STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175157	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Andover	621 W 21st Andover, KS 67002

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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 96 residents. The sample included 20 residents. Based on observation, record review and interviews, the facility failed to ensure adequate bariatric equipment was available to provide the necessary care and promote the resident's highest practicable level of function and quality of life for Resident (R) 43. The facility also failed to ensure R81 had foot pedals in use on the wheelchair and a call light available within reach. These deficient practices placed the residents at risk for impaired quality of life and health complications related to unmet needs. Findings Included: - R43's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of hypertensive heart disease (a condition where high blood pressure damages the heart muscles over time), heart failure (a condition of low heart output), diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), respiratory failure (a condition where there's not enough oxygen or too much carbon dioxide in the body), obesity (excessive body fat), bed confinement status, and palliative treatment (treatment designed to relieve or reduce the intensity of uncomfortable symptoms). The Admission Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS documented R43 was dependent on staff for toileting, dressing, personal hygiene, and bathing. The MDS recorded R43 was dependent on staff for wheelchair mobility and did not ambulate. The MDS recorded R43 had no functional impairment of the upper or lower extremities. The MDS documented R43 required set up and clean up for eating. R43's MDS documented it was very important to R45 to choose between a tub bath, shower, bed bath or sponge bath. The MDS recorded doing things with groups of people and going outside was very important to R43. The MDS noted R43 weighed 712 pounds. The Quarterly MDS dated [DATE] documented a BIMS score of 15. The MDS documented R43 was dependent on staff for most activities of daily (ADL) except personal hygiene and eating for which he required set up assistance. The MDS recorded that lying to sitting activity, transfers (to chairs, toilet, and showers) and walking were not attempted due to medical conditions or safety concerns. The MDS recorded the resident did not use a wheelchair or scooter. The MDS recorded R43 weighed 712 pounds. (continued on next page)

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	R43's ADL Function/Rehabilitation Potential Care Area Assessment (CAA) dated 07/08/24 documented R43's risk factors included further ADL decline, falls, incontinence, skin breakdown, and pain. The CAA documented the care plan would reflect R43's current ADL status and functional ability and R43 would maintain continence status, have decreased pain, and decreased fall and pressure ulcer risk. R43's Activities CAA dated 07/08/24 documented R43's risk factors included decreased socialization, depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). R43's care plan would be initiated to improve symptoms through one-on-one activity and would encourage participation in group activities. R43's Care Plan documented R43 had an ADL self-care performance deficit related to morbid obesity dated 07/17/24. The plan documented R43 was dependent on the assistance of two staff for bathing, repositioning in bed, and toilet use (dated 07/18/24). The plan directed staff that R43 required the assistance of two staff and a mechanical lift for transfers (07/18/24). R43's Care Plan documented the resident was dependent on staff to meet his emotional, intellectual, physical, and social needs due to the resident's immobility (07/18/24). The plan documented staff would invite R43 to scheduled activities and the facility would plan a program of activities that was of interest to the resident, and which empowered the resident by encouraging and allowing choices and self-expression. The plan was revised on 10/18/24 to note that if R43 chose not to participate in organized activities, he preferred to watch TV and play games on his tablet. R43's EMR under the Orders tab documented the following physician's order: Weights monthly starting on the first of each month dated 10/01/24. R43's EMR under the Weights and Vitals tab documented R43 weighed 711.7 pounds on 07/03/24. R43's medical record lacked any other recorded weights from 07/04/24 through 03/26/25. The record lacked evidence of refusals. R43's EMR under Tasks documented bathing was scheduled for Wednesday and Saturday in the evening. R43's Lookback Report from the Tasks lacked evidence of bathing from 01/01/25 through 03/25/25. There was no evidence of refusals. R43's EMR under Lookback Report under Transfers from 01/01/25 through 03/26/25 documented activity (transfers) did not occur. There was no evidence of refusals. On 03/25/25 at 08:25 AM, R43 laid on his bed looking at his iPad. On 03/27/25 at 10:40 AM, Licensed Nurse (LN) H stated R43's hospice service provided his bathing, and he always received a bed bath. LN H stated the facility was unable to obtain weights for R43 because the facility did not have a mechanical lift with scale that could accommodate R43's weight. LN H stated if staff needed to get R43 out of bed and out of his room or the facility, staff would have to use some sort of gurney (a wheeled stretcher for transporting patients) but the facility did not have one readily available. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/27/25 at 10:52 AM, Certified Nursing Aide (CNA) N stated hospice gives R43 a bed bath twice a week. She stated R43 usually refused to have facility staff give him a bath. CNA N stated when the facility must move R43, they used a gurney, and pulled him through the doorway. CNA N stated the facility's mechanical lift would not lift R43. On 03/72/25 at 11:36 AM, Administrated Nurse D stated the hospice bath aide gives R43 his bed bath and the facility staff offer twice a week. Administrative Nurse D stated the facility did not have a lift to get R43 out of bed. She stated the facility had to move R43 when the 100-hall flooded, and staff had to call Emergency Medical Response (EMR) to get the resident moved. She stated EMR slid R43 on a slide board on to the gurney and pulled him through the door. Administrative Nurse D confirmed the facility lacked the ability to obtain a weight on R43. The facility failed to provide an accommodation of needs policy. The facility failed to ensure adequate adaptive equipment including a suitable mechanical lift, and wheelchair was available to provide R43 the necessary care and promote the resident's highest practicable level of function and quality of life. This placed the resident at risk for decreased quality of life and health complications due to unmet needs. - R81's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses dementia (a progressive mental disorder characterized by failing memory and confusion), metabolic encephalopathy (a condition where the brain's function is impaired due to an imbalance in the body's metabolism), hyperlipidemia (condition of elevated blood lipid levels), anemia (an inadequate number of healthy red blood cells to carry adequate oxygen to body tissues), hypothyroidism (a condition characterized by decreased activity of the thyroid gland), insomnia (inability to sleep), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), unsteady on feet, lack of coordination, anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and palliative treatment (treatment designed to relieve or reduce the intensity of uncomfortable symptoms). The Significant Change Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of five which indicated severely impaired cognition. The MDS documented R81 required set up and clean up for eating and oral hygiene, partial to moderate assistance from staff for toileting, and substantial to maximum assistance with bathing. The MDS documented R81 used a wheelchair. R81's Functional Abilities (Self-Care Mobility) Care Area Assessment (CAA) dated 03/07/25 documented R81's risk factors include further activities of daily living (ADL) decline, falls, incontinence, skin breakdown, and pain. Care plan would reflect current ADL status and functional ability, maintain continence status, decrease pain, and decrease fall and pressure ulcer risk. R81's Falls CAA dated 03/07/25 documented R81 risk factors included falls and other major and minor injuries related to falls. R81's Care Plan revised 09/24/2024 documented R81 was at risk for falls related to poor safety awareness. The plan documented on 01/23/25 R81 had an unwitnessed fall. The plan documented on 02/10/25 R 81 had an unwitnessed fall, the provider followed up with labs and imaging. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/25/25 at 07:42 AM, R81's call light was clipped to the wall in the middle of her room. On 03/25/25 at 08:50 AM, Certified Nurse's Aide (CNA) M pushed R81 without foot pedals into the dining room. On 03/25/25 at 07:42 AM, R81's call light was clipped to the wall in the middle of her room. On 03/25/25 at 12:10 PM, CNA M pushed R81 without foot pedals out of the large dining room. On 03/26/25 at 07:42 AM, R81's call light was clipped to the wall in the middle of her room. On 03/27/25 at 09:47 AM, CNA M stated call lights should always be within the residents reach when the residents were in their rooms. She stated all the residents have foot pedals and should be used if the resident was being pushed. On 03/27/25 at 10:02 AM, Licensed Nurse (LN) G stated call lights should be placed near the resident, or with in reach. LN G stated residents should not be pushed without pedals. She stated residents that do not have foot pedals are able to propel themselves. On 03/27/25 at 11:36 AM, Administrative Nurse D stated residents call light should be within reach, if the resident was in their room. She stated all wheelchairs have foot pedals and should be used if the staff are pushing the wheelchair. The facility failed to provide a policy that obtained to foot pedals and call light use. The facility failed to ensure R81s call light was within his reach, and further failed to ensure R81 had foot pedals on her wheelchair, if staff were pushing her. This deficient practice left R81 vulnerable to unmet care needs due to the inability to call for staff assistance and possible injury from falls.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41037 The facility identified a census of 96 residents. The sample included 20 residents. Based on observation, record review, and interviews, the facility failed to develop a comprehensive care plan for Resident (R) 24 which included individualized, person-centered interventions for her trauma-based care. The facility also failed to develop a comprehensive care plan for R9 which included individualized person-centered intervention for his activities. This deficient practice placed these residents at risk for impaired care due to uncommunicated care needs. Findings included: - R24's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of posttraumatic stress disorder (PTSD- a mental disorder characterized by an acute emotional response to a traumatic event or situation involving severe environmental stress), cognitive communication deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), dementia (a progressive mental disorder characterized by failing memory and confusion), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). The Annual Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of four which indicated severely impaired cognition. The MDS documented R24 had no behaviors during the observation period. The MDS documented R24 had an active diagnosis of PTSD. The Quarterly MDS dated [DATE] documented a BIMS score of five which indicated severely impaired cognition. The MDS documented R24 had no behaviors during the observation period. The MDS documented R24 had an active diagnosis of PTSD. R24's Cognitive Loss/Dementia Care Area Assessment (CAA) dated 11/14/24 documented her risk factors included self-care deficits, falls with possible injuries, incontinence, decreased socialization, skin breakdown, weight loss, and fluid imbalance. R24's Care Plan dated 09/23/21 documented staff would analyze times of day, places, circumstances, triggers, and what de-escalates behavior and document. The plan of care lacked individualized triggered-specific interventions that identified ways to decrease exposure to triggers which could re-traumatize her. On 03/25/25 at 07:17 AM, R24 sat in her wheelchair next to the bed with the lights off in the room. On 03/27/25 at 09:52 AM, Certified Nurse Aide (CNA) N stated she was not aware R24 had a diagnosis of PTSD. CNA N stated R24 would often yell out. CNA N stated she would expect to find the information of R24's PTSD which included what might possibly re-traumatize her. CNA N stated she would also expect to find the interventions that would help address R24's trauma. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/27/25 at 10:37 AM, Licensed Nurse (LN) I stated R24's diagnose of PTSD could explain why R24 yelled out frequently. LN I stated she would expect the care plan to have information on what had happened to cause the PTSD and what interventions that were in place to prevent re-traumatization. On 03/27/25 at 11:00 AM, Social Services Staff X and Social Services Staff Y stated R24's last Trauma Informed Care assessment was completed on 02/26/20. Social Services Staff X and Social Services Staff Y stated the trauma-based assessment would only be assessed at the time of admission and only if Administrative Nurse D would request a reassessment. Social Services Staff X and Social Services Staff Y stated the MDS coordinator would be responsible to develop R24's care plan. Social Services Staff X and Social Services Staff Y stated R24 would not require any increased monitoring due to her diagnosis of PTSD. On 03/27/25 at 11:36 AM, Administrative Nurse D stated she would expect to find R24's PTSD addressed on her care plan. Administrative Nurse D stated she was not sure the frequency R24 should be assessed for her trauma-based care. Administrative Nurse D stated that would be handled by the social service department. The facility's Comprehensive Care Plans and Revisions policy last revised 09/11/24 documented the facility would ensure the timeliness of each resident's person-centered, comprehensive care plan, and to ensure that the comprehensive care plan was reviewed and revised by an interdisciplinary team composed of individuals who have knowledge of the resident and his/her needs, and that each resident and resident representative, if applicable, was involved in developing the care plan and making decisions about his or her care. The facility failed to develop a comprehensive care plan for R24 which included individualized person-centered interventions for her PTSD. This deficient practice placed R24 at risk for impaired care due to uncommunicated care needs and re-traumatization. - The Medical Diagnosis section within R9's Electronic Medical Records (EMR) included diagnoses of chronic kidney disease, quadriplegia (inability to move the arms, legs, and trunk of the body below the level of an associated injury to the spinal cord), type to diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), dysphagia (difficulty swallowing), and 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). R9's Admission Minimum Data Set (MDS) completed 01/20/25 noted a Brief Interview for Mental Status (BIMS) score of zero indicating severe cognitive impairment. The MDS noted he was dependent on staff assistance for bathing, transfers, dressing, personal hygiene, bed mobility, and toileting. The MDS noted he had one-sided upper and lower extremity impairment. The MDS noted he received enteral nutrition (provision of nutrients through the gastrointestinal tract when the resident cannot ingest, chew, or swallow food). R9's Cognitive Loss/Dementia Care Area Assessment (CAA) dated 01/23/25 documented his risk factors included self-care deficit, falls with injuries bowel incontinence, decreased socialization, skin breakdown, weight loss and fluid imbalance. