STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175172	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Topeka Center for Rehabilitation and Healthcare	2515 SW Wanamaker Road Topeka, KS 66614

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41713 The facility identified a census of 93 residents. The sample included 22 residents. Based on observation, record review, and interview, the facility failed to ensure staff provided care in a dignified manner for Resident (R) 66 and R78. This placed the residents at risk for decreased self-esteem and decreased self-worth. Findings included: - The Electronic Medical Record (EMR) for R66 documented diagnosis of post-traumatic stress disorder (PTSD- mental disorder characterized by an acute emotional response to a traumatic event or situation involving severe environmental stress), hypertension (HTN- elevated blood pressure), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and delusional disorder (untrue persistent belief or perception held by a person although evidence shows it was untrue). R66's Significant Change Minimum Data Set (MDS) dated [DATE] documented he had a Brief Interview for Mental Status (BIMS) score of four which indicated severely impaired cognition. R66 displayed physical behavioral symptoms directed toward others (hitting, kicking, pushing, scratching, grabbing, and abusing others sexually) that occurred for one to three days during the observation period. R66 was dependent on staff for all activities of daily living (ADLs) except for eating. R66's Cognition Care Area Assessment (CAA) dated 04/15/24 documented he had impaired cognitive function and was at the end of life with a terminal illness. R66 also had confusion. R66's Behavioral CAA dated 04/15/24 documented he had behaviors such as sexual inappropriateness with staff, choosing not to follow medical recommendations/orders, refusal of showers, waking frequently during the night, yelling instead of utilizing call light due to cognitive deficits, and mood state. R66's behaviors would be care planned. R66's Care Plan revised 04/03/24 directed staff that R66 yelled out, repeating Help me, believing he has sandals on and calling out names of individuals that are not present. Staff was directed to provide support to the resident and reassurance. The staff was directed to redirect negative behavior as needed. R66's Care Plan lacked staff direction for behaviors such as removing his sheet/covers and lacked any indication he was comfortable being visible and exposed to other residents and facility visitors. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/20/24 at 08:45 AM R66's door was wide open, he lay on his bed his whole body was uncovered. His body and his catheter (a flexible tube inserted through a narrow opening into a body cavity, particularly the bladder, for removing fluid) tubing was visible from the doorway. On 05/21/24 at 07:00 AM, R66's door was open. R66 lay on his bed, a sheet was noted between his legs, but his body was uncovered and visible from the hall. On 05/21/24 at 02:13 PM, R66 lay in bed yelling out a name repeatedly. R66's genital area was the only thing covered by a sheet. On 05/22/24 at 01:15 PM, LN H stated staff attempted to keep R66 covered most of the time, but he preferred to be uncovered most of the time and that was part of his behaviors. On 05/22/24 at 02:45 PM Administrative Nurse D stated she expected staff to keep R66 covered as much as possible but when he had behaviors he was not always aware he would remove his cover. The undated facility policy Promoting/ Maintaining Resident Dignity documented that it was the practice of the facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintained or enhanced resident's quality of life by recognizing each resident's individuality. Staff should speak respectfully to residents. Staff should maintain the resident's privacy. The facility failed to ensure staff maintained R66's privacy while he was in bed. This placed the resident at risk for decreased self-esteem and decreased self-worth. 50660 - R78's Electronic Medical Record (EMR) under the Diagnosis tab recorded diagnoses of cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). The Admission Minimum Data Set (MDS), dated [DATE] documented that R78 had a Brief Interview for Mental Status (BIMS) score of 13 indicating no cognitive impairment. The Quarterly MDS dated [DATE] documented R78 had a BIMS score of seven indicating severe cognitive impairment. R78's Care Plan dated 04/22/24 documented that R78 had impaired cognitive function or thought process related to short and long-term memory loss and directed staff to ask yes and no questions or limit choices to one or two things at a time. It directed staff to speak slowly and clearly to enable her to understand. R78's Care Plan lacked instruction to staff on what she preferred to be called and lacked any indication she wanted to be called Honey or other terms of endearment by staff. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/20/24 at 11:23 AM Licensed Nurse (LN) WW took R78 to her room to check her blood sugar before lunch. LN WW called R78 Honey as she reported and informed her of the results of her blood glucose check. LN WW informed R78 that she would receive some insulin (hormone used to lower blood glucose) and then again addressed the resident as Honey when she administered the insulin. On 05/22/24 at 02:45 PM Administrative Nurse D stated staff at times would call residents Honey or Darling without thinking about it but staff should try to call a resident by their given name unless it was specifically care planned for a specific endearment and approved by the resident and/or their representative. A review of the facility's Topeka Policies/Promoting Resident Dignity. dated 2023 stated that each resident had the right to be treated with dignity, consideration, courtesy, and respect with full recognition of their individuality. The facility failed to promote a dignified experience for R78. This deficient practice placed the resident at risk for decreased psychosocial well-being.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41713 The facility identified a census of 93 residents. The sample included 22 residents. Based on observation, record review, and interview, the facility failed to ensure that Resident (R) 14, R48, R45, and R32's call lights were within reach. The facility also failed to ensure R10's wheelchair had the necessary foot pedals attached while propelled by staff. This deficient practice placed these residents at risk of injury, delay in care, and decline in physical well-being. Findings included: - R14' Electronic Medical Record (EMR) documented diagnoses of congestive heart failure (CHF- a condition with low heart output and the body becomes congested with fluid), kidney failure (inability of the kidneys to excrete wastes, concentrate urine and conserve electrolytes), and hypertension (HTN- elevated blood pressure). R14's Admission Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 13 which indicated intact cognition. R14 was independent with personal hygiene and required supervision with toileting, and dressing. R14 required supervision with transfers. R14 was independent with wheelchair mobility. R14's Activities of Daily Living (ADL)DL Care Area Assessment (CAA) dated 05/07/24 documented he required varying levels of assistance with ADLs. R14 was currently receiving skilled therapy services. R14 required supervision or touching assistance with toileting hygiene and transfers. R14's Care Plan initiated 04/24/24 lacked staff direction regarding his call light. On 05/22/24 at 01:09 PM, R14 lay on his bed while care was provided by Licensed Nurse (LN) I. R14's call light was lying on the floor in his room several feet from his bed. LN I did not assist with picking up R14's call light and placing it within reach before leaving the room. On 05/22/24 at 01:20 PM LN I stated he had not realized R14's call light had been on the floor when he was in R14's room. On 05/22/24 at 02:45 PM Administrative Nurse D stated she expected staff to ensure that a resident's call light was within reach. Administrative Nurse D stated staff should be checking on all residents every couple of hours and checking to see if residents needed assistance and to make sure their call light was within reach. The undated Reasonable Accommodation of Needs policy documented the resident's individual needs and preferences shall be accommodated to the extent possible, except when the health and safety of the individual or other residents would be endangered. The resident's individual needs and preferences, adaptations may be made to the physical environment, including the resident's bedroom and bathroom, as well as the common areas in the facility. Wheelchairs are to be maintained by our facility for the general use of all residents. