he required a Hoyer lift (full-body mechanical lift) for all transfers. The plan noted he had assist bars on his bed. The plan noted that R5 used the bars during assisted repositioning and turning (12/05/22). R5's EMR revealed a Clinical Health Review completed on 09/29/24 noting an assessment was completed for side rails and restraints. The assessment noted he was not ambulatory, not able to get out of bed with assistance from staff, not able to turn unassisted, had poor balance and trunk control, and had impaired memory, cognition, and decision-making function. The assessment indicated side rails were utilized for bed mobility and repositioning. The evaluation did not acknowledge the use of R5's low air-loss mattress. R5's EMR lacked a safety assessment for the use of his bed cane which addressed the risk of entrapment between the device and the mattress, a consent for the use, and lacked evidence the resident and/or responsible party were advised of the risks and/or benefits of the use of the bed canes. The facility was unable to provide this documentation as requested on 10/24/24. A review of the low air-loss mattress manufacturer's operation (Drive Model #14048 Series) manual indicated the usage of bed rails with the air mattress system should be assessed based on the risk of entrapment. On 10/23/24 at 08:45 AM R5 sat up in his bed and ate his breakfast. His bed was in the medium to higher position. His low air-loss mattress was set to his current weight at 250 pounds (lbs.) and he had bilateral side rails mounted at the head of his bed. On 10/24/24 at 09:00 AM Licensed Nurse (LN) G stated side rail assessments were completed quarterly by Administrative Nurse D. He stated staff should check the sidebars to ensure no gaps or entrapment hazards were created by the bed or bars. He stated he was not sure if the side rail assessments included the risks associated with the low air-loss mattresses. On 10/24/24 at 11:45 AM Certified Nurse's Aide (CNA) M stated staff were expected to check each resident's bed, mattress, and railing to ensure safety. On 10/24/24 at 12:15 PM Administrative Nurse D stated the side rails assessments were part of the clinical assessment completed quarterly. She stated the assessment should include risks associated with the railing, bed, and environment. The facility did not provide a bed rail policy. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility failed to ensure that R5 had a safety assessment for the use of side rails that acknowledged the risks from use with the low air-loss mattress, consent for the use of the side rails, and failed to ensure the resident and/or responsible party were advised of the risks and/or benefits of the use of the side rails. This placed R5 at risk for uninformed decisions and impaired safety related to the risks associated with the use of side rails. 41713 - R17's Medical Diagnosis tab of the Electronic Medical Record (EMR) documented diagnoses of cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), and hemiplegia and hemiparesis (weakness and paralysis on one side of the body). R17's Significant Change Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 99 indicating he could not recall or answer the interview questions. R17 had both long and short-term memory deficits. R17 had impairment on one side of both his upper and lower extremities. R17 required partial assistance from staff for transfers. R17 required substantial assistance from staff for showering. R17 was dependent on staff for toileting and lower body dressing. R17 required a wheelchair for mobility. The MDS indicated R17 had no side rails. R17's Cognition Care Area Assessment (CAA) dated 08/14/24 documented his BIMS score was 99 due to the resident being unable to verbalize words. The resident could communicate through yes and no words only. R17 was able to write his needs and wants on paper but was sometimes unclear. R17's Care Plan revised on 07/15/24 directed staff that R17 had a left-side bed cane (side rail device attached to bed to improve bed mobility) added to his bed for mobility, so he could turn in bed and sit on the edge of the bed without assistance. R17 felt the bed cane enhanced his ability to rise independently and safely. R17's EMR under Physician Orders lacked documentation related to his bed cane. R17's Clinical Health Review dated 10/23/24 documented R17 was able to get in or out of bed without assistance. R17 was able to turn side to side in bed unassisted. R17 had impaired memory and had conditions that required medications which required increased safety measures. R17 used a side rail, grab, or transfer bar for positioning, support, or mobility. Based on the assessment, side rails, grab or transfer bars would be utilized on one or both sides of the bed to promote increased independence, participation in bed mobility, and positioning. R17's EMR on 1023/24 lacked a documented safety assessment for the use of side rails which addressed entrapment, and consent for the use of the side rails, and failed to ensure the resident and/or responsible party were advised of the risks and/or benefits of the use of the side rails. On 10/22/24 at 07:42 AM observation revealed R17's bed had a side rail attached to the left side of his bed. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/24/24 at 12:06 PM, Licensed Nurse (LN) G stated that bed rails were not really used much in the facility. LN G stated some of the residents did have bed canes. LN G stated he was not sure if a specific bed cane assessment was done that would include the risks of using the bed cane. On 10/24/24 at 12:12 PM Administrative Nurse D stated residents were assessed quarterly if they used a bed cane. Administrative Nurse D stated when the bed cane was attached to the bed the rail was pulled in as close to the bed as it could be. Administrative Nurse D stated she was not certain if the bed rail assessment included or listed the risks of using them. Administrative Nurse D stated the facility did not have a specific policy that addressed bed cane or side rail use but instead, followed the standards of practice. The facility did not provide a bedrail policy. The facility failed to ensure that R17 had a safety assessment for the use of side rails that acknowledged the risk of entrapment, and consent for the use of the side rails, and failed to ensure the resident and/or responsible party were advised of the risks and/or benefits of the use of the [NAME] ails. This placed R17 at risk for uninformed decisions and impaired safety related to the risks associated with the use of side rails. - R12's Medical Diagnosis tab of the Electronic Medical Record (EMR) documented diagnoses of peripheral vascular disease (PVD- slow and progressive circulation disorder causing narrowing, blockage, or spasms in a blood vessel), acquired absence of left and right leg above the knee, and quadriplegia (inability to move the arms, legs, and trunk of the body below the level of an associated injury to the spinal cord). R12's Significant Change Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. R12 had impairment of both upper and lower extremities on both sides. R12 used a wheelchair for mobility. R12 required substantial assistance to being dependent on staff for his functional abilities. R12 was on hospice services. The MDS indicated he had no side rails. R12's Quarterly MDS dated [DATE] documented a BIMS score of 15 which indicated intact cognition. R12 had impairment of both upper and lower extremities on both sides. R12 used a wheelchair for mobility. R12 required substantial assistance to being dependent on staff for his functional abilities. R12 was on hospice services. The MDS indicated he had no side rails. R12's Care Plan directed staff that he used a trapeze bar (a short horizontal bar that hangs from the ceiling or pole used to assist in repositioning while in bed). R12's care plan lacked staff direction for his use of his bed cane (side rail device attached to the bed to improve bed mobility). Staff was directed to check the low air loss pump and pressure one time per shift, to ensure that the pump was set for body weight. Staff was directed the current setting for weight was at a level four but no higher than a five. Staff was directed that R12 had been choosing to have staff turn the pump setting to nine. Staff was directed to continue to educate R12 on the use of the low air loss mattress and the risks related to not using the device as recommended. R12's EMR under Physician Orders lacked documentation related to his bed cane bed rail. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R12's Clinical Health Review dated 10/04/24 documented R12 was not able to get in or out of bed without assistance. R12 was not able to get in and out of bed with the use of a side rail, grab or transfer bar, with or without assistance. R12 was able to turn side to side in bed unassisted. R12 was able to turn side to side in bed with the use of a side rail, grab, or transfer bar, with or without assistance. R12 used a side rail, grab, or transfer bar for positioning, support, or mobility. Based on the assessment, side rails, grab or transfer bars would be utilized on one or both sides of the bed to promote increased independence, participation in bed mobility, and positioning. R17's EMR on 10/23/24 lacked an assessment for the safe use of side rails which acknowledged risks from low air loss mattress and entrapment, consent for the use of the side rails, and failed to ensure the resident and/or responsible party were advised of the risks and/or benefits of the use of the side rails. A review of the low air-loss mattress manufacturer's operation (Drive Model #14027) manual indicated the usage of bed rails with the air mattress system should be assessed based on the risk of entrapment. On 10/22/24 at 07:43 AM an inspection of R12's room revealed a bordered mattress and bed cane side rail on both sides of his bed. R12's bed had a Drive Model low air-loss mattress system set at 350. On 10/24/24 at 12:06 PM, Licensed Nurse (LN) G stated that bed rails were not used much in the facility. LN G stated some of the residents did have bed canes. LN G stated he was not sure if a specific bed cane assessment was done that would include the risks of using the bed cane. On 10/24/24 at 12:12 PM Administrative Nurse D stated residents were assessed quarterly if they used a bed cane. Administrative Nurse D stated when the bed cane was attached to the bed the rail was pulled in as close to the bed as it could be. Administrative Nurse D stated she was not certain if the bed rail assessment included or listed the risks of using them. On 10/24/24 at 12:30 PM Administrative Staff A stated the facility followed the standards of practice regarding bed rails. The facility did not provide a bed rail policy. The facility failed to ensure that R12 had a safety assessment for the use of side rails that acknowledged the risks from the low air-loss mattress, consent for the use of the side rails, and failed to ensure the resident and/or responsible party were advised of the risks and/or benefits of the use of the side rails. This placed R12 at risk for uninformed decisions and impaired safety related to the risks associated with the use of side rails.