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R9's Care Plan dated 03/19/25 documented he was on Enhanced Barrier Precautions (EBP - infection control interventions designed to reduce transmission of resistant organisms which employ targeted gown and glove use during high contact care). The plan of care lacked person centered activities for R9. Review of R9's EMR under Reports for Activity Participation lacked documentation of any activity participation. The facility was unable to provide any activity documentation upon request. On 03/24/25 at 07:45 AM, R9 lay flat in his bed. R9's enteral feeding pump ran at 70 milliliters/hour (ml/hr.). R9's roommates TV was on, the curtain that divided the room was pulled to block the TV from R9's vision. No music or TV was on in the room on R9's side of the room. On 03/27/25 at 09:52 AM, Certified Nurse Aide (CNA) N stated R9 enjoyed having his TV or radio on when he was in bed. CNA N stated everyone had access to the residents' care plan and the Kardex (nursing tool that gives a brief overview of the care needs of each resident). On 03/27/25 at 10:37 AM, Licensed Nurse (LN) I stated R9 enjoyed listening to music when he was in bed. LN I stated his activities of choice should be on his care plan. LN I stated everyone had access to the residents' care plan and the Kardex. On 03/27/25 at 11:36 AM, Administrative Nurse D stated R9 enjoyed music. Administrative Nurse D stated his person-centered activities should be care planned. The facility's Comprehensive Care Plans and Revisions policy last revised 09/11/24 documented the facility would ensure the timeliness of each resident's person-centered, comprehensive care plan, and to ensure that the comprehensive care plan was reviewed and revised by an interdisciplinary team composed of individuals who have knowledge of the resident and his/her needs, and that each resident and resident representative, if applicable, was involved in developing the care plan and making decisions about his or her care. The facility failed to identify and create a person-centered comprehensive care plan that included meaningful activities for R9. This deficient practice placed R9 at risk for a decline in physical, mental, and psychosocial well-being and independence.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45668 The facility reported a census of 96 residents. The sample included 20. Based on observations, interviews, and record review, the facility failed to revise Residents (R)73s care plan to reflect her visitation requirements and R85's fall intervnetions. These deficient practices placed the residents at risk for impaired care due to uncommunicated care needs. Findings Included: - The Medical Diagnosis section within R73's Electronic Medical Records (EMR) included diagnoses of aphasia (difficulty speaking), hemiparesis/hemiplegia (weakness and paralysis on one side of the body), 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), muscle weakness, and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). R73's Quarterly Minimum Data Set (MDS) completed 01/03/25 noted a Brief Interview for Mental Status (BIMS) score of ten indicating mild cognitive impairment. The MDS noted she was dependent on staff assistance for bathing, transfers, dressing, personal hygiene, bed mobility, and toileting. The MDS noted she was at risk for falls, 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) and had an indwelling urinary catheter (tube placed in the bladder to drain urine into a collection bag). R73's Cognitive Loss Care Area Assessment (CAA) completed 09/17/24 indicated she had cognitive loss related to her orientation, memory, and recall deficits. The CAA noted she was at risk for falls, skin breakdown, weight loss, and a decline of her activities of daily living (ADL). The plan noted her care plan addressed her risks. R73's Care Plan initiated 10/09/23 indicated she had a self-care performance deficit related to her medical diagnoses. The plan noted she required substantial staff assistance for transfers, bathing, personal hygiene, dressing, and toileting. The plan instructed staff to provide a safe care environment due to her risk of falling. The plan instructed staff to ensure her call light remained within reach, keep room clear from clutter, and assist her with ADLs (10/14/23). The plan noted she had difficulty with communication. The plan instructed staff to allow adequate time for conversation, allow her to express her thoughts, and anticipate her needs (10/17/23). R73's EMR under Special Instructions indicated R73's family representative was only allowed to visit her in a common area. A Facility Reported Investigation completed 02/09/25 indicated staff overheard R73's family representative yelling and witnessed the representative's arm around R73's neck in an aggressive manner. The report indicated staff immediately separated the representative and removed them from the building. The report indicated local law enforcement was notified of the incident. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/25/25 at 11:01 AM, R73 sat in her wheelchair in her room. She stated her mom was not allowed to return to the facility per R73's wishes. She stated if she had to talk with her representative, she wanted staff to be present or in a supervised area. On 03/027/25 at 09:52 AM, Licensed Nurse (LN) I stated the care plan should reflect relevant information related to the resident's care. She stated R73'S representative can only visit in the common area due to safety concerns. He stated the care plan should reflect that information. On 03/027/25 at 11:34 PM, Administrative Nurse D stated 73's family representative was not allowed back at the facility per R73's request. She stated she was not sure if R73's care plan reflected the incident or contained information about the representative. The facility's Comprehensive Care Plans and Revisions policy last revised 09/11/24 documented the facility would ensure the timeliness of each resident's person-centered, comprehensive care plan, and to ensure that the comprehensive care plan was reviewed and revised by an interdisciplinary team composed of individuals who have knowledge of the resident and his/her needs, and that each resident and resident representative, if applicable, was involved in developing the care plan and making decisions about his or her care. The facility failed to revise R73's care plan to reflect visitation requirements. This deficient practice placed R73 at risk for impaired quality of life and safety concerns. 41037 - R85's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of lack of coordination, fracture right hip (broken bone), dementia (a progressive mental disorder characterized by failing memory and confusion), muscle weakness, aphasia (condition with disordered or absent language function), and communication deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness). The Admission Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of seven which indicated severely impaired cognition. The MDS documented R85 was independent with bed mobility. The MDS documented R85 required supervision to touch assistance with personal hygiene and dressing. The MDS documented R85 had no limitations with upper and lower extremity range of motion (ROM - the full movement potential of a joint, usually its range of flexion and extension). The MDS documented R85 had one non-injury fall since admission or previous MDS assessment. The Quarterly MDS dated [DATE] documented a BIMS score of zero which indicated severely impaired cognition. The MDS documented that R85 had limited ROM to lower extremity on one side. The MDS documented R85 was dependent on staff assistance for eating, oral hygiene, personal hygiene, her bathing, toileting activity, and transfers. The MDS documented R85 had orthopedic surgery. R85's Falls Care Area Assessment (CAA) dated 12/04/24 documented her risk factors included falls with major and minor injuries related to past falls. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R85's Care Plan dated 12/02/24 documented a medication review would be completed by the physician. The plan of care dated 12/18/24 documented for a no apparent acute injury staff would determine and address causative factors of the fall. The plan of care dated 12/08/24 documented R85 had a witnessed fall on 12/17/24 and staff would offer her to take rest breaks when wandering on the unit. The plan of care dated 01/09/25 staff would increase observation for 72 hours post fall. The plan of care dated 01/10/25 documented R85 had a fall in the dining room and staff would encourage her to wear non-skid footwear. The plan of care dated 01/14/25 documented R85 had an injury of unknown origin, and the therapy department would evaluate her ambulation needs and any assistive devices needed. The plan care dated 03/20/25 documented R85 had an unwitnessed fall so staff would provide purposeful rounding for 72 hours and place a floor mat on the left side of her bed. The plan of care dated 03/26/25 directed staff to offer R85 cares during rounding. The care plan lacked new long-term interventions to prevent future falls. R85's EMR under the Progress Notes tab the following Health Status Note dated 12/02/24 at 01:48 PM documented R85 was found on the floor in another resident's room. No injuries noted. On 12/02/24 at 12:03 PM an Admission Note documented a visit dictated by the physician. No medication changes were documented. On 12/05/24 at 11:48 AM an Encounter Note dictated by the physician which documented that R85's Depakote (mood stabilizer) medication was discontinued per family's request. On 12/18/24 at 01:00 AM an Event Note that documented R85 had a witnessed fall while she was wandering in the hallway. On 12/18/24 at 08:57 AM a Health Status Note documented R85 continued fall follow-up monitoring. RF85 had a skin tear documented on her right elbow. On 01/09/25 at 06:30 PM an Event Note documented R85 was found on the floor in her room. No injuries noted. On 01/10/25 at 03:50 PM an Alert Note documented R85 was found on the floor in the dining room. R85 was found lying on her right side. On 01/14/25 at 07:07 PM an Event Note documented R85 complained of right hip pain during staff provided incontinence care. The physician was notified, and an X-ray was obtained, and the results showed a displaced intertrochanteric fracture of her right femur. R85 was admitted to the hospital with a right hip fracture. On 03/20/25 at 09:28 AM a Health Status Note documented R85 was found on the floor mat next to her bed. On 03/25/25 at 04:59 PM an Event Note documented R85 was found sitting on the floor on the floor mat next to her bed. On 03/26/25 at 07:27 AM, R85 laid asleep on her bed in the lowest position with the floor mat next to the bed on the right side of the bed. (continued on next page)

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Life Care Center of Andover	621 W 21st Andover, KS 67002

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/27/25 at 09:52 AM, Certified Nurse Aide (CNA) N stated R85 was on the secured unit until her right hip fracture. CNA N stated R85 was a high fall risk and was to have her bed in the lowest position and a fall mat next to her bed. CNA N stated everyone had access to the care plan and the Kardex (nursing tool that gives a brief overview of the care needs of each resident). CNA N stated she would review R85's care plan to find all the fall interventions that were in place to prevent falls. On 03/27/25 at 10:37 AM, Licensed Nurse (LN) I stated everyone had access to the residents' care plan and the Kardex. LN I stated R85's fall interventions should be on her care plan. LN I stated R85 should have her call light within reach, fall mat on the floor next to her bed and the bed in the lowest position. On 03/27/25 at 11:36 AM, Administrative Nurse D stated R85 had the right hip fracture from the possible fall on 01/10/25. Administrative Nurse D stated R85 had not had any pain from 01/10/25 to 01/14/25 when staff had reported the pain while they provided care. Administrative Nurse D stated they had found the right hip fracture after the x-ray. Administrative Nurse D stated after the 72-hour observation interventions was completed, she stated there was no new interventions placed on R85's care plan to prevent future falls. The facility's Comprehensive Care Plans and Revisions policy last revised 09/11/24 documented the facility would ensure the timeliness of each resident's person-centered, comprehensive care plan, and to ensure that the comprehensive care plan was reviewed and revised by an interdisciplinary team composed of individuals who have knowledge of the resident and his/her needs, and that each resident and resident representative, if applicable, was involved in developing the care plan and making decisions about his or her care. The facility failed to revise R85's plan of care to include the new fall preventive measures to prevent future falls for a resident who was a high fall risk. This deficient practice placed R85 at risk of falls and possible future injuries.