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility failed to ensure R14's call light was within reach. This placed R14 at risk for injury, delayed care, and possible decline in physical well-being due to unmet care needs. - The electronic medical record (EMR) for R48 documented diagnosis of hypertension (HTN- elevated blood pressure), 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), and hemiplegia and hemiparesis (weakness and paralysis of one side of the body). R48's Admission Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. R48 required partial to moderate assistance from staff with bed mobility and transfers. R48 required the use of a wheelchair or mobility. R48's Quarterly MDS dated [DATE] documented he had a BIMS score of 15 which indicated intact cognition. R48 was independent with activities of daily living (ADLs) and used a walker to assist with mobility. R48's Care Plan last revised on 05/01/24 directed staff to anticipate and meet R48's needs. Staff was directed to assist R48 with moving his bedside tray. R48's lacked staff direction for his call light. On 05/22/24 at 12:58 PM, R48 lay in bed. R48's spouse (and fell ow resident) stated that R48 needed assistance, but his call light cord was on the floor and out of his reach. R48's call light was observed under his bed out of his reach. R48's spouse turned her call light on so staff would come to assist R48 and retrieve his call light from off the floor. On 05/22/24 at 01:03 PM Certified Nurse Aide (CNA) Q stated each resident should be checked every two hours by staff which included checking to make sure the resident's call light was within reach. On 05/22/24 at 01:15 PM Licensed Nurse (LN) H stated nursing staff should be checking residents every two hours to see if they need any assistance or change. LN H stated staff should ensure that each resident had their call light during each check and if not should assist them with placing the call light in reach. On 05/22/24 at 02:45 PM Administrative Nurse D stated a resident's call light should be available, and within reach at all times. Administrative Nurse D stated nursing staff should be checking on residents every couple of hours to make sure the call light was within reach. The undated Reasonable Accommodation of Needs policy documented the resident's individual needs and preferences shall be accommodated to the extent possible, except when the health and safety of the individual or other residents would be endangered. The resident's individual needs and preferences, adaptations may be made to the physical environment, including the resident's bedroom and bathroom, as well as the common areas in the facility. Wheelchairs are to be maintained by our facility for the general use of all residents. The facility failed to ensure R48's call light was within reach. This placed R48 at risk for injury, delayed care, and possible decline in physical well-being due to unmet care needs. 49634 (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- R45's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of multiple sclerosis (MS- progressive disease of the nerve fibers of the brain and spinal cord), dementia (a progressive mental disorder characterized by failing memory, and confusion), hypertension (HTN-elevated blood pressure), edema (swelling resulting from an excessive (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and muscle weakness. The Significant Change Minimum Data Set (MDS) for R45 dated 02/13/24 recorded a Brief Interview for Mental Status (BIMS) score of nine which indicated moderately impaired cognition. The MDS recorded R45 was independent with eating and was dependent on staff for bed mobility. R45's Functional Abilities CAA dated 02/13/24 documented R45 was at an increased risk of decline due to her need for assistance with activities of daily living (ADLs). Nursing should continue to assist with ADLs to reduce decline. R45's Cognition Loss/Dementia CAA dated 02/13/24 documented R45 had a diagnosis of dementia and MS. R45's Care Plan dated 07/07/24 documented that staff would ensure R45's call light was within reach and encouraged her to use the call light for assistance as needed. The plan of care dated 07/07/23 stated R45 had the potential for fluid deficit due to diuretic use. Staff should encourage R45 to drink fluids of choice. On 04/20/24 at 09:35 AM R45's food sat on the bedside table. R45 lay flat in bed with her head on her bed. R45's breakfast tray consisted of a biscuit, cut in half, gravy, and juice. R45 was scraping her biscuit with her fork into her mouth. R45 reached for her juice and knocked her juice over. R45 was able to scrape enough to eat half of her biscuit. R45's call light was draped over the lamp on the end table, out of reach. On 04/21/24 at 08:20 AM R45 laid on her bed on her back, and her call light was draped over the end table out of reach. R45's lunch was on the bedside table; she was lying flat with her head on the mattress. R45 slid her sandwich with her fork to the edge of her plate where she was then able to grab the piece of the meat. R45 was able to reach and eat the meat only from the food on her tray. R45 spilled her red juice on her bedside table while trying to reach for the juice. On 05/23/24 at 10:17 AM Certified Nursing Aide (CNA) P stated she usually worked on the South side of the building. She stated the call light should always be within the resident's reach and never draped over the lamp. CNA P stated when she was the person taking care of R45, she pulled her up in bed and ensured she had pillows behind her to prop her up. She stated she ensured R45 would easily reach her food. On 05/23/24 at 10:59 AM Licensed Nurse (LN) H stated all call lights should be within reach of the residents. LN H stated R45 should be pulled up in bed and should never left to eat lying flat. On 05/23/24 at 11:46 AM Administrative Nurse D stated R45's call light should always be within her reach. Administrative Nurse D said R45 should be sat up in her bed to eat. She stated that R45's food and drinks should also be within her reach. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's Reasonable Accommodation of Needs policy documented that the community environment and staff behavior are directed toward assisting the resident in maintaining and, or achieving independent functioning, dignity, and well-being, and in the promotion of a home-like environment. The resident has the right to receive services in the community with reasonable accommodations of their needs and preferences except when to do so would endanger the health and safety of other residents. The resident's individual needs and preferences, including the need for adaptive devices and modifications to the physical environment, shall be evaluated upon admission and reviewed on an ongoing basis. The facility failed to ensure R45 had the required equipment and assistance to support her highest level of well-being. This placed R45 at risk for impaired physical and mental well-being due to unmet needs. - R32's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of the acquired absence of right leg below the knee, muscle weakness, hypertension (HTN-elevated blood pressure), chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing, altered mental status, artificial opening of urinary tract, kidney disease, dysphagia (swallowing difficulty), depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), Stage 3 (full thickness pressure injury extending through the skin into the tissue below) pressure ulcer of right buttocks, and a contracture (abnormal permanent fixation of a joint or muscle) of the right hand. The Significant Change in Status Minimum Data Set (MDS) dated [DATE] recorded that a Brief Interview for Mental Status (BIMS) was unable to be performed and a staff assessment should be conducted. The MDS documented R32 was severely impaired and never or rarely made decisions. The MDS recorded R32 required extensive assistance for all activities of daily living (ADLs) except eating, for which he needed set up and cues. R32 had no behaviors. The MDS documented R32 was dependent on staff for bed mobility. R32's Cognitive Loss Care Area Assessment (CAA) dated 05/03/24 documented that R32 was at increased safety risk due to his cognitive impairment and memory loss. Nursing should coordinate R32's care with social services. R32's Falls CAA dated 05/03/24 documented that R32 was at an increased risk of falls due to his medications. Nursing should continue to monitor for adverse reactions to reduce fall risk. R32's Care Plan dated 08/09/22 directed staff to ensure R32's call light was within his reach and encouraged him to use the call light for assistance as needed. On 05/20/24 at 08:23 AM R32 laid in the bed on his back. R32's bed was in a high position, and he was wearing a pressure-relieving boot. R32's call light was between his wall and his bed on the floor. R32's call light was out of reach. On 05/22/24 at 07:20 AM R32 laid on the bed on his back. R32's bed was in a high position; he was wearing a pressure-relieving boot. R32's call light was behind the head of the bed on the floor and out of his reach. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/23/24 at 10:17 AM Certified Nurse's Aide (CNA) P stated call lights should always be within reach of the resident to call for assistance. On 05/23/24 at 10:59 AM Licensed Nurse (LN) H stated the call light should be within reach of the residents when residents were in their rooms. On 05/23/24 at 11:46 AM Administrative Nurse D stated, stated the resident's call light should always be within their reach. The facility's Reasonable Accommodation of Needs policy documented that the community environment and staff behavior are directed toward assisting the resident in maintaining and, or achieving independent functioning, dignity, and well-being, and in the promotion of a home-like environment. The resident has the right to receive services in the community with reasonable accommodations of their needs and preferences except when to do so would endanger the health and safety of other residents. The resident's individual needs and preferences, including the need for adaptive devices and modifications to the physical environment, shall be evaluated upon admission and reviewed on an ongoing basis. The facility failed to ensure that R32's call light was within reach. This placed R32 at risk for impaired physical and mental well-being due to unmet needs. 41037 - R10's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of muscle weakness, cognitive-communication deficiency, lack of coordination, and Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure). 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 Quarterly MDS dated [DATE] documented a BIMS score of three which indicated severely impaired cognition. The MDS documented that R10 had a limited range of motion (ROM- the full movement potential of a joint, usually its range of flexion and extension) to bilateral lower extremities. The MDS documented R10 was dependent on staff assistance to walk 10 feet. R10's Cognitive Loss/Dementia Care Area Assessment (CAA) dated 09/05/23 documented R10 had a lack of coordination, a history of falls, and a diagnosis of Alzheimer's disease. R10's Care Plan revised on 08/25/22 documented that nursing staff would encourage R10 to participate to the fullest extent possible with each interaction. On 05/20/24 at 07:59 AM R10's bilateral feet slid along the floor as an unidentified staff member pushed R10's wheelchair down the hallway to the dining room without foot pedals. On 05/23/24 at 10:18 AM, Certified Nurse Aide (CNA) P stated R10 who had severely impaired cognition should not be pushed in her wheelchair without foot pedals. CNA P stated R10 could fall out of her wheelchair if she put her feet down on the floor which could result in a fracture. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/23/24 at 10:59 AM, Licensed Nurse (LN) H stated a severely cognitively impaired resident would be unable to remember to hold their feet up in the air and should have foot pedals on their wheelchair when staff propelled the wheelchair. On 05/23/24 at 11:47 AM, Administrative Nurse D stated a resident who severely impaired cognition should have foot pedals on their wheelchair when staff pushed them in their wheelchair. The facility's Accidents policy dated 06/2023 documented the facility strived to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. The facility-oriented and resident-oriented approaches to safety are used to gather, to implement a system approach to safety, which considers the hazards identified in the environment and individual resident risk factors, and then adjusts interventions accordingly. The facility failed to ensure foot pedals were provided for R10's wheelchairs to prevent her feet from dragging on the floor. This deficient practice placed R10 at risk for injuries related to unmet care needs.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 49634 The facility reported a census of 93. Based on observations, record reviews, and interviews, the facility failed to act promptly to address and resolve recurring grievances reported by the Resident Council. This deficient practice placed the residents at risk for decreased psychosocial well-being and impaired quality of life. Findings Included- - A review of the facility's Resident Council Minutes from 12/2023 through 05/2024 revealed the council had recurring concerns with staff cell phone usage, resident care, call light times, bathing, care provided to cognitively impaired residents, cleanliness of dining room tables, floors, and dishes. The Resident Council Minutes form instructed any old business that was unresolved to be moved to a new business. The 12/2023 Resident Council Minutes documented new business (concerns) including the night shift checklist not getting done, which consisted of cleaning the dining room, the tables, and the wheelchairs. Another concern was the aides on their cell phones. The council was concerned that the wait time for personal care of impaired residents was too long. The council minutes indicated management was keeping a close eye on the staff's use of phones and was trying to improve the cleaning of the dining room with teamwork. The minutes lacked all actions taken or outcomes for the repeat concerns. The 01/2024 Resident Council Minutes listed that new business concerns included staff on their phones. The council minutes indicated that there was a grievance with staff members on their phones and management was looking into phone usage. The minutes lacked actions taken or resolution for the repeat concern. The 02/2024 Resident Council Minutes listed new business. concerns were showers were not being done consistently or being rushed. The council was also concerned about the care consistently being done in a timely manner for impaired residents. The resident council was concerned with the drink cart not being offered around consistently. The council members were concerned with medication not being given to residents on time. The minutes listed that management was looking into staff documenting showers and would educate staff on the importance of medication times. The minutes lacked further actions taken or resolution for the concerns. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 03/2024 Resident Council Minutes listed new business concerns that the residents were not always getting silverware with the meals. The minutes recorded there was not a dietary member present to answer their concerns. The council had concerns the snacks were not getting refilled on the carts, there were not enough snacks or not enough snacks to go around. The council was also concerned the dining room was not being cleaned (tables and floors) and trays were not being collected. The residents' water pitchers were not being filled: residents were not getting the correct medications, and medications were not being given on time. The minutes documented the management response was the pharmacy monitors the medication schedule. The council stated the timely care for impaired residents had not improved, and the management's response was unit managers would start making rounds. The council reported call lights were not being answered in a timely manner, and the response was management would address concerns if they knew the time and day the call lights were not getting answered in a timely manner. Resident council minutes discussed whether the residents should get staff names when their call lights were not being answered promptly. The minutes lacked actions taken or outcomes for the repeat concerns. The 04/2024 Resident Council Minutes listed new business concerns that the dining room was not being cleaned, and trays were not being picked up. The council asked if the tables could be washed off before the next meal. The council reported the snacks were not being refilled; snacks were not available in the South hallway. The minutes indicated dietary staff was to address the concerns. staff were on their phones and the staff were turning call lights off without addressing the resident's needs. The resident council minutes indicated residents should get the staff's name when their call light gets turned off and the staff does not return for care. The minutes lacked actions taken or outcomes for the repeat concerns. The 05/2024 Resident Council Minutes listed a new business concern that the food was cold. The minutes indicated management was going to be helping serve food trays. The drink carts were not being offered and coffee was rarely ready or not offered at all. But the minutes recorded Dietary was to address that issue. The council members reported there was no staff in the South dining room to help residents and the resident's choices of foods were not being offered. The resident minutes indicated dietary were to address issues. The council said they would like the relocation of the smoking area and reported the bathrooms were not being consistently cleaned. The council did not feel there was enough staff on the night shift and the timely care for impaired residents was still a concern. On 05/20/24 at 07:29 AM in the 300-hall dining, a cart full of food trays was left in the dining room from the evening meal. On 05/20/24 at 08:25 AM in the north dining room, there was food on the floor. The walls had black scuff marks on them. The tablecloths had juice stains present and the wall had juice-colored streaks going down the wall from the height of the table to the floor. There was dried ketchup or BBQ sauce on the tablecloth and wall trim. On 05/21/24 at 11:04 AM the resident council voiced concerns about the overall cleanliness of the building. The council stated the trays were not gathered in the evening, and the floors, and tables in the dining rooms were always dirty. The resident council stated the floors were always sticky, in the dining room and resident rooms. The resident council stated they had voiced concern about cleanliness several times and nothing has been done about it. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's Resident Council policy documented the facility supports residents' desires to be involved and have input in the operations of the facility through the Resident Council. The residents to have input in the operation of the facility, discussion of concerns, consensus building, and communication between residents and facility staff. The facility failed to adequately address and resolve recurring issues reported by the Resident Council. This deficient practice placed the residents at risk for decreased psychosocial well-being and impaired quality of life.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 50660 The facility identified a census of 93 residents. The sample included 22 residents with three residents reviewed for beneficiary notifications. Based on record review and interview the facility failed to ensure they issued the CMS (Center for Medicare/Medicaid Services) form 10055 Advance Beneficiary Notice of Non-coverage (ABN) for Resident (R) 5 and R36. This placed these residents at risk of uninformed treatment decisions and unexpected costs. Findings included: - A review of R5's Electronic Medical Record (EMR) documented that the Medicare Part A episode began on 02/17/24 and ended on 05/05/24. R5 remained in the facility for custodial care. The facility did not issue the SNF ABN 10055. A review of R36 EMR documented that the Medicare Part A episode began on 11/29/23 and ended on 12/27/23. R36 remained in the facility for custodial care. The facility did not issue the SNF ABN 10055. On 05/23/24 at 9:02 AM Social Services Y revealed that she has never given an ABN Form CMS-10055. She stated she had no knowledge of the ABN form or when and why it would be used. On 05/23/24 at 9:07 AM Consultant GG revealed that she had seen the ABN Form CMS-10055 in use at other buildings but never in this facility. The facility policy Advanced Beneficiary Notice Policy last revised February 2024 directed the Business Office Manager or Designee as the contact person for information regarding Medicare eligibility, coverage, and applying for benefits. A notice alerting residents/representatives of this contact person shall be posted conspicuously in the facility. The facility failed to issue R5 and R36 the ABN form CMS-10055. This placed these residents at risk of uninformed treatment decisions and unexpected costs.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 41713 The facility identified a census of 93 residents. The sample included 22 residents. Based on observation, record review, and interview, the facility failed to ensure a safe, clean, and homelike environment was provided for the residents. This placed residents at risk of infection, decreased psychosocial well-being, and impaired safety and comfort. Findings included: - On 05/20/24 at 06:58 AM in the North dining room there was a rolling cart that was full of trays that had dirty, leftover plates and covers from the meal the night before. The plates contained uneaten food, cups, used napkins, and other trash. There were soiled drink cups left on the tables and food crumbs all over the floor (no residents were present in the dining room at this time). On 05/20/24 at 07:00 AM the area near the ice machine off the North dining room had a strong, foul, odor. On 05/20/24 at 07:10 AM the south hall had a heavy urine smell outside of and in between the South dining room and R33's room. An inspection of R33's room revealed an unknown liquid substance on his floor next to a dresser. The walls of R33's room were heavily scratched up at wheelchair height. R33's floor had a dry but sticky residue. The liquid spill remained on his floor until 08:00 AM. On 05/20/24 at 07:15 AM the floor outside R26's room had dried brown coffee-like stains and a candy wrapper on the floor. On 05/20/24 at 08:23 AM R32 lay in the bed on his back. R32's room smelled of urine, and the hallway outside his room also smelled of urine. On 05/20/24 at 11:50 AM R7, R1, R33, and R80 were wheeled into the dining room. The residents were left in the dining room without television or entertainment until lunch arrived at 12:30 PM. Staff found the remote at the nurse's station and turned on the television at 12:35 PM. On 05/20/24 at 08:25 AM in the North dining room, there was food on the floor that had not been swept up from the previous night's meal. The walls had black scuff marks on them. The tablecloths had juice stains present and the wall had juice-colored streaks going down the wall from the height of the table to the floor. There was dried red condiment sauce on the tablecloth and wall trim. On 05/20/24 at 09:50 AM R14 rested on his bed. He had a portable urinal (a container made of durable plastic and a secure lid used to for emptying the bladder of urine) on the bedside table a few feet from his bed. The floor was sticky between the bed and the bedside table, and the room had a strong urine smell. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/21/24 at 07:04 AM R1's room and outside hallway had a heavy urine odor. A small puddle of unknown liquid lay on the floor of his room. R1's one-to-one staff stated the liquid was most likely water R1 spilled from breakfast. She stated R1 had incontinence and did not always allow staff to toilet him. R1 stated the walls have been scuffed up for a while and he was unsure if the facility was going to paint over the marks. On 05/21/24 at 07:15 AM R14's floor beside the table and his bed was still sticky. On 05/21/24 at 04:20 PM, an inspection of the activity room next to the South dining room revealed two large towels on the floor soaked in an unknown liquid. R4 stated residents always spill drinks and food in the small dining room preventing others from being able to use the area. She stated staff were often too busy and the messes get left without being cleaned for a long time. On 05/22/24 at 07:20 AM R32 laid on the bed on his back. R32's bed was in a high position. R32's room and outside of the room smelled of strong urine. R32's floor was sticky. R32's, call light was between the bed and the wall on the floor. R32's call light was out of reach. On 05/22/24 at 01:12 PM, an inspection of the bathroom connected to the South dining room revealed a heavy urine smell. The floor of the bathroom was sticky with an unknown residue. The toilet had dried urine stains around the base of it. A small brown crumb-like substance lay on the ground next to the toilet. On 05/22/24 at 02:45 PM Administrative Nurse D stated on 05/20/22 the facility had a few call-ins on the previous night shift and a few ill dietary staff that morning. Administrative Nurse D stated typically dietary staff and housekeeping both had the responsibility to clean the dining rooms after meals. Administrative Nurse D could not state the reasoning as to why the dining rooms were left dirty and messy from the night before but would be finding out. Administrative Nurse D stated she expected resident room floors to be swept and mopped daily. Administrative Nurse D stated she was upset when she saw what a mess the facility was when she arrived on the morning of 05/20/24. The Safe, Clean, Comfortable, Homelike Environment policy documented that residents had the right to a safe, clean, comfortable, and homelike environment, including but not limited to receiving treatment and support for daily living safely. The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, home-like setting. These characteristics included: Cleanliness and order; comfortable and adequate lighting; inviting color and decor; personalized furniture and room arrangements; pleasant, neutral scents; plants and flowers, where appropriate; sufficient individual closet space; comfortable temperatures; and comfortable noise levels. The facility failed to ensure staff maintained and provided a safe, clean, and homelike environment to the residents when the dining rooms were left unclean from the prior night's meal service. The facility failed to ensure resident rooms were mopped and cleaned and free from urine odor. This placed the residents at risk of infection, decreased psychosocial well-being, and impaired safety and comfort.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 45668 The facility identified a census of 93 residents. The sample included 22 residents with three residents reviewed for abuse. Based on observation, record review, and interviews, the facility failed to ensure Resident (R)28 remained free from staff-to-resident abuse and/or mistreatment when R28 received intentional rough treatment from direct care staff. This deficient practice placed R28 at risk for impaired psychosocial well-being, pain, and fear. Findings Included: - The Medical Diagnosis section within R28's Electronic Medical Records (EMR) included diagnoses of muscle weakness, morbid obesity (severely overweight), bipolar disorder (a major mental illness that causes people to have episodes of severe high and low moods), seizures (violent involuntary series of contractions of a group of muscles), and peripheral vascular disease (PVD- slow and progressive circulation disorder causing narrowing, blockage, or spasms in a blood vessel). R28's Admission Minimum Data Set (MDS) completed 02/27/24 noted a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. The MDS indicated she required substantial to maximal assistance from staff for bathing, transfers, toileting, bed mobility, personal hygiene, and dressing. The MDS indicated she had impairments to both sides of her lower extremities. The MDS indicated she used tobacco products. The MDS indicated no observed behavioral concerns. R28's Functional Abilities Care Area Assessment (CAA) completed 03/01/24 indicated she was at risk for a decline in her activities of daily living (ADLs) related to her medical diagnoses. The CAA indicated staff were to follow her current plan of care to prevent further declines. R28's Care Plan initiated on 02/22/24 indicated she required extensive assistance from one staff for personal hygiene, toileting, dressing, bathing, and walking with her four-wheeled walker. The plan noted she was independent with bed mobility. The plan indicated she was continent of the bladder but required prompting during the evening. The plan noted she had a childhood trauma of sexual assault and encouraged her to discuss her thoughts. A Facility Reported Incident (7685) investigation noted that on 05/07/24 at 08:50 AM, R15 (a cognitively intact resident) reported to Administrative Nurse D that she witnessed Certified Nurse Aid (CNA) O provide rough care and almost push R28 off her bed. The report noted CNA O provided incontinence care for R28; R28 instructed CNA O to stop pushing on her back due to pain, but CNA O continued to push harder. The report documented CNA O was suspended pending investigation for allegations of abuse. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/20/24 at 11:20 AM R28 lay in her bed. R28 stated on the evening of the incident, CNA O entered her room to assist her with toileting care. She stated she was sore and asked him to go easy when changing her. She stated he began pushing hard on her back during care. She stated it caused severe pain in her lower back and legs. She said she asked CNA O to stop pushing on her back and he continued to push harder. She stated she began screaming in pain and her roommate yelled at CNA O to stop. She stated her legs were halfway off the bed and if it had not been for her pushing against the air conditioning unit on the wall, she would have fallen out of the bed. She stated CNA O finished and left the room. She stated she had not seen him since the incident. She stated no other staff were aware of the incident until Administrative Nurse D and Administrative Staff A were notified. On 05/23/24 at 09:00 AM CNA O and R15 were both unavailable for interview. On 05/23/24 at 10:20 AM CNA P stated the facility held frequent abuse training. She stated staff were required to report alleged abuse immediately to Administrative Staff A and Administrative Nurse D. She stated staff were expected to ensure the residents' comfort and stop treatments if the resident was in pain or asked to stop. On 05/23/24 at 11:47 AM Administrative Nurse D stated CNA O had been terminated and was unavailable for interview due to his incarceration for an unrelated domestic violence allegation. Administrative Nurse D stated the facility holds abuse-related in-services upon hire, annually, and as needed. She stated the training included prevention, identifying, and reporting requirements for abuse. The facility's Abuse Prevention Program created 06/2023 indicated the facility will protect each resident from abuse, neglect, and misappropriation. The policy indicated the facility was responsible for ensuring the ongoing safety of each resident from abuse. The policy indicated the facility will provide education and training to ensure staff identify abuse and report per regulatory guidelines. The facility failed to ensure R28 remained free from staff to-resident abuse and mistreatment when staff were intentionally rough with care to R28. This deficient practice placed R28 at risk for impaired psychosocial well-being, pain, and fear.