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49634 The facility identified a census of 29 residents. The sample included 13 residents with five residents reviewed for unnecessary medications. Based on observation, record review, and interviews, the facility failed to follow physicians' ordered parameters related to blood glucose monitoring for Resident (R)10 and R15. This deficient practice placed R10 and R15 at risk for delayed treatment of hyperglycemia (greater than the normal amount of glucose in the blood, hypoglycemia (abnormally low blood glucose), and unnecessary medication complications. Findings included: - R10's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of sleep apnea (a disorder of sleep characterized by periods without respirations), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), dysplasia (abnormal development of tissues and organs), major depressive disorder (major mood disorder that causes persistent feelings of sadness), cognitive communication deficit, muscle weakness, dementia (a progressive mental disorder characterized by failing memory and confusion), delusional disorder (a type of mental health condition in which a person can't tell what's real from what's imagined), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and hypertension (HTN-elevated blood pressure). The Annual Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of nine which indicated moderately impaired cognition. The MDS documented R10 needed partial to moderate assistance with toileting. The MDS documented R0 had DM. The MDS documented R10 received insulin (a hormone that lowers the level of glucose in the blood) during the observation period. R10's Nutritional Status Care Area Assessment (CAA) dated 10/03/24 documented that R10 had a recent hospital stay. R10 had surgery to repair bowel adhesions that were increasing the risk of obstruction. The CAA documented R10 had a decline in nutrition related to not being hungry and reported occasional nausea. R10 returned to the facility on a mechanical soft diet. The facility anticipates R10's appetite, intake, and weight to improve as the healing process occurs. The dietitian would oversee R10's regimen and chart for any additional needs. R10's diet will be care planned; staff was to cue R10 to consume the meals served. R10's EMR under Orders revealed the following physicians' orders: Glargine insulin (long-acting insulin) subcutaneous (beneath the skin), solution pen-injector 100 units per milliliter (ml) inject 15 units subcutaneously at bedtime, notify the physician of blood glucose less than 60 ml per deciliter (dl) or greater than 400 ml/dl for 30 days for 09/25/24. Novolog Flex-Pen (short-acting insulin) subcutaneous solution pen-injector 100 units per ml inject 10 units subcutaneously three times a day, notify provider for blood glucose less than 60 ml/dl or higher than 400 ml/dl related to DM, hold if blood glucose was lower than 110 ml/dl dated 02/08/24. R10's EMR under the Treatment Administration Record (TAR) recorded the following blood glucose levels under 110 ml/dl that lacked evidence R10's insulin was held per physician's order. (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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	08/09/24 AM 82 ml/dl 09/07/24 PM 104 ml/dl 09/12/24 AM 106 ml/dl 09/17/24 PM 106 ml/dl 10/04/24 AM 84 ml/dl 10/14/24 AM 108 ml/dl 10/14/24 PM 99 ml/dl 10/15/24 AM 105 ml/dl On 10/22/24 at 07:33 AM R10 sat in the dining room with his walker next to him. He was drinking coffee. On 10/24/24 at 12:05 PM, Licensed Nurse (LN) G stated the TAR shows the nurse staff the resident's parameters when the nurses document the blood sugar. LN G stated nurse staff would verify and then give insulin or hold insulin. LN G stated it was the nurses' responsibility to verify blood sugar and insulin. On 10/24/24 at 12:14 PM Administrative Nurse D stated verifying blood sugars was the nurse's responsibility. She stated the nurse takes the blood sugar, verifies with the TAR, and either gives insulin, holds insulin, or calls the physician. The facility did not provide a policy for unnecessary medication or medication monitoring. The facility failed to hold R10's insulin for blood glucose levels outside the ordered parameters. This deficient practice placed R10 at risk for complications related to hypoglycemia and unnecessary medications. - R15's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), obesity, dialysis (a procedure where impurities or wastes are removed from the blood), hypertension (HTN-elevated blood pressure), and abnormalities of gait and mobility. The Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS documented R15 had impairment on one side of his body. The MDS documented R15 was independent in toileting, eating, and bathing. The MDS documented R15 had DM. R15 Nutritional Status Care Area Assessment (CAA) dated 07/30/24 documented R15 was alert and oriented. He was able to make his own food choices, often declined meals and alternate menus, and purchased snacks. R15's weight was followed by his physician and dialysis. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R15's Care Plan revised 10/21/24 documented R15 was at risk for hyperglycemia and hypoglycemia related to his diabetes and use of insulin to manage his blood sugars. R15's plan of care documented he would have no unmonitored hyperglycemia or hypoglycemia. R15's plan of care documented he needed to have insulin administered per his physicians' orders; staff were to take his blood sugar and give the ordered amount of insulin. R15's EMR under Orders revealed the following physicians' orders: Aspart insulin (short-acting insulin) solution Pen-injector 100 units per millimeter (ml) inject seven units subcutaneously (beneath the skin) three times a day related to DM. Hold for finger stick blood sugar below 110 milliliters per deciliter (ml/dl) and call the physician if blood sugar reading was less than 70 ml/dl or over 400 ml/dl dated 01/24/24. Lantus Solostar (long-acting insulin) insulin solution Pen-injector insulin 100 units per ml inject 20 units subcutaneously at bedtime related to DM. Notify physician of blood sugar less than 70 ml/dl or greater than 400 ml/dl dated 01/24/24. R15's EMR under the Treatment Administration Record (TAR) recorded the following blood glucose levels below 110 ml/dl that lacked evidence R15's insulin was held per physician's order. 08/29/24 AM 107 ml/dl 09/10/24 PM 107 ml/dl 09/16/24 AM 106 ml/dl 09/17/24 PM 105 ml/dl 09/26/24 AM 108 ml/dl 09/14/24 AM 94 ml/dl 10/01/24 PM 104 ml/dl 10/20/24 AM 106 ml/dl On 10/22/24 at 08:13 AM R15 sat at the dining room table visiting with peers. On 10/24/24 at 12:05 PM, Licensed Nurse (LN) G stated the TAR shows the nurse staff the resident's parameters when the nurses document the blood sugar. LN G stated nurse staff would verify and then give insulin or hold insulin. LN G stated it was the nurses' responsibility to verify blood sugar and insulin. On 10/24/24 at 12:14 PM Administrative Nurse D stated verifying blood sugars was the nurse's responsibility. She stated the nurse takes the blood sugar, verifies with the TAR, and either gives insulin, holds insulin, or calls the physician. The facility did not provide a policy for unnecessary medication or medication monitoring. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility failed to follow physicians' ordered parameters related to blood glucose monitoring for R15. This placed the resident at risk for complications related to medications.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 41713 The facility identified a census of 29 residents. The facility had one main kitchen and one main dining area. Based on observation, record review, and interview the facility failed to ensure the director of food and nutrition services had the required qualifications of a certified dietary manager (CDM). This placed residents at risk for unmet dietary and nutritional needs. Findings included: - On 10/22/24 at 07:20 AM Dietary BB stated she had not taken her test to get her dietary manager certification but was scheduled to take it on 11/16/24. Dietary BB stated that the registered dietician was available to call anytime but only came to the facility twice a month to review the residents' diet. The facility did not provide a policy regarding the CDM. The facility failed to ensure the director of food and nutrition services had the required qualifications of a CDM. This placed residents at risk for unmet dietary and nutritional needs.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 41713 The facility identified a census of 29 residents. The facility had one main kitchen. Based on observation, and interview, the facility failed to ensure staff stored food items by the professional standards for food service safety. This placed residents at risk of foodborne illness and cross-contamination (the transfer of harmful substances to food). Findings included: - Upon entry of the kitchen on 10/22/24 at 07:11 AM, observation revealed the coffee station table and the area had a dry, brown-tinged towel in front of the coffee maker. In the dishwasher area, there were two trays with dishes left from the night before that had not been washed. The dishwashing area had a musty odor. In the drink refrigerator, a pitcher of some sort of juice or drink was not labeled or dated. The pitcher of Kool-Aid lacked a label or date. There was a tray with 12 clear plastic drinking glasses filled with juice and three clear plastic drinking glasses filled with milk that lacked a cover, label, or date. The condiment refrigerator had a covered and labeled salad with a date of 10/18/24. Two covered fruit cups lacked a label or date. Two bowls of applesauce and peaches lacked a label or date. On 10/22/24 at 07:20 AM Dietary BB stated she had not had the chance yet to go through the refrigerators and freezers this morning to look for any items that had not been labeled or dated. Dietary BB stated she expected all food items to be dated and labeled when opened or placed into a new container or sealed bag. Dietary BB stated that juice and milk glasses should have a plastic wrap cover when stored in the refrigerator as well as a date on them. The facility did not provide a policy on food storage. The facility failed to ensure staff stored food items by the professional standards for food service safety. This placed residents at risk of foodborne illness and cross-contamination.