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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** 41037 The facility identified a census of 96 residents. The sample included 20 residents, with four residents reviewed for activities of daily living (ADLs). Based on observation, record review, and interviews, the facility failed to ensure Resident (R) 55 was provided a touch pad call light. This deficient practice placed R55 at risk of unmet care needs and inability to call for assistance if needed. Findings included: - R55's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of spastic quadriplegic cerebral palsy (a progressive disorder of movement, muscle tone, or posture caused by injury or abnormal development in the immature brain, most often before birth), protein-calorie malnutrition (inadequate intake of protein and calories which may cause wasting of muscle and tissue), muscle spasms, muscle weakness, need for assistance with personal care, muscle weakness, and pneumonitis due to inhalation of food and vomit (an inflammation of the lungs). The Annual Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of zero which indicated severely impaired cognition. The MDS documented R55 had bilateral upper and lower limitation in range of motion (ROM - the full movement potential of a joint, usually its range of flexion and extension). The MDS documented R55 was dependent on staff assistance for his activities of daily living (ADL). The MDS documented R55 was independent with mobility in a motorized wheelchair. The MDS documented R55 had a feeding tube. The MDS documented R55 was at risk for development of 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 and had a pressure reducing device on his bed and in his wheelchair. The Quarterly MDS dated [DATE] documented a BIMS score of zero which indicated severely impaired cognition. The MDS documented that R55 had bilateral upper and lower limitation in ROM. The MDS documented R55 was dependent on staff assistance for his ADLs and dependent on staff assistance for wheelchair mobility. The MDS documented R55 had a feeding tube. The MDS documented R55 was at risk for development of pressure ulcers and had a pressure reducing device on his bed and in his wheelchair. R55's Cognitive Loss/Dementia Care Area Assessment (CAA) dated 08/15/24 documented risk factors included self-care deficits, falls, decreased socialization, bowel and bladder incontinence, skin breakdown, weight loss, and fluid imbalance. The facility would care plan his current ADL status. R55's Care Plan dated 11/07/23 documented staff would provide him with a mechanical pad call light in order to request staff assistance. On 03/25/25 at 08:16 AM, R55 laid on his bed, head of the bed was slightly elevated. R55's bed was elevated three feet of the floor with bed rails up in place bilaterally. R55's push button call light was attached to the right bed rail and hung off the bed out of his reach. R55's bilateral hands were clenched tightly closed with no palm grippers in place. R55's low air mattress was unplugged from the wall and was not working. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/27/25 at 09:52 AM, Certified Nurse Aide (CNA) N stated R55 could not operate a push button call light. CNA N stated she was not sure who would assess the residents for the appropriate equipment. On 03/27/25 at 10:37 AM, Licensed Nurse (LN) I stated R55 could not operate the push button call light. On 03/27/25 at 11:36 AM, Administrative Nurse D stated R55 was not able to operate the push button call light. Administrative Nurse D stated he probably would do better if he had a touch pad call light. The facility's Activities of Daily Living (ADLs) policy last reviewed 09/10/24 documented a resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living. The facility failed to ensure R55 had a touch pad call light. This deficient practice placed R55 at risk of uncommunicated needs and ability to call for assistance.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41713 The facility identified a census of 96 residents. The sample included 20 residents, with four residents reviewed for activities of daily living (ADL). Based on observation, record review, and interview, the facility failed to ensure staff provided consistent bathing to dependent Resident (R) 18, R15, R43, and R55 per their preferred preferences. Findings included: - R18's Electronic Medical Record (EMR) documented diagnoses of pressure ulcer (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) of the buttock, Guillan-Barre syndrome (a disorder in which the body's immune system attacks the nerves), and congestive heart failure (CHF- a condition with low heart output and the body becomes congested with fluid). R18's Admission Minimum Data Set (MDS) dated [DATE] documented she had a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. R18 had functional limitation in range of motion with impairment on one side of her upper extremity. R18 used a walker and a wheelchair to assist with mobility. R18 was dependent on staff for toileting, bathing, dressing, and putting on footwear. R18 had an indwelling catheter (tube placed in the bladder to drain urine into a collection bag) to assist with bladder continence. R18 was frequently incontinent of bowel. R18 was a risk for pressure ulcer development. R18 required supplemental oxygen. R18's Functional Abilities Care Area Assessment (CAA) dated 08/26/24 documented her risk factors include further ADL decline, falls, incontinence, skin breakdown, and pain. The care plan would reflect her current ADL status and functional ability, maintain continence status, decrease pain, and decrease fall and pressure ulcer risk. R18's Care Plan revised 01/13/25 directed staff to check her nail length and trim and clean them on bath days as necessary. Staff were directed that R18 was totally dependent on two staff to provide a bath or shower and as necessary. R18's care plan lacked staff direction on her preferred bath or shower days. R18's Documentation Survey Report v2 for December 2024 documented an ADL bathing task on Tuesday and Sunday days as needed. R18 received a bed bath on 12/03/24. R18 refused a bath on 12/17/24. On 12/06/24 at 01:59 PM a Health Status Note late entry note, documented R18 had a bed bath on 12/06/24, with nail care done, and linens changed. On 12/12/24 at 08:55 PM a Health Status Note in the EMR documented R18 had a bed bath on 12/10/24, with nail care done, and linens changed. R18's EMR lacked a Health Status Note documenting a bath was offered to or refused by R18 between 12/12/24 and 12/19/24. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/20/24 at 09:25 AM a Health Status Note in the EMR documented R18 had a bed bath on 12/20/24, with nail care done, and linens changed. On 12/24/24 at 09:16 AM a Health Status Note in the EMR documented R18 refused a shower on 12/24/24. R18 stated she just had one. On 12/31/24 at 04:41 PM a Health Status Note documented a late entry that R18 had a bed bath 12/31/24. R18's EMR lacked a Health Status Note documentation of a bath offered or refused by R18 between 12/25/24 and 12/30/24. R18's January 2025 Documentation Survey Report v2 in the EMR documented an ADL bathing task on Tuesday and Sunday days as needed. R18 received a bed bath on 01/31/25. On 01/14/25 at 09:18 AM a Health Status Note documented R18 had a bed bath 01/14/25. R18's EMR Progress Notes tab lacked documentation that she received, was offered, or refused any bathing other than on 01/14/25 and 01/31/25 for the month of January 2025. R18's February 2025 Documentation Survey Report v2 in the EMR documented an ADL bathing task on Tuesday and Sunday days as needed. R18 received a bed bath on 02/04/25. The report had an entry on 02/16/25 marked not applicable activity did not occur. On 02/04/25 at 10:49 AM a Health Status Note documented a late entry note that R18 had a bed bath on 02/04/25. R18's hair was washed, and the linens were changed. On 02/11/25 at 04:11 AM a Health Status Note documented a late entry that R18 refused a shower on 02/11/25. R18's EMR Progress Notes tab lacked documentation that she received, was offered, or refused any bathing between 02/05/25 and 02/10/25. R18's EMR Progress Notes tab lacked documentation that she received, was offered, or refused any bathing between 02/12/25 and 02/24/25. On 02/25/2025 at 09:31 AM a Health Status Note documented a note that R18 had a bed bath 02/25/25. R18's hair was washed, nail care was done, and linens changed. R18's March 2025 Documentation Survey Report v2 in the EMR documented an ADL bathing task on Tuesday and Sunday days. The report documented R18 received a bed bath on 03/11/25, 03/16/25, 03/18/25, and 03/23/25. The report documented not applicable, activity did not occur, on 03/02/25, 03/09/25, and 03/25/25. R18's EMR Progress Notes tab lacked documentation that she received, was offered, or refused any bathing between 02/26/25 and 03/03/25. (Eight days) (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/04/25 at 09:53 AM a Health Status Note documented a late entry note that R18 had a bed bath on 03/04/25. Nail care was done, and the linens changed. No new skin concerns noted. On 03/11/25 at 02:19 AM a Health Status Note documented a late entry note R18 had a bed bath 03/11/25. Her hair was washed, nail care was done, and the linens changed. No new skin concerns was noted. On 03/18/25 at 08:55 AM a Health Status Note documented a late entry note that R18 had a bed bath on 03/18/25. On 03/27/25 at 09:15 AM, R18 stated she did get bed baths or shower at least once a week but sometimes it was longer in between them. R18 stated she knew that the facility was short of staff, and they would not always get hers done as she required more help bathing than some of the other residents. On 03/27/25 at 10:33 AM, Certified Nurse Aide (CNA) P stated the nurse's station had a bathing schedule list that had who was to get bathed each day on it. CNA P stated most of the time the bathing was able to be completed daily but some days when the unit was short of staff a resident might have to wait until the next day. CNA P stated typically a resident would be offered bath by the aide twice then the aide would tell the nurse if the resident had refused. On 03/27/25 at 10:40 AM, Licensed Nurse (LN) J stated there was a list at the nurse's station that had the days each resident was scheduled for bathing or a shower, which was typically twice a week per the resident's preference. LN J said the aides would offer the resident a bath twice and then the nurse would be told. LN J said after the aide told the nurse that a resident had refused the nurse would offer one more time and if the resident still refused then the nurse should document a note of the refusal. The facility's Activities of Daily Living (ADL) policy last reviewed 09/10/24 documented the resident would receive assistance as needed to complete ADLs. Any change in their ability to perform ADLs would be reported to the nurse. Quality of care is a fundamental principle that applied to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility would ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that a resident was given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living. A resident who was unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. The facility failed to ensure staff provided consistent bathing to dependent R18 per her preferred bathing preferences. This deficient practice placed these residents at risk for skin breakdown and possible injury/infection. 45668 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- The Medical Diagnosis section within R15's Electronic Medical Records (EMR) included diagnoses of type two diabetes (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), major depressive disorder (major mood disorder), morbid obesity (severely overweight), general anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and schizoaffective disorder (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought). R15's Quarterly Minimum Data Set (MDS) completed 03/07/25 noted a Brief Interview for Mental Status (BIMS) score of eleven indicating mild cognitive impairment. The MDS noted she had physically aggressive behaviors towards others. The MDS noted she was dependent on staff assistance for bed mobility, toileting, bathing, transfers, personal hygiene, and dressing. The MDS noted she was frequently incontinent of bowel and bladder. The MDS noted she was not on a toileting program. The MDS noted she was at risk for skin breakdown and pressure ulcers but had no unhealed wounds. The MDS noted she had pressure-reducing devices and a repositioning program in place. R15's Behavioral Care Area Assessment (CAA) completed 11/01/24 indicated she was at risk for physical aggression, decreased socialization, isolation, and anxiety. The plan indicated her care plan was to reflect interventions to decrease her behaviors and agitation. R15's Functional Abilities CAA completed 11/01/24 indicated she was at risk for a decline in her activities of daily living (ADL) related to her medical diagnoses. The plan indicated her care plan was to reflect interventions to maintain her current level of functioning. R15's Care Plan initiated on 03/04/20 indicated she was at risk for ADL deficit due to her medical diagnoses and behaviors. The plan noted she was dependent on two staff for assistance with bathing, transfers, bed mobility, toileting, personal hygiene, and dressing (12/03/23). The plan noted she was resistant to care and wished to set her own schedule (12/03/23). The plan instructed staff to allow her to make her own decisions and encourage participation (12/03/23). The plan instructed staff to give clear explanations during each interaction, leave and return five to ten minutes after refusals, and praise appropriate behaviors (12/03/23). A review of R15's EMR under Documentation Survey Report from 01/01/25 through 03/27/25 (86 days reviewed) revealed she received bathing opportunities on occasions (01/09, 01/20, 02/10, and 03/03). The review revealed bathing was marked rejected on two occasions (1/30 and 3/3). The review revealed bathing was not given under Not Applicable circumstances on 19 occasions (1/2, 1/6, 1/13, 1/16, 1/23, 1/27, /1/30, 2/3, 2/6, 2/13, 2/17, 2/20, 2/24, 2/27, 3/6, 3/10, 3/13, 3/17, 3/17, 3/20, and 3/24). R15's EMR under Progress Notes revealed an Interdisciplinary Team (IDT) note completed on 03/13/25. The note revealed she had continued refusal of care and medications due to her medical diagnosis. The note revealed was not receiving behavioral health services. The note indicated the team will continue to monitor her changes and worsening mental health. On 03/24/25 at 10:03 AM, R15 lay in her bed on her right side next to her side rail. She stated she had not had a bath in almost a month and staff would not provide them when it was convenient for her. R15's hair was matted and greasy. Her nails were dirty. R15 stated she would often refuse care when she was upset or didn't like the staff taking care of her. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/27/25 at 09:52 AM, Certified Nurse's Aide (CNA) N stated R15 had ongoing behaviors. She stated it was hard to get her to take baths and provide care due to her behaviors and rejection of care. She stated staff often would ask multiple times if she wanted care or baths and she would still refuse. On 03/27/25 at 10:37 AM, Licensed Nurse (LN) I stated R15 would often refuse ADL care and medications. She stated nursing would often offer the medications but R15 would refuse care. She stated R15 could be physically aggressive towards staff but most of the time she just refuses. On 03/27/25 at 11:34 AM, Administrative Nurse D stated staff were expected to provide consistent care for R15 and report refusals to the nurse. She stated that R15 should be educated on the importance of medication and care. She stated staff should make multiple attempts to provide these things to her. She stated staff could also call the resident representative for assistance with refusals. The facility's Activities of Daily Living (ADL) policy last reviewed 09/2024 indicated all residents would be provided ADL assistance and consistent bathing opportunities for all residents. The policy noted residents will be assessed for their specific care needs and provided interventions. The facility failed to provide consistent bathing opportunities for R15. This deficient practice placed R15 at risk for impaired psycho-social well-being and skin breakdown. 49634 - R43's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of hypertensive heart disease (a condition where hypertension (high blood pressure) damages the heart muscles over time), heart failure (a condition of low heart output), diabetes mellitus (DM -when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), respiratory failure (a condition where the lungs struggle to exchange oxygen and carbon dioxide effectively, leading to low oxygen levels in the blood (hypoxemia) and or high carbon dioxide levels (hypercapnia), obesity (excessive body fat), bed confinement status, and palliative treatment (treatment designed to relieve or reduce the intensity of uncomfortable symptoms). The Admission Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS documented R43 was dependent on staff for toileting, dressing and bathing. The MDS documented R43 required set up and clean up for eating. The Quarter MDS dated [DATE] documented a BIMS of 15 which indicated intact cognition. The MDS documented R43 was dependent on staff for toileting, dressing and bathing. The MDS documented R43 required set up and clean up for eating. R43's Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) dated 01/10/25 documented the risk factors for R43 included decline in activities of daily living (ADL), falls, incontinence, skin breakdown, and pain. R43's care plan will reflect current ADL status and functional ability, maintain continence status, decrease pain, decrease fall, and pressure ulcer risk. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R43's Care Plan dated 07/17/24 documented R43 has an ADL self-care performance deficit related to obesity, and R43 would maintain current level of function. R43's plan documented staff would check fingernail length, clean, and trim nails on bath day. R43's plan documented two staff were required to give R43 a bath. R43's EMR under Task documented R43 preferred bathing on Wednesday and Saturday in the evening. R43's Lookback Report from the Tasks lacked evidence of bathing from 01/01/25 through 03/25/25. The EMR lacked evidence of refusals. On 03/26/25 at 08:44 AM, R43 laid on his bed looking at iPad. R43's hair appeared greasy. On 03/27/25 at 08:15 AM, R43 laid on his bed looking at his iPad. R43 had a green hospital gown on with a food stain on the front of his gown. R43's hair appeared greasy. On 03/27/25 at 10:40 AM, Licensed Nurse (LN) H stated a hospice aide gave R43 his bath. She stated, he received two bed baths a week. On 03/27/25 at 10:52 AM, Certified Nursing Aide (CNA) N stated R43 has refused bathing from the facility aides. She stated the hospice aide comes twice a week to give R43 a bed bath. On 03/72/25 at 11:36 AM, Administrated Nurse D stated the hospice bath aide gives R43 a bed bath, she stated the facility aide should be offering R43 bed baths on his scheduled days also. The facility's Activities of Daily Living (ADLs) policy last reviewed 09/10/24 documented the resident would receive assistance as needed to complete ADLs. Any change in their ability to perform ADLs would be reported to the nurse. Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility would ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that a resident was given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living. A resident who was unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. The facility failed to provide consistent bathing for R43 who required assistance with bathing. This deficient practice placed R43 at risk for complications related to poor hygiene and impaired dignity. 41037 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- R55's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of spastic quadriplegic cerebral palsy (a progressive disorder of movement, muscle tone, or posture caused by injury or abnormal development in the immature brain, most often before birth), protein-calorie malnutrition (inadequate intake of protein and calories which may cause wasting of muscle and tissue), muscle spasms, muscle weakness, need for assistance with personal care, muscle weakness, and pneumonitis due to inhalation of food and vomit (an inflammation of the lungs). The Annual Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of zero which indicated severely impaired cognition. The MDS documented R55 had bilateral upper and lower limitation in range of motion (ROM - the full movement potential of a joint, usually its range of flexion and extension). The MDS documented R55 was dependent on staff assistance for his activities of daily living (ADL). The MDS documented R55 was independent with mobility in a motorized wheelchair. The MDS documented R55 had a feeding tube. The MDS documented R55 was at risk for development of 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). The MDS documented R55 had a pressure reducing device on his bed and in his wheelchair. The MDS lacked documentation R55 was provided a restorative nursing program during the observation period. The Quarterly MDS dated [DATE] documented a BIMS score of zero which indicated severely impaired cognition. The MDS documented that R55 had bilateral upper and lower limitation in ROM. The MDS documented R55 was dependent on staff assistance for his ADLs. The MDS documented R55 was dependent on staff assistance for wheelchair mobility. The MDS documented R55 had a feeding tube. The MDS documented R55 was at risk for development of pressure ulcers. The MDS documented R55 had a pressure reducing device on his bed and in his wheelchair. The MDS lacked documentation R55 was provided a restorative nursing program during the observation period. R55's Cognitive Loss/Dementia Care Area Assessment (CAA) dated 08/15/24 documented risk factors included self-care deficits, falls, decreased socialization, bowel and bladder incontinence, skin breakdown, weight loss, and fluid imbalance. The facility would care plan his current ADL status. R55's Care Plan dated 09/24/23 documented he required assistance of two staff members for his bathing activity. Review of R55's EMR under the Reports tab and Bathing task was reviewed for the following dates 01/01/25 to 03/24/25 (82 days). The EMR documented five Showers (SW) on 01/03/25, 01/14/25, 01/17/25, 02/06/25, and 03/13/25. The EMR documented one Not Applicable (NA) on 01/25/25. The EMR documented two Bed Bath (BB) on 01/28/25 and 02/10/25. The EMR documented 11 Activity Did Not Occur (8) on 01/08/25, 01/21/25, 02/03/25, 02/13/25, 02/17/25, 02/20/25, 02/24/25, 03/03/25, 03/06/25, 03/17/25, and 03/20/25. R55's clinical record lacked evidence he was offered or refused care during the 82-days reviewed. On 03/24/25 at 09:44 AM, R55 laid flat on his bed with his enteral feeding (within or via the small intestine). R55's enteral formula container and water bag was undated and unlabeled. R55's hair looked oily and had a body odor noted. R55's bilateral hands were clenched tightly closed without any type of contracture prevention device. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/27/25 at 09:52 AM, Certified Nurse Aide (CNA) N stated R55 received his bathing on dayshift. CNA N stated he never refused his bath/shower. CNA N stated the only reason he would not be taken to the shower would be if there was a problem with his gastrostomy tube (G-tube: tube surgically placed through an artificial opening into the stomach). On 03/27/25 at 10:37 AM, Licensed Nurse (LN) I stated R55 never refused his bath/shower. LN I stated R55 had infection around his G-tube currently that the physicians were treating, so he would need his bath to keep that area clean. On 03/27/25 at 11:36 AM, Administrative Nurse D stated R55 should receive two baths weekly. Administrative Nurse D stated if a resident refused his bath, the CNAs would report that to the charge nurse, then the charge nurse would try to find out why the resident had refused. Administrative Nurse D stated the staff attempt to provide the resident's preference for bathing. The facility's Activities of Daily Living (ADL) policy last reviewed 09/10/24 documented the resident would receive assistance as needed to complete ADLs. Any change in their ability to perform ADLs would be reported to the nurse. Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility would ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that a resident was given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living. A resident who was unable to carry out ADLs received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. The facility failed to provide consistent bathing for R55 who was dependent on staff for bathing. This deficient practice had the risk for poor hygiene, skin breakdown, decreased self-esteem, and dignity.