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45668 The facility identified a census of 93 residents. The sample included residents with three residents reviewed for abuse and neglect. Based on record review and interviews, the facility failed to ensure Resident (R)38 remained free from misappropriation when staff took possession of her debit cards resulting in unauthorized charges. This deficient practice placed R38 at risk for impaired psychosocial well-being. Findings Included: - The Medical Diagnosis section within R38's Electronic Medical Records (EMR) included diagnoses of multiple sclerosis (MS- progressive disease of the nerve fibers of the brain and spinal cord), morbid obesity (severely overweight), Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness), and major depressive disorder (major mood disorder). A review of R38's Quarterly Minimum Data Set (MDS) completed 02/09/24 noted a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. The MDS indicated she was independent with dressing, bed mobility, transfers, bathing, personal hygiene, and toileting. The MDS indicated she used a manual wheelchair. R38's Psychosocial Wellbeing Care Area Assessment (CAA) completed 08/15/23 indicated she was at risk for decreased psychosocial well-being related to having little interest or pleasure in activities. The CAA indicated a care plan will address her decreased well-being. R38's Functional Abilities CAA completed 08/15/23 indicated she required limited assistance for transfers, mobility, locomotion, bathing, and meals related to her medical diagnoses. The CAA indicated a care plan will address her activities of daily living (ADLs). A review of R38's Care Plan initiated on 12/27/23 indicated she could independently complete her hygiene, transfers, bed mobility, dressing, and bathing. The plan indicated she used a wheelchair and could propel herself. The plan indicated had a history of behaviors related to self-isolation and tearfulness related to the loss of her son in 2022 and was still grieving. The plan encouraged staff to recognize her grief and provide emotional support. The plan instructed staff to offer supportive activities. A Facility Reported Incident (7531) report indicated on 04/29/24 R38 reported $577.50 worth of transactions were charged to her debit card. The report indicated R38 reported the charges to Social Services Staff X on 04/29/24. The report indicated five separate charges appeared on R38's bank statement beginning on 04/20/24. The report documented R38 gave her debit card to two different staff on two occasions so staff could purchase items for R38 from the facility's vending machines. The report documented the two staff were Certified Nurses Aide (CNA) MM and CNA NN on 04/20/24. The report noted both staff were immediately suspended pending investigation and the local police department was notified of the possible misappropriation. The report documented the facility reimbursed R38's $577.50 and educated staff not to handle resident money. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/20/24 at 10:39 AM R38 reported on 04/29/23, she received her bank statement for her new debit card and found multiple fraudulent charges on her bank statement she did not make. She stated she immediately reported the charges to Administrative Staff A and Social Service X. She stated upon further investigation she found Social Service X found almost $600 in fraudulent or unauthorized charges. She stated she had staff use her card to buy her items from the vending machine. She stated both CNA MM and CNA NN used her card on 04/20/24 before the unauthorized charges were made. She stated CNA NN returned her card and informed her that the card had been declined after purchasing a bag of chips on 04/20/24. She stated she told CNA NN she knew there was more money in her account than that. A review of R38's bank statements indicated online charges of Fashion Nova for $85.27 (04/20/24), [NAME].com for $138.92 (04/22/24), Walmart for $166.56 (04/23/24), Amazon.com for $142.13 (04/24/24), Walmart for $32.80 (04/24/24), and Walmart for $11.82 (04/24/24). On 05/23/24 at 11:47 AM Administrative Nurse D stated the employees involved were immediately suspended. She stated CNA MM was terminated and CNA NN was put on the Do Not Return list for agency staff. She stated all staff have been trained on abuse, neglect, and exploitation. She stated all staff were informed not to accept money or bank cards from the resident for transactions. She stated online order requests from the residents will be handled by the social services staff going forward. The facility's Abuse Prevention Program created 06/2023 indicated the facility will protect each resident from abuse, neglect, and misappropriation. The policy indicated the facility was responsible for ensuring the ongoing safety of each resident from abuse. The policy indicated the facility will provide education and training to ensure staff identify abuse and report per regulatory guidelines. The facility failed to ensure R38 remained free from misappropriation when staff used R38's of her debit card resulting in unauthorized charges. This deficient practice placed R38 at risk for decreased psychosocial well-being.

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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** 41713 The facility identified a census of 93 residents. The sample included 22 residents. Based on observation, record review, and interview, the facility failed to ensure that Resident (R)14's comprehensive care plan was developed to address interventions for his activities of daily living (ADLs) and enteral feeding (provision of nutrients through the gastrointestinal tract when the resident cannot ingest, chew or swallow food). This placed R14 at risk of impaired care due to uncommunicated care needs. Findings included: - R14' Electronic Medical Record (EMR) documented diagnoses of congestive heart failure (CHF- a condition with low heart output and the body becomes congested with fluid), kidney failure (inability of the kidneys to excrete wastes, concentrate urine and conserve electrolytes), and hypertension (HTN- elevated blood pressure). R14's Admission Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 13 which indicated intact cognition. R14 was independent with personal hygiene and required supervision with toileting, and dressing. R14 required supervision with transfers. R14 was independent with wheelchair mobility. R14's ADL Care Area Assessment (CAA) dated 05/07/24 documented he required varying levels of assistance with ADLs. R14 was currently receiving skilled therapy services. R14 required supervision or touching assistance with toileting hygiene and transfers. R14's Care Plan revised 05/13/24 directed staff to administer treatments as ordered and monitor for effectiveness for his 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). R14's Care Plan lacked staff direction regarding ADL care and enteral feeding. On 05/22/24 at 01:09 PM R14 laid on his bed with enteral feeding infusing via gastrostomy tube (G-tube: tube surgically placed through an artificial opening into the stomach) continuously. On 05/22/24 at 01:17 PM Licensed Nurse (LN) I stated she had not noticed that R14's care plan did not include interventions to address his ADLs or the enteral feeding. LN I stated she would make sure this issue was brought to the attention of Administrative Nurse D. On 05/22/24 at 02:45 PM Administrative Nurse D stated the comprehensive care plan was developed after the MDS had been completed. Administrative Nurse D stated R14's care plan should include any concern areas that were triggered on the MDS. Administrative Nurse D stated R14's care plan would be revised to address his ADLs and enteral feeding with appropriate interventions. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Comprehensive Care Plans policy documented: The comprehensive care plan was based on a thorough assessment that included, but was not limited to, the MDS and physician's orders. The assessments of residents were ongoing, and the care plan was revised as information about the resident's condition changed. The care plan should describe the resident's nursing, medical, physical, mental, and psychosocial preferences. The care plan should include person-specific, measurable objectives and time frames with a goal to measure their progress towards meeting such. The facility failed to ensure that R14's comprehensive care plan was developed to address interventions for his ADLs and enteral feeding enteral feeding. This placed R14 at risk for impaired care due to uncommunicated care needs.