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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 96 residents. The sample included 20 residents, with four 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 staff set the appropriate weight for Resident (R) 245's low air-loss mattresses (specialized air mattress used to reduce pressure on the body) and failed to ensure R55's low air-loss mattress was plugged in and functioning. This deficient practice placed both residents at risk for complications related to skin breakdown and pressure ulcers. Findings Included: - The Medical Diagnosis section within R245's Electronic Medical Records (EMR) included diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), major depressive disorder (major mood disorder), end-stage renal failure (kidney failure), and a gastrostomy tube (G-tube: tube surgically placed through an artificial opening into the stomach). R245's Admission Minimum Data Set (MDS) completed 01/13/25 noted a Brief Interview for Mental Status (BIMS) score of zero indicating severe cognitive impairment. The MDS noted she was dependent on staff assistance for bathing, transfers, dressing, personal hygiene, bed mobility, and toileting. The MDS noted she had bilateral upper extremity impairment. The MDS noted she admitted with a stage two (partial-thickness skin loss into but no deeper than the dermis including intact or ruptured blisters) pressure ulcer (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). The MDS noted she had pressure-reducing devices for her bed and wheelchair. The MDs noted she received hospice services (end-of-life comfort care). The MDS noted she weighed 228 pounds (lbs.). R245's Pressure Ulcer Care Area Assessment (CAA) completed 01/14/25 indicated she was at risk for further pressure ulcers related to her urinary incontinence, impaired mobility, and history of pressure ulcers. The CAA noted she required frequent repositioning and a special mattress. R245's Care Plan initiated on 01/09/25 indicated she was dependent on staff assistance for bed mobility, transfers, toileting, bathing, dressing, and personal hygiene. The plan noted she was at risk for impaired skin integrity and pressure ulcers. The plan instructed staff to provide preventative skin care, turning/repositioning, weekly skin checks, and provide a pressure redistribution mattress. A review of the low air-loss mattress manufacturer's operation (Meridian Medical) manual indicated 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 selected. R245's EMR under Vitals revealed she weighed 228.1 pounds (lbs.) on 03/21/25. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/24/25 at 09:20 AM, R245 slept in her bed. R245's bed was set to a low height with her call light next to her bed within reach. R245's low air-loss mattress was set to 400 lbs. (maximum setting). The mattress pump had fixed weight settings of 80 lbs, 110 lbs, 140 lbs, 170 lbs, 200 lbs, 230 lbs, 260 lbs, 290 lbs, 320 lbs, 350 lbs, and 400 lbs. On 03/24/25 at 12:35 PM, R245 rested in her bed. Her low air-loss mattress pump was set at 400 lbs. On 03/25/25 at 08:01 AM, R245's low air-loss mattress pump was changed to a firmness pump. On 03/27/25 at 09:52 AM, Certified Nurse's Aide (CNA) N stated staff just checked to make sure the pump was turned on and the bed was inflated. She stated some of the mattresses were calculated by the resident's weight. On 03/27/25 at 10:32 AM, Licensed Nurse I stated staff were expected to ensure the low air-loss mattress was functioning and turned on. She stated the beds were set by the resident's current weight. On 03/27/25 at 11:32 AM, Administrative Nurse D stated most of the mattresses in the facility were set by comfort settings but some of them went by what the resident weighed to ensure the correct pressure was being applied. The facility's Skin Integrity and Pressure Ulcer- Prevention and Management policy revised 08/2021 indicated the facility implements individualized interventions based on each resident's comprehensive assessment and risk. The policy noted the facility will implement interventions that prevent pressure-related injures to include repositioning, comprehensive skin assessments, safe lifting devices, and pressure redistribution surfaces. 41037 - R55's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of spastic quadriplegic cerebral palsy (a progressive disorder of movement, muscle tone, or posture caused by injury or abnormal development in the immature brain, most often before birth), protein-calorie malnutrition (inadequate intake of protein and calories which may cause wasting of muscle and tissue), muscle spasms, muscle weakness, need for assistance with personal care, muscle weakness, and pneumonitis due to inhalation of food and vomit (an inflammation of the lungs). The Annual Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of zero which indicated severely impaired cognition. The MDS documented R55 had bilateral upper and lower limitation in range of motion (ROM - the full movement potential of a joint, usually its range of flexion and extension). The MDS documented R55 was dependent on staff assistance for his activities of daily living (ADL). The MDS documented R55 was independent with mobility in a motorized wheelchair. The MDS documented R55 had a feeding tube. The MDS documented R55 was at risk for development of 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). The MDS documented R55 had a pressure reducing device on his bed and in his wheelchair. The MDS lacked documentation R55 was provided a restorative nursing program during the observation period. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Quarterly MDS dated [DATE] documented a BIMS score of zero which indicated severely impaired cognition. The MDS documented that R55 had bilateral upper and lower limitation in ROM. The MDS documented R55 was dependent on staff assistance for his ADLs. The MDS documented R55 was dependent on staff assistance for wheelchair mobility. The MDS documented R55 had a feeding tube. The MDS documented R55 was at risk for development of pressure ulcers. The MDS documented R55 had a pressure reducing device on his bed and in his wheelchair. The MDS lacked documentation R55 was provided a restorative nursing program during the observation period. R55's Pressure Ulcer Care Area Assessment (CAA) dated 08/15/24 documented he was at risk of development of pressure ulcers due to his fluid deficit, his current ADL status, and his functional ability. R55's Care Plan dated 08/07/23 documented a pressure reducing mattress was placed on his bed. The plan of care dated 11/09/23 documented a low air loss mattress was placed R55's bed. Review of R55's clinical record lacked documentation of monitoring his low air loss mattress function. On 03/25/25 at 08:16 AM, R55 laid on his bed, head of the bed was slightly elevated. R55's bed was elevated three feet of the floor and the low air mattress was unplugged from the wall and not functioning. On 03/27/25 at 09:52 AM, Certified Nurse Aide (CNA) N stated staff just checked to make sure the pump was turned on and the bed was inflated. She stated some of the mattresses were calculated by the resident's weight. On 03/27/25 at 10:32 AM, Licensed Nurse I stated staff were expected to ensure the low air-loss mattress was functioning and turned on. She stated the beds were set by the resident's current weight. On 03/27/25 at 11:32 AM, Administrative Nurse D stated most of the mattresses in the facility were set by comfort settings but some of them went by what the resident weight to ensure the correct pressure was being applied. The facility's Skin Integrity and Pressure Ulcer- Prevention and Management policy revised 08/2021 indicated the facility implements individualized interventions based on each resident's comprehensive assessment and risk. The policy noted the facility will implement interventions that prevent pressure-related injures to include repositioning, comprehensive skin assessments, safe lifting devices, and pressure redistribution surfaces.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41037 The facility identified a census of 96 residents. The sample included 20 residents with four residents reviewed for positioning and mobility. Based on observation, record review, and interviews, the facility failed to ensure Resident (R)55 was provided services and treatment to prevent worsening of contractures (abnormal permanent fixation of a joint or muscle) in his left hand. This deficient practice placed R55 at risk for discomfort and decreased range of motion (ROM - the full movement potential of a joint, usually its range of flexion and extension). Findings included: - R55's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of spastic quadriplegic cerebral palsy (a progressive disorder of movement, muscle tone, or posture caused by injury or abnormal development in the immature brain, most often before birth), protein-calorie malnutrition (inadequate intake of protein and calories which may cause wasting of muscle and tissue), muscle spasms, muscle weakness, need for assistance with personal care, muscle weakness, and pneumonitis due to inhalation of food and vomit (an inflammation of the lungs). The Annual Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of zero which indicated severely impaired cognition. The MDS documented R55 had bilateral upper and lower limitation in range of motion (ROM - the full movement potential of a joint, usually its range of flexion and extension). The MDS documented R55 was dependent on staff assistance for his activities of daily living (ADL). The MDS documented R55 was independent with mobility in a motorized wheelchair. The MDS documented R55 had a feeding tube. The MDS documented R55 was at risk for development of 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). The MDS documented R55 had a pressure reducing device on his bed and in his wheelchair. The MDS lacked documentation R55 was provided a restorative nursing program during the observation period. The Quarterly MDS dated [DATE] documented a BIMS score of zero which indicated severely impaired cognition. The MDS documented that R55 had bilateral upper and lower limitation in ROM. The MDS documented R55 was dependent on staff assistance for his ADLs. The MDS documented R55 was dependent on staff assistance for wheelchair mobility. The MDS documented R55 had a feeding tube. The MDS documented R55 was at risk for development of pressure ulcers. The MDS documented R55 had a pressure reducing device on his bed and in his wheelchair. The MDS lacked documentation R55 was provided a restorative nursing program during the observation period. R55's Cognitive Loss/Dementia Care Area Assessment (CAA) dated 08/15/24 documented risk factors included self-care deficits, falls, decreased socialization, bowel and bladder incontinence, skin breakdown, weight loss, and fluid imbalance. The facility would care plan his current ADL status. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R55's Care Plan dated 11/14/24 documented staff would apply palm grips on bilateral hands. The plan of care documented R55 was to wear the palm grips four to six hours a day seven days a week. The plan of care documented the staff would monitor his skin integrity, pain, and circulation. The plan of care documented nursing staff would provide a passive ROM program to R85's upper extremities, with stretching, flexion, and extension of his digits, wrists, and shoulders. The plan of care documented nursing staff would provide the restorative program up to 15 minutes per day and up to seven days a week. Review of R55's clinical record under the Medication Administration Record (MAR), under the Treatment Administration Record (TAR), and under the Reports tab for the Documentation Survey Report form 01/01/25 to 03/25/25 (84 days) lacked documentation of a nursing restorative program and application of his palm grippers. On 03/24/25 at 09:44 AM, R55 laid flat on his bed with his enteral feeding (within or via the small intestine). R55's enteral formula container and clear bag was undated and unlabeled. R55's hair looked oily and had a body odor noted. R55's bilateral hands were clenched tightly closed without any type of contracture prevention device. On 03/25/25 at 08:16 AM, R55 laid on his bed, head of the bed was slightly elevated. R55's bed was elevated three feet of the floor with siderails up in place bilaterally. R55's push button call light was attached to the right siderail and hung off the bed out of his reach. R55's bilateral hands were clenched tightly closed with no palm grippers in place. On 03/26/25 at 07:35 AM, R55 laid on his bed with elevated three feet off the floor. Bilateral side rails up and locked in place R55's hand was tightly clenched closed with no palm grippers in place. On 03/26/25 at 09:12 AM, Administrative Nurse D stated she did not believe R55 had any type of contracture preventive devices. She would have to review his chart. On 03/27/25 at 09:52 AM, Certified Nurse Aide (CNA) N stated if R55 was to wear palm grippers usually the therapy department would apply them and remove them. CNA N stated if nursing staff would be responsible to apply his palm grippers therapy would educate the staff about the application and removal of palm grippers. CNA N stated if a resident a restorative program of splint application that would be documented on the POC under the Tasks tab. On 03/27/25 at 10:37 AM, Licensed Nurse (LN) I stated therapy would usually apply the hand grippers and monitor the amount of time to be worn and removed. LN I stated if nursing was responsible for the application of the On 03/27/25 at 11:36 AM, Administrative Nurse D stated she had found R55's palm grippers and was going to have the therapy department reevaluate his contractures. The facility's Restorative Nursing policy last revised 09/20/24 documented to promote the resident 's optimum function, a restorative program would be developed by proactively identifying, care planning and monitoring of a resident's assessments and indicators. Nursing Assistants must be trained in the techniques that promote resident involvement in restorative activities. Restorative programs may be initiated by nursing and /or therapy.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41037 45668 The facility reported a census of 96 residents with 20 residents sampled. Based on observation, interview, and record review the facility failed to provide timely incontinenct care to Resident (R) 81, to prevent an incontinence episode during the lunchtime meal in the dining room, which left a puddle of urine on the floor by the resident. This failure placed the resident at risk for potetial negative psychosocial well-being, due to embarassment and frustration. The facility staff also failed to ensure they educated R10 regarding keeping the urinary catheter bag below the level fo the bladder, in order to prevent the potential infection control issue, which could lead to urinary tract infections. Findings included: - The Medical Diagnosis section within R10's Electronic Medical Records (EMR) included diagnoses of general anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), obstructive uropathy (blockage in the urinary tract), benign prostatic hyperplasia (BPH - non-cancerous enlargement of the prostate which can lead to interference with urine flow, urinary frequency, and urinary tract infections), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and history of falls. R10's Quarterly Minimum Data Set (MDS) completed 12/26/24 noted a Brief Interview for Mental Status (BIMS) score of six indicating severe cognitive impairment. The MDS noted he used a wheelchair for mobility. The MDS noted he required substantial to maximal assistance with dressing, bed mobility, bathing, transfer, personal hygiene, and toileting. The MDS noted he had an indwelling urinary catheter (Foley Catheter - tube placed in the bladder to drain urine into a collection bag). R10's Urinary Incontinence Care Area Assessment (CAA) completed 04/24/24 indicated he was at risk for urinary tract infections (UTI) and discomfort related to his medical diagnoses. The CAA noted staff would monitor for abnormalities related to his Foley catheter. R10's Care Plan initiated on 09/04/19 indicated he required supervision to touch assistance from staff for bed mobility, transfers, dressing, personal hygiene, toileting, and bathing. The plan noted he had an indwelling urinary catheter due to obstructive uropathy. The plan instructed staff to provide catheter care each shift and ensure the catheter tubing and urine collection bag remained below the level of the bladder. The plan instructed staff to monitor the tubing for kinks. On 03/24/25 at 09:30 AM, R10 lay in his bed asleep. R10's catheter collection bag was placed on the side of his bed. The urine collection bag was above the level of his bladder and urine pooled in the tubing of his urinary catheter. On 03/24/25 at 02:15 PM, R10 sat in his wheelchair in the front hallway. R10's urine collection bag was hung off his armrest on the left side of his wheelchair. Bright yellow urine pooled in the catheter tubing. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/25/24 at 07:13 AM, R10 sat in his wheelchair in the front hallway. His urinary catheter collection bag hung off the left side handrail of his wheelchair. R10 sat in the lobby with his catheter bag above his bladder level. The bag hung off his armrest until he returned to his bed to rest after breakfast. On 03/27/25 at 09:30 AM, Certified Nurse Aide (CNA) M stated R10 catheter tubing and urine collection bags must be hung below the level of the bladder to prevent infections. On 03/27/25 at 10:30 AM, Licensed Nurse (LN) I stated catheter bags need to remain below the level of the resident's bladder to prevent backflow of old urine into the bladder. On 03/27/25 at 11:32 AM, Administrative Nurse D stated staff were expected to ensure each catheter was positioned below the resident's bladder. She stated that R10 liked to place his catheter bag on his wheelchair armrest, but it still was an infection risk. The facility's Indwelling Urinary Catheter Management policy issued 06/2023 indicated the facility was to ensure standards of practice were followed to ensure safe and sanitary urinary catheter care. The policy indicated staff were to ensure unobstructed urine flow within the catheter by inspecting the tubing for kinks, frequent emptying, and maintaining the catheter collection bag below the level of the resident's bladder. 49634 - R81's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), metabolic encephalopathy (a condition where the brain's function is impaired due to an imbalance in the body's metabolism), hyperlipidemia (condition of elevated blood lipid levels), anemia (an inadequate number of healthy red blood cells to carry adequate oxygen to body tissues), hypothyroidism (a condition characterized by decreased activity of the thyroid gland), insomnia (inability to sleep), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), unsteady on feet, lack of coordination, anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and palliative treatment (treatment designed to relieve or reduce the intensity of uncomfortable symptoms). The Significant Change Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of five which indicated severely impaired cognition. The MDS documented R81 required set up and clean up for eating and oral hygiene, partial to moderate assistance from staff for toileting, and substantial to maximum assistance with bathing. The MDS documented R81 did not have a bladder program and was frequently incontinent. R81's Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA) dated 03/07/25 documented R81's risk factors included skin breakdown, falls, and recurrent UTI's. The CAA documented the care plan would reflect current toileting skills. R81's Care Plan dated 09/21/24 documented R81 had urinary incontinence and would have no skin breakdown related to urinary incontinence, staff would provide peri care as needed. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/24/25 at 12:12 PM, R81 sat in the large dining room, R81 was incontinent of bladder. R81's bladder incontinence left a puddle of urine on the floor, in the area where other residents were eating lunch. On 03/27/25 at 09:46 AM, Certified Nurse Aide (CNA) M stated residents should be asked if they need toileted more often. CNA M stated most of the residents are toileted before meals, or before they were laid down. On 03/27/25 at 10:02 AM, Licensed Nurse (LN) G stated all nursing staff were responsible to ensure residents were toileted as needed. She stated nursing should anticipate the resident's needs. On 03/27/25 at 11:36 AM, Administrative Nurse D stated staff should anticipate the resident's needs, and ask residents more often. She stated staff know the residents well and can anticipate their needs. The facility's Bowel and Bladder Program policy dated 09/24/24 documented the facility would ensure that a resident who was continence of bladder on admission receives care, including assistance, and service to maintain continence unless their clinical condition was or becomes such that continence was not possible to maintain. The facility would ensure that a resident who was admitted with incontinence of bladder, receives appropriate treatment and service to prevent urinary tract infections and to restore as much normal bladder function as possible.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45668 The facility identified a census of 96 residents. The sample included 20 residents, with four residents reviewed for tube feeding. Based on observation, record review, and interviews, the facility failed to ensure safe enteral nutritional feedings for Residents (R)71, R245, R9, and R55. This deficient practice placed the residents at risk for malnutrition and complications related to their enteral feedings (provision of nutrients through the gastrointestinal tract when the resident cannot ingest, chew, or swallow food). Findings Included: - The Medical Diagnosis section within R71's Electronic Medical Records (EMR) included diagnoses of cognitive communication deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness), hemiparesis/hemiplegia (weakness and paralysis on one side of the body), dysphagia (difficulty swallowing), cerebrovascular disease (abnormal blood flow to the brain), and a gastrostomy tube (G-tube: tube surgically placed through an artificial opening into the stomach). R71's Quarterly Minimum Data Set (MDS) completed 01/20/25 noted a Brief Interview for Mental Status (BIMS) score of zero indicating severe cognitive impairment. The MDS noted she was dependent on staff assistance for bathing, transfers, dressing, personal hygiene, bed mobility, and toileting. The MDS noted she had one-sided upper and lower extremity impairment. The MDS noted she received enteral nutrition (provision of nutrients through the gastrointestinal tract when the resident cannot ingest, chew, or swallow food). The MDS indicated not weight loss. R71's Feeding Tube Care Area Assessment (CAA) completed 10/11/24 indicated she received enteral nutrition with a gastrostomy tube. The CAA noted care plan interventions were implemented to maintain his nutritional status. The CAA noted he was at risk for complications related to his enteral feedings including aspiration (an inflammatory condition of the lungs caused by inhaling foreign material or vomit) and fluid imbalance. R71's Care Plan initiated on 11/17/23 indicated she was dependent on staff assistance for bed mobility, transfers, toileting, bathing, dressing, and personal hygiene. The plan noted she received enteral feedings via a feeding tube (tube for introducing high-calorie fluids into the stomach). The plan instructed staff to elevate the head of her bed at 45 degrees for thirty minutes after feedings. The plan instructed staff to check tube placement and residual volume (amount of fluid in the stomach) per the facility's protocol. R71's EMR under Orders revealed an order (dated 10/02/24) for staff to inspect and verify the positioning of her PEG tube each shift. The order instructed staff to provide enteral access site care each shift and as needed. The order instructed staff to check for residual fluids at the beginning of each shift and record the amount. The order instructed staff to maintain the head of her bed at 30 degrees or greater each shift. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R71's EMR under Orders revealed an order (dated 10/02/24) for staff to administer Osmolite 1.5 (nutritional supplement used for tube feedings) at 65 milliliters per hour (ml/hour) for 24 hours via enteral feeding pump for a total of 1430ml. The Order instructed staff to also flush with 150ml of purified water every four hours. On 03/24/25 at 10:04 AM, R71 slept in her bed. R71 positioning was almost flat with her low air-loss mattress (adjustable air mattress system used to prevent pressure on the body) pump set to firm. R71's enteral pump was running at 65 ml/hr. R71 had an unlabeled/undated bag of Osmolite 1.5 supplement. On 03/24/25 at 02:32 PM, R71 slept flat in her bed as her continuous supplement pump ran at 65 ml/hr. The supplement bag was still unlabeled/undated. On 03/25/25 at 09:21 AM, R71's body positioning was adjusted, and her supplement bag was labeled/dated. On 03/27/25 at 09:52 AM, Certified Nurse's Aide (CNA) N stated residents were not to lay flat in bed when tube feeding was administered due to the risk of aspiration and choking. She stated staff were to make sure residents on tube feeding were in an elevated position while in bed. On 03/27/25 at 10:32 AM, Licensed Nurse I stated staff were expected to date and label the enteral feeding bags when they were administered and hung in the resident's rooms. She stated staff needed to know the date and time the administration was started to ensure consistent nutrition was being given. She stated the head of the resident's bed was elevated at least 45 degrees to prevent aspiration or acid reflux during feeding. On 03/27/25 at 11:32 AM, Administrative Nurse D stated staff were expected to elevate the enterally feed residents to at least 45 degrees while administering enteral nutrition. She stated the bags should always be labeled with the date and time to ensure consistent feedings. The facility did not provide a policy related to enteral nutrition as requested on 03/27/25. - The Medical Diagnosis section within R245's Electronic Medical Records (EMR) included diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), major depressive disorder (major mood disorder), end-stage renal failure (kidney failure), and a gastrostomy tube (G-tube: tube surgically placed through an artificial opening into the stomach). R245's Admission Minimum Data Set (MDS) completed 01/13/25 noted a Brief Interview for Mental Status (BIMS) score of zero indicating severe cognitive impairment. The MDS noted she was dependent on staff assistance for bathing, transfers, dressing, personal hygiene, bed mobility, and toileting. The MDS noted she had bilateral upper extremity impairment. The MDS noted she received enteral nutrition (provision of nutrients through the gastrointestinal tract when the resident cannot ingest, chew, or swallow food). The MDS noted she admitted with a stage two (partial-thickness skin loss into but no deeper than the dermis including intact or ruptured blisters) pressure ulcer (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). The MDS noted she had pressure reducing devices for her bed and wheelchair. The MDs noted she received hospice services (end of life comfort care). (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R245's Feeding Tube Care Area Assessment (CAA) completed 02/12/25 indicated she received enteral nutrition with a gastrostomy tube. The CAA noted care planned interventions were implemented to maintain his nutritional status. The CAA noted he was at risk for complications related to his enteral feedings including aspiration and fluid imbalance. R245's Falls Care Area Assessment (CAA) completed 02/12/25 indicated she was at-risk for a deficit of her activities of daily living (ADL) related to her medical diagnoses. The CAA noted her care plan addressed her ADL decline. R245's Care Plan initiated 01/09/25 indicated she was dependent on staff assistance for bed mobility, transfers, toileting, bathing, dressing, and personal hygiene. The plan noted she received enteral feedings via a feeding tube (tube for introducing high-calorie fluids into the stomach). The plan instructed staff to elevate the head of her bed at 45 degrees for thirty minutes after feedings. The plan instructed staff to check tube placement and residual volume (amount of fluid in the stomach) per the facility's protocol. R245's EMR under Orders revealed an order (dated 01/08/25) for staff to inspect and verify the positioning of her percutaneous endoscope gastrostomy tube (PEG-a tube inserted through the wall of the abdomen directly into the stomach) each shift. The order instructed staff to provide enteral access site care each shift and as needed. The order instructed staff to check for residual fluids at the beginning of each shift and record the amount. The order instructed staff to maintain the head of her bed at 30 degrees or greater each shift. R245's EMR under Orders revealed an order (dated 01/08/25) for staff to administer TwoCal HN (nutritional supplement used for tube feedings) at 50 milliliters per hour (ml/hour) continuously via enteral pump. The Order instructed staff to also flush with 170 ml of purified water every four hours. On 03/24/25 at 09:21 AM, R245 slept flat in her bed. R245's bed was in the low position. Her Low-air-loss (adjustable air mattress system used to alleviate pressure areas of the body) mattress pump was set to 400lbs (maximum weight). R245's enteral feeding pump was set to 55 ml/hr and an unlabeled/undated bag of unknown supplement was being administered. The bag was 1/3 full of supplement. On 03/24/25 at 12:12 PM, R245 slept in bed. Enteral pump still set to 55 ml/hr. Enteral supplement bags still not labeled or dated. Unknown type of supplement in bag. On 03/25/25 at 07:43 AM, R245 slept flat in bed and the enteral feeding bag was not labeled or dated. There was an unknown supplement in feeding bag and the enteral pump was running at 55 ml/hr. The enteral bag was almost empty. On 03/25/25 at 09:18 AM, R245's positioning adjusted with head elevated. The enteral pump was set to 55 ml/hr and the enteral feedings bag was now labeled and dated. On 03/27/25 at 09:52 AM, Certified Nurse's Aide (CNA) N stated residents were not to lay flat in bed when tube feeding was administered due to the risk for aspiration and choking. She stated staff were to make sure residents on tube feeding were in an elevated position while in bed. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/27/25 at 10:32 AM, Licensed Nurse I stated staff were expected to date and label the enteral feeding bags when they were administered and hung in the resident's rooms. She stated staff need to know the date and time the administration was started to ensure consistent nutrition was being given. She stated the head of the resident's beds were elevated at least to 45 degrees to prevent aspiration or acid reflux during feeing. On 03/27/25 at 11:32 AM, Administrative Nurse D stated staff were expected to elevate the enterally feed resident's to at least 45 degrees while administering enteral nutrition. She stated the bags should always be labeled with the date and time to ensure consistent feedings. The facility failed to provide a policy related to enteral nutrition at requested on 03/27/25. - The Medical Diagnosis section within R9's Electronic Medical Records (EMR) included diagnoses of chronic kidney disease, quadriplegia (inability to move the arms, legs, and trunk of the body below the level of an associated injury to the spinal cord), type to diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), dysphagia (difficulty swallowing), and 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). R9's Admission Minimum Data Set (MDS) completed 01/20/25 noted a Brief Interview for Mental Status (BIMS) score of zero indicating severe cognitive impairment. The MDS noted he was dependent on staff assistance for bathing, transfers, dressing, personal hygiene, bed mobility, and toileting. The MDS noted he had one-sided upper and lower extremity impairment. The MDS noted he received enteral nutrition (provision of nutrients through the gastrointestinal tract when the resident cannot ingest, chew, or swallow food). R9's Feeding Tube Care Area Assessment (CAA) completed 01/23/24 indicated she received enteral nutrition with a gastrostomy tube (G-tube: tube surgically placed through an artificial opening into the stomach). The CAA noted care planned interventions were implemented to maintain his nutritional status. The CAA noted he was at risk for complications related to his enteral feedings including aspiration and fluid imbalance. R9's Care Plan initiated 03/12/25 indicated he was at risk for skin breakdown, pressure injuries, urinary tract infections (UTIs), and wound infections. The plan noted he had an indwelling urinary catheter (tube placed in the bladder to drain urine into a collection bag). The plan lacked information related to his enteral feedings or management of his percutaneous endoscope gastrostomy tube (PEG-a tube inserted through the wall of the abdomen directly into the stomach). The plan instructed staff to elevate the head of her bed at 45 degrees for thirty minutes after feedings. The plan instructed staff to check tube placement and residual volume (amount of fluid in the stomach) per the facility's protocol. R9's EMR under Orders revealed an order (dated 01/31/25) for staff to inspect and verify the positioning of her PEG-tube each shift. The order instructed staff to provide enteral access site care each shift and as needed. The order instructed staff to check for residual fluids at the beginning of each shift and record the amount. The order instructed staff to maintain the head of her bed at 30 degrees or greater each shift. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R9's EMR under Orders revealed an order (dated 01/31/25) for staff to administer Jevity 1.5 (nutritional supplement used for tube feedings) at 70 milliliters per hour (ml/hour) for 24 hours via enteral feeding pump for a total of 1430 ml. The Order instructed staff to also flush with 200 ml of purified water every four hours. On 03/24/25 at 07:45 AM, R9 lay flat in his bed. R9's enteral feeding pump ran at 70 ml/hr. A clear unlabeled/undated bag of unknown supplement was administered to him through the feeding pump. On 03/27/25 at 09:52 AM, Certified Nurse's Aide (CNA) N stated residents were not to lay flat in bed when tube feeding was administered due to the risk for aspiration and choking. She stated staff were to make sure residents on tube feeding were in an elevated position while in bed. On 03/27/25 at 10:32 AM, Licensed Nurse I stated staff were expected to date and label the enteral feeding bags when they were administered and hung in the resident's rooms. She stated staff need to know the date and time the administration was started to ensure consistent nutrition was being given. She stated the head of the resident's beds were elevated at least to 45 degrees to prevent aspiration or acid reflux during feeing. On 03/27/25 at 11:32 AM, Administrative Nurse D stated staff were expected to elevate the enterally feed resident's to at least 45 degrees while administering enteral nutrition. She stated the bags should always be labeled with the date and time to ensure consistent feedings. The facility failed to provide a policy related to enteral nutrition at requested on 03/27/25. - The Medical Diagnosis section within R55's Electronic Medical Records (EMR) included diagnoses of spastic quadriplegic cerebral palsy (a progressive disorder of movement, muscle tone, or posture caused by injury or abnormal development in the immature brain, most often before birth), protein-calorie malnutrition (inadequate intake of protein and calories which may cause wasting of muscle and tissue), muscle spasms, muscle weakness, need for assistance with personal care, muscle weakness, and pneumonitis due to inhalation of food and vomit (inflammation of the lungs). R55's Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of zero which indicated severely impaired cognition. The MDS indicated he had bilateral upper and lower limitations in range of motion (ROM - the full movement potential of a joint, usually its range of flexion and extension). The MDS documented that R55 was dependent on staff assistance for his activities of daily living (ADL). The MDS documented that R55 was independent with mobility in a motorized wheelchair. The MDS noted he received enteral nutrition (provision of nutrients through the gastrointestinal tract when the resident cannot ingest, chew, or swallow food). R55's Feeding Tube Care Area Assessment (CAA) completed 08/15/24 indicated she received enteral nutrition with a gastrostomy tube (G-tube: tube surgically placed through an artificial opening into the stomach). The CAA noted that planned interventions were implemented to maintain his nutritional status. The CAA noted he was at risk for complications related to his enteral feedings including aspiration (an inflammatory condition of the lungs caused by inhaling foreign material or vomit) and fluid imbalance. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R55's Care Plan initiated on 07/25/23 indicated he was at risk for a decline in his activities of daily living (ADL). The plan noted he was dependent on staff for assistance with bathing, toileting, personal hygiene, dressing, transfers, and bed mobility. The plan noted he required enteral nutrition via a gastrostomy tube (G-tube: tube surgically placed through an artificial opening into the stomach). The plan instructed staff to elevate the head of her bed at 45 degrees for thirty minutes after feedings. The plan instructed staff to check tube placement and residual volume (amount of fluid in the stomach) per the facility's protocol. R55's EMR under Orders revealed an order (dated 09/02/24) for staff to inspect and verify the positioning of her PEG tube each shift. The order instructed staff to provide enteral access site care each shift and as needed. The order instructed staff to check for residual fluids at the beginning of each shift and record the amount. The order instructed staff to maintain the head of her bed at 30 degrees or greater each shift. R55's EMR under Orders revealed an order (dated 09/02/24) for staff to administer Jevity 1.5 (nutritional supplement used for tube feedings) at 75 milliliters per hour (ml/hour) continuously via an enteral pump. The Order instructed staff to also flush with 250 ml of water every four hours. On 03/24/25 at 07:56 AM, R55 lay in his bed. The head of his bed was slightly elevated but below 30 degrees. R55's enteral pump ran at 75 ml/hr. His clear enteral bag was unlabeled and undated with an unknown supplement inside. On 03/25/25 at 07:50 AM, R55 lay in his bed. The head of his bed again was slightly elevated but not below 34 degrees. His enteral nutrition pump ran at 75 ml/hr. His enteral supplement bag was again not dated or labeled. On 03/27/25 at 09:52 AM, Certified Nurse's Aide (CNA) N stated residents were not to lay flat in bed when tube feeding was administered due to the risk of aspiration and choking. She stated staff were to make sure residents on tube feeding were in an elevated position while in bed. On 03/27/25 at 10:32 AM, Licensed Nurse I stated staff were expected to date and label the enteral feeding bags when they were administered and hung in the resident's rooms. She stated staff needed to know the date and time the administration was started to ensure consistent nutrition was being given. She stated the head of the resident's bed was elevated at least 45 degrees to prevent aspiration or acid reflux during feeding. On 03/27/25 at 11:32 AM, Administrative Nurse D stated staff were expected to elevate the enterally feed residents to at least 45 degrees while administering enteral nutrition. She stated the bags should always be labeled with the date and time to ensure consistent feedings. The facility failed to provide a policy related to enteral nutrition as requested on 03/27/25.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41713 The facility identified a census of 96 residents. The sample included 20 residents, with three sample residents reviewed for respiratory care. Based on observation, record review, and interview, the facility failed to ensure Resident (R) 4 had her physician-ordered supplemental oxygen on as ordered. The facility failed to ensure R4's nasal cannula (NC - a thin hollow tube that assists in providing supplemental oxygen) was appropriately stored when not used. The facility failed to ensure R43's continuous positive airway pressure (CPAP- ventilation device that blows a gentle stream of air into the nose to keep the airway open during sleep) mask was stored appropirately when not in use. This deficient practice placed R4 and R43 at risk of respiratory complications and possible infection. Findings included: - R4's Electronic Medical Record (EMR) documented diagnoses of respiratory failure (a condition where the lungs are unable to adequately perform their primary function of gas exchange), chronic obstructive pulmonary disease (COPD - a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), congestive heart failure (CHF - a condition with low heart output and the body becomes congested with fluid), and dementia (a progressive mental disorder characterized by failing memory and confusion). R4's Annual Minimum Data Set (MDS) dated [DATE] documented she had a Brief Interview for Mental Status (BIMS) scored of nine which indicated moderately impaired cognition. R4 required partial assistance from staff for the activities of daily living (ADL). R4 required oxygen therapy (the administration of oxygen at concentrations greater than that in ambient air). R4's Functional Abilities Care Area Assessment (CAA) dated 06/18/24 documented she was at risk for functional decline due to COPD, impaired mobility, CHF, and multiple co-morbidities. Staff would continue to monitor R4 and provide assistance daily. R4's Care Plan last revised on 01/24/25 directed staff that she was on oxygen therapy related to COPD. Staff were directed that R4 was to be administered oxygen at three liters via NC. Staff were directed to observe for signs and symptoms of respiratory distress and report it to the physician. R4's Order Summary documented a physician's order dated 12/11/19 for oxygen at three liters per minute per NC for COPD. R4's Order Summary documented a physician's order dated 06/19/19 to clean oxygen concentrator (a machine that provides supplemental oxygen) filter with soap and water weekly every Sunday. R4's Order Summary documented a physician's order dated 08/07/24 to check oxygen saturation (percentage of oxygen in the blood) every shift. R4's Order Summary documented a physician's order dated 03/19/25 to change oxygen tubing every Sunday on night shift. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/25/25 at 07:39 AM, R4 laid on her bed resting. R4's oxygen concentrator was on in her room and the oxygen NC was laid on her bedside table and was not bagged. On 03/26/25 at 08:02 AM, R4 ambulated down the hallway, with the assistance of a walker. R4 did not have her supplemental oxygen on. On 03/27/25 at 10:15 AM, R4 sat on the side of her bed watching tv. R4's oxygen concentrator was on, but she did not have the NC in her nose. The NC laid on her bed, unbagged. On 03/27/25 at 10:30 AM, Certified Nurse Aide (CNA) P stated R4 was aware that she was to always have her supplemental oxygen on, but she would put on and take off her NC when she wanted. CNA P stated R4's NC should be stored in a bag when it was not in use. CNA P stated when R4 took her NC off she would not place it in the provided bag. On 03/27/25 at 10:40 AM, Licensed Nurse (LN) H stated she was aware that R4 was supposed to have her oxygen on all the time, but she put it on and took the NC off when she wanted to. LN H stated R4 did not have a portable oxygen tank to take with her when she walked with her walker. LN H stated R4 was reminded frequently to use her supplemental oxygen and to put the NC in the provided bag when she did not have it on, but R4 was very forgetful. On 03/27/25 at 11:37 AM, Administrative Nurse D stated R4 was non-compliant a lot with her supplemental oxygen. Administrative Nurse D stated R4's care plan should reflect that she refused to have her supplemental oxygen on. Administrative Nurse D stated R4's NC should be stored in the provided bag when not being used and that R4 would not always remember to place the NC in the bag. The facility's Oxygen Administration (Safety, Storage, Maintenance) policy revised on 10/11/24 documented to assure that oxygen was administered and stored safely within the healthcare centers or in an outside storage area. An oxygen order should be written for specific liter flow required. Oxygen supplies should be changed weekly and when visibly soiled. The equipment should be labeled with the resident's name and dated when setup or changed out. Oxygen and respiratory supplies should be stored in a bag labeled with the resident's name when not in use. The facility failed to ensure R4 had her physician-ordered supplemental oxygen on as ordered. The facility failed to ensure R4's NC was appropriately stored when not used. This deficient practice placed R4 at risk of respiratory complications and possible infection. 49634 The facility identified a census of 96 residents. The sample included 20 residents, with three sample residents reviewed for respiratory care. Based on observation, record review, and interview, the facility failed to ensure R43's continuous positive airway pressure (CPAP- ventilation device that blows a gentle stream of air into the nose to keep the airway open during sleep) mask was stored appropriately when not in use. This deficient practice placed R4 and R43 at risk of respiratory complications and possible infection. Findings included: (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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- R43's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of hypertensive heart disease (a condition where hypertension (high blood pressure) damages the heart muscles over time), heart failure (a condition of low heart output), diabetes mellitus (DM -when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), respiratory failure (a condition where the lungs struggle to exchange oxygen and carbon dioxide effectively, leading to low oxygen levels in the blood (hypoxemia) and or high carbon dioxide levels (hypercapnia)), obesity (excessive body fat), bed confinement status, and palliative treatment (treatment designed to relieve or reduce the intensity of uncomfortable symptoms). The Annual Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS documented R43 was dependent on staff for toileting, dressing, and bathing. The MDS documented R43 required set up and clean up for eating. The MDS documented R43 was on hospice. The Quarter MDS dated [DATE] documented a BIMS of 15 which indicated intact cognition. The MDS documented R43 was dependent on staff for toileting, dressing, and bathing. The MDS documented R43 required set up and clean up for eating. The MDS documented R43 was on hospice. The MDS documented R43 used a noninvasive mechanical ventilator (a medical procedure that uses a machine to assist or take over the work of breathing). R43's Functional Abilities (Self-Care Mobility) Care Area Assessment (CAA) dated 01/10/25 documented R43's risk factors include further activities of daily living (ADL) decline, falls, incontinence, skin breakdown, and pain. The MDS documented R43's care plan would reflect current ADL status and functional ability, maintain continence status, decrease pain, and decrease fall and pressure ulcer risk. R43's Care Plan date 07/17/24 documented R43 had altered respiratory status and difficulty breathing related to sleep apnea (a disorder of sleep characterized by periods without respirations), staff were to observe for changes in orientation, increased restlessness, anxiety, and air hunger. The plan documented staff were to position R43 with proper body alignment for optimal breathing pattern. R43's EMR under the Orders tab revealed the following physician orders: CPAP, fill humidifier with sterile or distilled water every shift dated 07/01/24. CPAP Clean reservoir with warm soapy water, rinse; set out to dry everyday shift, seven days dated 07/02/24. Clean CPAP mask with warm soapy water, rinse, and air dry as needed dated 07/02/24. CPAP on while sleeping/napping and off while awake every shift dated 07/02/24. On 03/25/25 at 08:25 AM, R43 laid on his bed looking at his iPad. R43's CPAP laid in his windowsill; the CPAP was not stored in a sanitary manner. On 03/27/25 at 10:02 AM Licensed Nurse (LN)H stated all respiratory equipment should be placed in an appropriate bag labeled with the resident's name when the resident was not using the equipment. She stated R43 would not have been able to place the mask in the windowsill. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/27/25 at 10:52 AM, Certified Nurse's Aide (CNA) N stated R43 was able to take off his mask but was not able to place his mask in the windowsill. She stated the mask should be in a bag when not in use. On 03/27/25 at 11:36 AM, Administrative Nurse D stated all respiratory equipment should be stored in a sanitary manner when not in use. The facility did not provide a policy pertaining to the storage of respiratory equipment when not in use.

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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 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41037 The facility identified a census of 96 residents. The sample included 20 residents, with one resident reviewed for trauma informed care (treatment or care directed to prevent re-experiencing or reducing the effects of traumatic events). Based on observation, record review, and interviews, the facility failed to identify trauma-based triggers related to Resident (R) 24's post-traumatic stress disorder (PTSD- mental disorder characterized by an acute emotional response to a traumatic event or situation involving severe environmental stress) and failed to implement individualized interventions to prevent re-traumatization. These deficient practices placed R24 at risk for decreased psychosocial well-being and ineffective treatment. Findings included: - R24's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of PTSD, cognitive communication deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), dementia (a progressive mental disorder characterized by failing memory and confusion), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). The Annual Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of four which indicated severely impaired cognition. The MDS documented R24 had no behaviors during the observation period. The MDS documented R24 had an active diagnosis of PTSD. The Quarterly MDS dated [DATE] documented a BIMS score of five which indicated severely impaired cognition. The MDS documented R24 had no behaviors during the observation period. The MDS documented R24 had an active diagnosis of PTSD. R24's Cognitive Loss/Dementia Care Area Assessment (CAA) dated 11/14/24 documented her risk factors included self-care deficits, falls with possible injuries, incontinence, decreased socialization, skin breakdown, weight loss, and fluid imbalance. R24's Care Plan dated 09/23/21 documented staff would analyze times of day, places, circumstances, triggers, and what de-escalates behavior and document. The plan of care lacked individualized triggered-specific interventions that identified ways to decrease exposure to triggers which could re-traumatize her. On 03/25/25 at 07:17 AM, R24 sat in her wheelchair next to the bed with the lights off in the room. On 03/27/25 at 09:52 AM, Certified Nurse Aide (CNA) N stated she was not aware R24 had a diagnosis of PTSD. CNA N stated R24 would often yell out. CNA N stated she would expect to find the information of R24's PTSD which included what might possibly re-traumatize her. CNA N stated she would also expect to find the interventions that would help address R24's trauma. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/27/25 at 10:37 AM, Licensed Nurse (LN) I stated R24's diagnose of PTSD could explain why that R24 yelled out frequently. LN I stated she would expect what had happened to cause the PTSD and what interventions that were in place to prevent re-traumatization on the care plan. On 03/27/25 at 11:00 AM, Social Services Staff X and Social Services Staff Y stated R24's last Trauma Informed Care assessment was completed on 02/26/20. Social Services Staff X and Social Services Staff Y stated the trauma-based assessment would only be assessed at the time of admission and only if Administrative Nurse D would request a reassessment. Social Services Staff X and Social Services Staff Y stated the MDS coordinator would be responsible to develop R24's care plan. Social Services Staff X and Social Services Staff Y stated R24 would not require any increased monitoring due to her diagnosis of PTSD. On 03/27/25 at 11:36 AM, Administrative Nurse D stated she would expect to find R24's PTSD addressed on her care plan. Administrative Nurse D stated she was not sure the frequency R24 should be assessed for her trauma-based care. Administrative Nurse D stated that would be handled by the social service department. The facility's Trauma-Informed Care policy last reviewed 09/06/24 documented based on the comprehensive assessment of a resident, this facility must ensure that residents who are diagnosed mental disorder or psychosocial adjustment difficulty, or who had a history of trauma and/or post-traumatic stress disorder, received appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well being. The facility must ensure that residents who are trauma survivors received culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. Trigger-specific interventions would identify ways to decrease the resident 's exposure to triggers which re-traumatize the resident, as well as identify ways to mitigate or decrease the effect of the trigger on the resident. The facility would monitor the effects of their approaches to ensure they are implemented as intended and are having the desired effect to achieve the measurable objectives and the resident's goals for care. For residents with a history of trauma in particular, the facility should evaluate whether the interventions have been able to mitigate (or reduce) the impact of identified triggers on the resident that may cause re-traumatization. Remember to involve the resident and/or his or her family or representative in this evaluation to ensure clear and open discussion and better understand if interventions must be modified.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 96 residents. The sample included 20 residents with two reviewed for bed rails. Based on observation, record review, and interviews, the facility failed to ensure that Residents (R) 15 and R55 had a safety assessment for the use of side rails that acknowledged the risks of their low air-loss mattress. This deficient practice placed both 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 R15's Electronic Medical Records (EMR) included diagnoses of type two diabetes (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), major depressive disorder (major mood disorder), morbid obesity (severely overweight), general anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and schizoaffective disorder (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought). R15's Quarterly Minimum Data Set (MDS) completed 03/07/25 noted a Brief Interview for Mental Status (BIMS) score of eleven indicating mild cognitive impairment. The MDS noted she had physically aggressive behaviors towards others. The MDS noted she was dependent on staff assistance for bed mobility, toileting, bathing, transfers, personal hygiene, and dressing. The MDS noted she was frequently incontinent of bowel and bladder. The MDS noted she was not on a toileting program. The MDS noted she was at risk for skin breakdown and pressure ulcers but had no unhealed wounds. The MDS noted she had pressure-reducing devices and a repositioning program in place. R15's Behavioral Care Area Assessment (CAA) completed 11/01/24 indicated she was at risk for physical aggression, decreased socialization, isolation, and anxiety. The plan indicated care plan was to reflect interventions to decrease her behaviors and agitation. R15's Functional Abilities CAA completed 11/01/24 indicated she was at risk for a decline in her activities of daily living (ADL) related to her medical diagnoses. The plan indicated care plan was to reflect interventions to maintain her current level of functioning. R15's Care Plan initiated on 03/04/20 indicated she was at risk for activities of daily living (ADL) deficit due to her medical diagnoses and behaviors. The plan noted she was dependent on two staff for assistance with bathing, transfers, bed mobility, toileting, personal hygiene, and dressing (12/03/23). The plan noted she was at risk for skin break and had a low air-loss mattress. The plan noted she had bed rails to aid in mobility (04/24/24). The plan noted an evaluation would be completed for the use of bed rails upon admission, quarterly, and with changes in the condition of the resident (04/24/24). The plan instructed staff to educate on the potential risks and negative outcomes of bed rail use (04/24/24). (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R15's EMR under Assessments revealed a Bedside Mobility Assessment Tool (BMAT) completed on 09/05/23. The assessment stated she may use the bedside rails to reposition and maintain her positioning. The assessment lacked the risk assessment for her low air-loss mattress. A review of R15's EMR on 03/27/25 revealed no documentation showing the identified risks related to the use of her low air-loss mattress in conjunction with her bed's side rails. On 03/25/25 at 07:20 AM, R15 slept in her bed on her right side. R15's head was sunk low on the bed next to her side rails. R15's low air-loss mattress was set at the maximum firmness. On 03/27/25 at 09:52 AM, Certified Nurse's Aide (CNA) N stated staff were expected to inspect the low air-loss mattresses each time they entered the rooms but was not sure what they were to be set at. She stated the bed rails should not have gaps due to the risk of entrapment. On 03/27/25 at 10:37 AM, Licensed Nurse (LN) I stated she was not sure if bed rail assessments include low air-loss mattresses. She stated the assessment for bed rails was completed quarterly and annually. On 03/27/25 at 11:34 AM, Administrative Nurse D stated bed rail assessments were completed upon admission, annually, quarterly, and with changes in conditions. She stated the low air-loss mattress risk assessment was included in the completed assessments. The facility's Bed Rails policy revised 12/2022 indicated the facility was to ensure bed rails were used appropriately to prevent entrapment. The policy noted the facility will review all risks and benefits prior to installation. The policy indicated the facility was to provide ongoing inspections and assessments. The facility failed to ensure that R15 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 R5 at risk for uninformed decisions and impaired safety related to the risks associated with the use of side rails. 41037 - R55's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of spastic quadriplegic cerebral palsy (a progressive disorder of movement, muscle tone, or posture caused by injury or abnormal development in the immature brain, most often before birth), protein-calorie malnutrition (inadequate intake of protein and calories which may cause wasting of muscle and tissue), muscle spasms, muscle weakness, need for assistance with personal care, muscle weakness, and pneumonitis due to inhalation of food and vomit (an inflammation of the lungs). (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Annual Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of zero which indicated severely impaired cognition. The MDS documented R55 had bilateral upper and lower limitation in range of motion (ROM - the full movement potential of a joint, usually its range of flexion and extension). The MDS documented R55 was dependent on staff assistance for his activities of daily living (ADL). The MDS documented R55 was independent with mobility in a motorized wheelchair. The MDS documented R55 had a feeding tube. The MDS documented R55 was at risk for development of 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). The MDS documented R55 had a pressure reducing device on his bed and in his wheelchair. The MDS lacked documentation R55 was provided a restorative nursing program during the observation period. The Quarterly MDS dated [DATE] documented a BIMS score of zero which indicated severely impaired cognition. The MDS documented that R55 had bilateral upper and lower limitation in ROM. The MDS documented R55 was dependent on staff assistance for his ADLs. The MDS documented R55 was dependent on staff assistance for wheelchair mobility. The MDS documented R55 had a feeding tube. The MDS documented R55 was at risk for development of pressure ulcers. The MDS documented R55 had a pressure reducing device on his bed and in his wheelchair. The MDS lacked documentation R55 was provided a restorative nursing program during the observation period. R55's Cognitive Loss/Dementia Care Area Assessment (CAA) dated 08/15/24 documented risk factors included self-care deficits, falls, decreased socialization, bowel and bladder incontinence, skin breakdown, weight loss, and fluid imbalance. The facility would care plan his current ADL status. R55's Care Plan dated 10/15/23 documented he required two staff members with assistance of a Hoyer (total body mechanical lift) for all transfers. The plan of care dated 04/24/24 documented staff would complete an evaluation for use of bed rails at the time of admission, quarterly, and any change of condition. The plan of care documented staff would encourage R55 to use his bed rails to assist in bed mobility and transfers. The plan pf care documented staff would obtain resident or representative consent and education on potential risks and any negative outcomes of bed rail use. The plan of care documented staff would provide continued education and reminders on safe use of the bed rails as needed. Review of R55's EMR under Assessments tab revealed 7a Bedside Mobility Assessment Tool (BMAT) completed on 07/26/23. The assessment documented he had not been evaluated by therapy. The assessment had documented R55 was on bed rest or had bilateral non-weight bearing restrictions. The assessment lacked the risk assessment for her low air-loss mattress (a special mattress used to reduce pressure). On 03/25/25 at 08:16 AM R55 laid on his bed, head of the bed was slightly elevated. R55's bed was elevated three feet of the floor with bed rails up in place bilaterally. R55's push button call light was attached to the right bed rail and hung off the bed out of his reach. R55's bilateral hands were clenched tightly closed with no palm grippers in place. R55's low air mattress was unplugged from the wall and was no working. On 03/27/25 at 09:52 AM, Certified Nurse's Aide (CNA) N stated staff were expected to inspect the low air-loss mattresses each time they entered the rooms but was not sure what they were to be set at. She stated the bed rails should not have gaps due to the risk of entrapment. CNA N stated R55 was unable to use his bed rails with repositioning or with transfers. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/27/25 at 10:37 AM, Licensed Nurse (LN) I stated she was not sure if bed rail assessments include low air-loss mattresses. She stated the assessment for bed rails was completed quarterly and annually. LN I stated R55 was not able to use his bed rails to assist with bed mobility or transfers. On 03/27/25 at 11:34 AM, Administrative Nurse D stated bed rail assessments were completed upon admission, annually, quarterly, and with changes in conditions. She stated the low air-loss mattress risk assessment was included in the completed assessments. Administrative Nurse D stated R55 was not able to utilize his bed rails for bed mobility and transfers. Administrative Nurse D stated R55's representative wanted him to have bed rails because it made her feel safer. The facility's Bed Rails policy revised 12/2022 indicated the facility was to ensure bed rails were used appropriately to prevent entrapment. The policy noted the facility will review all risks and benefits prior to installation. The policy indicated the facility was to provide ongoing inspections and assessments.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. 41037 The facility identified a census of 96 residents. The sample included 20 residents and five Certified Nurse Aides (CNA) were reviewed for yearly performance evaluations and the associated in-service training. Based on record review and interview, the facility failed to ensure one of the five CNA staff reviewed had yearly performance evaluations completed. This placed the residents at risk for inadequate care. Findings included: - A review of the facility's staffing list revealed Certified Nurse Aide (CNA) O was employed with the facility for more than 12 months: CNA O hired on 06/13/23. CNA O had no yearly performance evaluation upon request. On 03/27/25 at 08:55 AM, Administrative Staff A stated the department directors were responsible to complete their staff yearly performance reviews. Administrative Staff A stated human resource department helps the department directors to track their yearly performance reviews and yearly required in-services. Administrative Staff A stated the facility was unable to locate the yearly performance review for CNA O's yearly performance review. The facility did not provide a policy related to yearly performance reviews for staff.

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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 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 41037 The facility identified a census of 96 residents. Based on record review and interviews, the facility failed to maintain the posted daily nurse staffing data for the required 18 months. Findings included: - Review of the posted staffing sheets from 09/24/23 to 03/24/25 revealed the facility could not provide posted staffing documentation for the following 29 dates: 01/01/24, 01/03/24, 01/09/24, 01/12/24, 02/06/24, 03/28/24, 04/26/24, 05/17/24, 05/23/24, 05/24/24, 05/27/24, 06/04/24, 06/05/24, 06/06/24, 06/07/24, 06/11/24, 06/19/24, 06/20/24, 07/02/24, 07/04/24, 07/09/24, 08/08/24, 09/02/24, 10/17/24, 11/29/24, 12/25/24, 12/26/24, 12/31/24, and 01/01/25. The following 12 dates lacked the resident census: 09/06/23, 09/07/23, 09/08/23, 09/09/23, 09/10/23, 09/11/23, 09/12/23, 09/13/23, 09/14/23, 09/15/23, 09/16/23, and 09/17/23. The following eight lacked the total number of nursing hours: 02/08/24, 03/07/24, 03/08/24, 03/23/24, 06/02/24, 06/17/24, 06/18/24, and 06/21/24. On 03/26/25 at 11:55 AM, Administrative Nurse D stated she was responsible to post the nursing hours when she worked and provided the sheets for days she was not in the facility. Administrative Nurse D stated that front desk staff would change the posted nursing hours sheet and place the previous days sheet in medical records. Administrative Nurse D stated medical records staff maintained the past nursing hours sheets. The facility's Staffing policy last reviewed 12/20/24 documented the facility maintained adequate staff on each shift to meet residents' needs, posts daily staffing data, and furnished staffing information to the state as specified in the Federal regulations.

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Life Care Center of Andover	621 W 21st Andover, KS 67002

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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 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41037 The facility identified a census of 95 residents. The sample included 20 residents, with one resident reviewed for trauma informed care (treatment or care directed to prevent re-experiencing or reducing the effects of traumatic events). Based on observation, record review, and interviews, the facility failed to identify and provide medically related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for Resident (R) 24, who has a history of posttraumatic stress disorder (PTSD-mental disorder characterized by an acute emotional response to a traumatic event or situation involving severe environmental stress). This deficient practice placed R24 at risk for further decline of her emotional and mental wellbeing. Findings included: - R24's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of PTSD, cognitive communication deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), dementia (a progressive mental disorder characterized by failing memory and confusion), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). The Annual Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of four which indicated severely impaired cognition. The MDS documented R24 had no behaviors during the observation period. The MDS documented R24 had an active diagnosis of PTSD. The Quarterly MDS dated [DATE] documented a BIMS score of five which indicated severely impaired cognition. The MDS documented R24 had no behaviors during the observation period. The MDS documented R24 had an active diagnosis of PTSD. R24's Cognitive Loss/Dementia Care Area Assessment (CAA) dated 11/14/24 documented her risk factors included self-care deficits, falls with possible injuries, incontinence, decreased socialization, skin breakdown, weight loss, and fluid imbalance. R24's Care Plan dated 09/23/21 documented staff would analyze times of day, places, circumstances, triggers, and what de-escalates behavior and document. The plan of care lacked individualized triggered-specific interventions that identified ways to decrease exposure to triggers which could re-traumatize her. On 03/25/25 at 07:17 AM, R24 sat in her wheelchair next to the bed with the lights off in the room. On 03/27/25 at 09:52 AM, Certified Nurse Aide (CNA) N stated she was not aware R24 had a diagnosis of PTSD. CNA N stated R24 would often yell out. CNA N stated she would expect to find the information of R24's PTSD which included what might possibly re-traumatize her. CNA N stated she would also expect to find the interventions that would help address R24's trauma. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/27/25 at 10:37 AM, Licensed Nurse (LN) I stated R24's diagnose of PTSD could explain why that R24 yelled out frequently. LN I stated she would expect what had happened to cause the PTSD and what interventions that were in place to prevent re-traumatization on the care plan. On 03/27/25 at 11:00 AM, Social Services Staff X and Social Services Staff Y stated R24's last Trauma Informed Care assessment was completed on 02/26/20. Social Services Staff X and Social Services Staff Y stated the trauma-based assessment would only be assessed at the time of admission and only if Administrative Nurse D would request a reassessment. Social Services Staff X and Social Services Staff Y stated the MDS coordinator would be responsible to develop R24's care plan. Social Services Staff X and Social Services Staff Y stated R24 would not require any increased monitoring due to her diagnosis of PTSD. On 03/27/25 at 11:36 AM, Administrative Nurse D stated she would expect to find R24's PTSD addressed on her care plan. Administrative Nurse D stated she was not sure the frequency R24 should be assessed for her trauma-based care. Administrative Nurse D stated that would be handled by the social service department. The facility's Trauma-Informed Care policy last reviewed 09/06/24 documented based on the comprehensive assessment of a resident, this facility must ensure that residents who are diagnosed mental disorder or psychosocial adjustment difficulty, or who had a history of trauma and/or post-traumatic stress disorder, received appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well being. The facility must ensure that residents who are trauma survivors received culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. Trigger-specific interventions would identify ways to decrease the resident 's exposure to triggers which re-traumatize the resident, as well as identify ways to mitigate or decrease the effect of the trigger on the resident. The facility would monitor the effects of their approaches to ensure they are implemented as intended and are having the desired effect to achieve the measurable objectives and the resident's goals for care. For residents with a history of trauma in particular, the facility should evaluate whether the interventions have been able to mitigate (or reduce) the impact of identified triggers on the resident that may cause re-traumatization. Remember to involve the resident and/or his or her family or representative in this evaluation to ensure clear and open discussion and better understand if interventions must be modified.

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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. 45668 The facility identified a census of 96 residents with one kitchen and two dining rooms. Based on observation, record review, and interviews, the facility failed to follow sanitary dietary standards related to storage, preparation, and meal service. This deficient practice placed the residents at risk related to food-borne illnesses and food safety concerns. Findings Included: - On 03/24/25 at 07:10 AM, an inspection of the facility's kitchen was completed with the following concerns identified: An inspection of the dry food storage area revealed 4 large plastic bins of Fruits Loops, Raisin Bran, Frosted Flakes, and Frosted Mini Wheat. The bins lacked dates opened for the cereal. An inspection of the food serving area revealed a mobile counter for plate storage. The plates were stored upward with no barrier to prevent contamination of the eating surfaces. On 03/24/25 at 07:30 AM, an inspection of the main dining room revealed trash and food debris under the ice machine and condiment counter. On 03/24/25 at 07:40 AM, an inspection of the 500 hall dining room revealed a bottle of drain cleaner in a cabinet underneath the sink. The product contained the warning, Keep out of reach of children, hazardous to humans can cause eye irritation, harmful if swallowed. On 03/27/25 at 08:01 AM Dietary Staff BB stated all food items were expected to be labeled and dated once stored in the kitchen. She stated plates and cooking utensils were to be stored downward to prevent contamination. She stated the kitchen recently started cleaning the dining areas due to confusion that facility staff were expected to clean it before. The facility's Food Safety policy revised 09/2022 indicated all facility staff were expected to follow safe and sanitary practices related to food storage, preparation, and service. The policy noted food will be handled and stored in a manner to prevent contamination. The policy noted the kitchen was to be maintained in a functioning and sanitary manner.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 49634 The facility identified a census of 96 residents. The facility identified 32 residents on Enhanced Barrier Precautions (EBP - infection control interventions designed to reduce transmission of resistant organisms which employ targeted gown and glove use during high contact care) and three residents on contact precautions (safeguards designed to reduce the risk of transmission of microorganisms by direct or indirect contact). Based on record review, observations, and interviews, the facility failed to cover all linen, and store pillows in a sanitary manner. The facility further failed to ensure R69's urine bag was not dragging on the floor. The facility failed to ensure staff performed hand hygiene during wound dressing changes and urinary catheter (a tube inserted into the bladder to drain the urine into a collection bag) care. This deficient practice placed residents at risk for infections. Findings included: - On 03/24/25 at 08:28 AM, the following concerns were identified during the initial tour: in the shower room on hall 500 a linen cart was uncovered, and a pillow laid on top of the cabinets uncovered. The whirlpool had a Do Not Use sign which contained a stack of bedspreads in the middle of the shower room. On 03/24/25 at 08:32 AM, on hall 300 a linen cart was covered, and a pillow laid on top of the linen cart uncovered. On 03/24/25 at 12:06 PM, R69's urinary catheter bag drug on the floor, underneath his wheelchair during lunch time. On 03/25/25 at 08:25 AM, R43 laid on his bed looking at his iPad. R43's CPAP laid in his windowsill; the CPAP was not stored in a sanitary manner. On 03/25/25 at 09:58 AM, during wound care for R18 Administrative Nurse E, Administrative Nurse F, and Licensed Nurse (LN) K entered R18's room but failed to do hand hygiene or wash their hands before entering R18's room. Administrative Nurse F had her hands full of wound supplies from her wound cart. Administrative Nurse F placed a barrier on the counter in R18's room and placed the wound supplies on top of the barrier. Administrative Nurse F, Administrative Nurse E, and LN K donned gowns. LN K sanitized her hands prior to donning gloves. LN K placed a barrier on the bed under R18. LN K then obtained a package that had a wound wipe, she opened the wipe and wiped one of R18's wounds and threw the wipe in the trash can beside the bed. LN K failed to doff the dirty gloves before she opened and cleaned R18's second wound. Administrative Nurse E told LN K after she cleansed the next wound, she needed to change her gloves and do hand hygiene. LN K doffed her gloves and performed hand hygiene before donning clean gloves. On 03/26/25 at 08:20 AM, LN J did not perform hand hygiene between glove changes during R9's catheter care. On 03/26/25 at 09:12 AM, LN J did not perform hand hygiene between glove changes during R55's feeding tube (tube for introducing high-calorie fluids into the stomach), while changing the dressing. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/27/25 09:03 AM, LN I administered medication via feeding tube to R55. LN I gowned and gloved, gave apple juice, water, and two medications. LN I placed a cover over R55's abdomen, prior to giving medication. LN I adjusted R55's pillow, his gown covering his brief, and then adjusted R55's brief, LN I did not do hand hygiene or change gloves. LN I then started 30 milliliters (ml) of water flush and a prefilled vial of medication. LN I did not do hand hygiene or glove changes during administration of medication or water flush. The Infection Prevention policy revised on 12/21/21 documented the goals of the infection program was to reduce the risk of acquisition and transmission of health care associated infects. Monitor for any occurrences of infection and implement appropriate control measures. Identify and correct problems relating to infection prevent and control practices. The facility failed to cover all linen, and store pillows a sanitary manner, the facility failed to ensure R10's urine collection bag was below the level of his bladder and failed to ensure R69's urine bag was not dragging on the floor. The facility further failed to ensure R43's CPAP was stored in a sanitary manner, and R4's nasal cannula was also stored in a sanitary manner, and further failed to constantly do hand hygiene during wound dressing changes and urinary catheter care. This defiant practice placed the residents at risk for infections.