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 identified a census of 93 residents. The sample included 22 residents with five residents reviewed for comprehensive care plans. Based on observation, record review, and interviews, the facility failed to revise Resident (R)28 and R87's care plan to reflect their smoking interventions. The facility additionally failed to revise the care plan to include R31's side rails, R43's choices for his activities of daily living, and R1's preferred name of grandpa. These deficient practices place the residents at risk for impaired care due to uncommunicated care needs. Findings Included: - The Medical Diagnosis section within R28's Electronic Medical Records (EMR) included diagnoses of muscle weakness, morbid obesity (severely overweight), bipolar disorder (a major mental illness that causes people to have episodes of severe high and low moods), seizure (violent involuntary series of contractions of a group of muscles), and peripheral vascular disease (PVD- slow and progressive circulation disorder causing narrowing, blockage, or spasms in a blood vessel). R28's Admission Minimum Data Set (MDS) completed 02/27/24 noted a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. The MDS indicated she required substantial to maximal assistance from staff for bathing, transfers, toileting, bed mobility, personal hygiene, and dressing. The MDS indicated she had impairments to both sides of her lower extremities. The MDS indicated she used tobacco products. The MDS indicated no observed behaviors. R28's Functional Abilities Care Area Assessment (CAA) completed 03/01/24 indicated she was at risk for a decline in her activities of daily living (ADLs) related to her medical diagnoses. The CAA indicated staff were to follow her current plan of care to prevent further declines. R28's Care Plan initiated on 02/22/24 indicated she required extensive assistance from one staff for personal hygiene, toileting, dressing, bathing, and walking with her four-wheeled walker. The plan noted she was independent with bed mobility. The plan indicated she was continent of the bladder but required prompting during the evening. The plan lacked interventions related to her smoking assessment or safe smoking practices. R28's EMR under Assessments revealed a Smoking- Safety Screen completed 03/12/24 noted she had no cognitive loss, vision deficits, or dexterity problems. The screen noted she smoked five to 10 cigarettes daily. The screen documented she was safe to smoke with supervision. The screen documented a plan of care would be used to ensure the resident was safe while smoking. On 05/22/24 at 01:30 PM, R28 lined up at the south hall dining room to smoke on the patio. R28 wheeled herself out the door and stopped next to the raised garden bed. Staff provided R28 with her cigarette and kit for her. R28 smoked her cigarette without incident or issue and returned to her room. On 05/23/24 at 10:29 AM Certified Nurse Aide (CNA) P stated each resident was assessed quarterly for smoking. She stated safe smoking interventions should be identified in the care plan. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/23/24 at 10:45 AM Licensed Nurse (LN) H stated the care plan should reflect each resident's preferred activities and safety interventions. She stated the care plan should include if a resident smoked and what safety protocol to follow. On 05/23/24 at 12:39 PM Administrative Nurse D stated all staff had access to the care plans. She stated residents that who smoke were assessed quarterly to ensure their ability to safely smoke. She stated the smoking interventions should be reflected in the care plan. The facility's Comprehensive Care Plan policy dated 06/2023 indicated each resident will have an individualized person-centered care plan that includes measurable objectives and time frames to meet the resident's needs. The policy indicated the plan will be revised to include updated assessments and changes within the resident's care status. The facility failed to revise the care plans to include safe smoking interventions for R28. This deficient practice placed R28 at risk for impaired care due to uncommunicated care needs. -The Medical Diagnosis section within R87's Electronic Medical Records (EMR) included diagnoses of acute respiratory failure, anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), morbid obesity (severely overweight), asthma (a disorder of narrowed airways that caused wheezing and shortness of breath), and chronic obstructive pulmonary disorder (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing). A review of R87's Annual Minimum Data Set (MDS) completed 02/08/24 noted a Brief Interview for Mental Status (BIMS) score of four indicating severe cognitive impairment. The MDS indicated she required substantial to maximal assistance from one staff for transfers, bathing, dressing, personal hygiene, and bed mobility. The MDS indicated she had shortness of breath but did not indicate she smoked. The MDS indicated she had oxygen therapy. R87's Fall Care Area Assessment (CAA) completed 02/14/24 indicated she was at risk for falls and accidents related to her severe cognitive impairment, limited mobility, and need for assistance with her activities of daily living (ADLs). The CAA indicated a care plan will address her safety risks. A review of R87's Care Plan initiated on 02/06/24 indicated she required extensive assistance from one staff for transfers, bed mobility, personal hygiene, toileting, and mobility with her wheelchair. The plan indicated she received oxygen therapy related to her medical diagnosis. The plan instructed staff to provide oxygen as needed, position her to promote improved ventilation and breathing and provide frequent reminders to wear her oxygen nasal cannula (oxygen mask supplying air to both nostrils). R87's EMR under Assessments revealed a Smoking- Safety Screen completed 04/07/24 noted she had no cognitive loss, vision deficits, or dexterity problems. The screen noted she smoked one to two cigarettes daily. The plan indicated she was safe to smoke with supervision. The screen indicated a plan of care would be used to ensure the resident was safe while smoking. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/22/24 at 01:30 PM, R87 lined up at the south hall dining room to join the smoking activity. Staff removed her oxygen cylinder. R87 was wheeled outside to the designated patio. R87 received an extended cigarette holder. Staff then applied the cigarette and supervised R87 while she smoked her cigarette. On 05/23/24 at 10:29 AM Certified Nurse's Aide (CNA) P stated each resident was assessed quarterly for smoking. She stated safe smoking interventions should be identified in the care plan. On 05/23/24 at 10:45 AM Licensed Nurse (LN) H stated the care plan should reflect each resident's preferred activities and safety interventions. She stated the care plan should include if a resident smoked and what safety protocol to follow. On 05/23/24 at 12:39 PM Administrative Nurse D stated all staff had access to the care plans. She stated residents that who smoke were assessed quarterly to ensure their ability to safely smoke. She stated the smoking interventions should be reflected in the care plan. The facility's Comprehensive Care Plan policy dated 06/2023 indicated each resident will have an individualized person-centered care plan that includes measurable objectives and time frames to meet the resident's needs. The policy indicated the plan will be revised to include updated assessments and changes within the resident's care status. The facility failed to revise the care plans to include safe smoking interventions for R87. This deficient practice placed R87 at risk for impaired care due to uncommunicated care needs. - The Medical Diagnosis section within R1's Electronic Medical Records (EMR) included diagnoses of dementia, type two diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made or the body cannot respond to the insulin), muscle weakness, major depressive disorder (major mood disorder), and heart failure. R1's Annual Minimum Data Set (MDS) completed 05/01/24 noted a Brief Interview for Mental Status (BIMS) score of three indicating severe cognitive impairment. The MDS noted he had no upper extremity impairments but had lower extremity impairments. The MDS indicated he used a wheelchair and was independent in mobility. The MDS indicated he had a history of physically and verbally aggressive behaviors. The MDS indicated he had wandering behaviors one to three days a week. R1's Dementia Care Area Assessment (CAA) completed 05/01/24 indicated he was at risk for cognitive decline related to his secure cognitive impairment related to his medical diagnoses and memory loss. The CAA noted he had a history of wandering behaviors The CAA indicated a care plan will be implemented to address his cognitive loss. R1's Behavioral CAA completed 05/01/24 indicated he had a history of behaviors including hitting, yelling, kicking, threatening, and cursing. The CAA indicated a care plan will be implemented to address his behaviors. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R1's Care Plan initiated on 04/29/19 indicated he was at risk for falls and behaviors. The plan noted he required extensive assistance from staff for bed mobility, personal hygiene, dressing, transferring, and bathing. The plan noted he used a manual wheelchair and could propel himself. The plan indicates R1 was a veteran and enjoyed watching television, Bingo, pet therapy, and catholic church. The plan instructed staff to respect R1's refusals and provide alternate activities. The plan did not acknowledge R1's preference to be called Grandpa. On 05/20/24 at 08:04 AM R1 sat in the dining room waiting for his breakfast. An unidentified staff member asked him, Are you doing okay this morning Grandpa? R1 stated he was doing okay. On 05/21/24 at 12:30 PM, R1 was wheeled into the south dining hall by his one-to-one staff. Certified Nurses Aide (CNA) OO stated, Okay Grandpa are you ready to eat? R1 acknowledged he was ready to eat. R1 stated he liked to be called grandpa and was okay with it. CNA OO stated most staff refer to him as Grandpa because he's been there so long. CNA OO was not sure if the care plan addressed R1's name preferences. On 05/23/24 at 12:45 PM Administrative Nurse D stated most staff call R1 grandpa but was not sure if the care plan addressed his name preferences. She stated R1 liked to be called grandpa. She stated the care plans should reflect the resident's needs and preferences. The facility's Comprehensive Care Plan policy dated 06/2023 indicated each resident will have an individualized person-centered care plan that includes measurable objectives and time frames to meet the resident's needs. The policy indicated the plan will be revised to include updated assessments and changes within the resident's care status. The facility failed to revise the care plans to include R1's name preferences. This deficient practice placed R1 at risk for impaired care due to uncommunicated care needs. 41037 - R31's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of intellectual disabilities, quadriplegia (inability to move the arms, legs, and trunk of the body below the level of an associated injury to the spinal cord), muscle weakness, dysphagia (swallowing difficulty), hemiparesis (muscular weakness of one half of the body), and hemiplegia (paralysis of one side of the body). 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 no staff interview was needed. The Quarterly MDS dated [DATE] documented a BIMS score of one which indicated severely impaired cognition. The MDS documented that R31 required set-up or clean-up assistance with meals. The MDS documented R31 received a mechanically altered diet during the observation period. The MDS documented R31 was dependent on staff assistance for the ability to roll from side to side. R31's Cognitive Loss/Dementia Care Area Assessment (CAA) dated 07/19/23 documented R31 had a diagnosis of intellectual disabilities. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R31's Care Plan revised on 04/ 19/24 documented R31 was dependent on one staff member for assistance with bed mobility. R31's Care Plan lacked direction to staff for side rails. R31's EMR under the Assessments tab revealed no risk assessment for side rail use prior to side rails being added to R31's bed. A Nursing: Quarterly or Annual Evaluation dated 04/09/24 revealed a Falls/Bedrails/Restraints assessment that documented no new side rails had been added to R31's bed since the last assessment. The facility was unable to provide any alternatives tried prior to the installation of bedrails, a risk for entrapment assessment and documentation of the risk, a documented consent, or risk versus benefit was reviewed by the resident or the resident representative. On 05/21/24 at 08:55 AM R31 lay on her bed with her body leaned to the left side close to the side rails attached to her bed. R31's head of her bed was elevated, and the bedside table was pulled across the bed in front of R31. R31's breakfast tray was on the bedside table with her butter and jelly packages unopened. R31's fingers on both hands had a limited range of motion (ROM- the full movement potential of a joint, usually its range of flexion and extension). On 05/23/24 at 10:18 AM, Certified Nurse Aide (CNA) P stated everyone had access to each of the resident's care plans. CNA P stated side rails should be listed on a resident's care plan. CNA P stated she was not sure if R31 had side rails on her bed. On 05/23/24 at 10:59 AM, Licensed Nurse (LN) H stated everyone had access to the care plan but she was not sure if R31 had side rails on her bed. LN H stated that side rails should be care planned for safety. On 05/23/24 at 11:47 AM, Administrative Nurse D stated everyone had access to each of the resident's care plan or their Kardex (a nursing tool that gives a brief overview of the care needs of each resident). Administrative Nurse D stated R31's Care Plan should have included her need and ability to utilize the side rails. The facility's Comprehensive Care Plan policy dated 06/2023 documented an individualized comprehensive person-centered care plan that includes measurable objectives and time frames to meet the resident's medical, nursing, mental, cultural, and psychological needs is developed for each resident. Each resident's comprehensive care plan was designed to aid in preventing or reducing declines in the resident's functional status and/or functional levels. The facility failed to revise R31's Care Plan to include side rails that had been installed on her bed. This deficient practice placed R31 at risk of impaired care due to uncommunicated care needs, - R43's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of dementia (a progressive mental disorder characterized by failing memory, and confusion), coronary artery disease (CAD-abnormal condition that may affect the flow of oxygen to the heart), hemiparesis (muscular weakness of one half of the body), hemiplegia (paralysis of one side of the body), muscle weakness, and lack of coordination. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Significant Change Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of eight which indicated moderately impaired cognition. The MDS documented R43 had a limited range of motion (ROM- the full movement potential of a joint, usually its range of flexion and extension) on one side. The MDS documented R43 was dependent on staff assistance for transfers, toileting, personal hygiene, dressing, and bathing. The Quarterly MDS dated [DATE] documented a BIMS score of three which indicated severely impaired cognition. The MDS documented that R43 had limited ROM to one side. The MDS documented R43 was dependent on staff assistance for transfers, toileting, dressing, and bathing. The MDS documented R43 received hospice care during the observation period. The MDS documented that R43 required substantial to maximum staff assistance for personal hygiene. R43's Functional Abilities Care Area Assessment (CAA) dated 12/07/23 documented he was dependent on staff assistance for activities of daily living (ADL) and was under hospice care. R43's Care Plan dated 04/19/24 documented he was dependent on two staff members for bathing and required supervision to set up assistance for personal hygiene. The plan of care lacked direction to staff for R43's choices for personal hygiene and shaving. On 05/20/24 at 08:42 AM R43 lay in bed. R43 had facial hair. R43 stated he did not get shaved every day and needed assistance with shaving. On 05/20/24 at 11:36 AM R43 sat reclined in a Broda chair (specialized wheelchair with the ability to tilt and recline) in the small north activity room. R43 was unable to let a staff member he needed assistance. R43 facial hair remained unshaven. On 05/21/24 at 12:25 PM, R43 sat reclined in a Broda chair in the north small activity room. R43's facial hair remained unshaven. A puddle of liquid was noted under R43's Broda chair. On 05/22/24 at 07:50 AM R43 sat upright in a Broda chair in the dining room. R43 facial hair remained unshaven. R43 stated no one had offered to assist him with shaving his facial hair. On 05/23/24 at 10:18 AM, Certified Nurse Aide (CNA) P stated everyone had access to the care plan or Kardex (a nursing tool that gives a brief overview of the care needs of each resident). CNA P stated the resident choices and preferences should be found on the care plan. On 05/23/24 at 10:59 AM, Licensed Nurse (LN) H stated everyone had access to each of the resident's care plans or Kardex which contained each resident's preferences. LN H stated R43's care plan should have his preferences or choices listed. On 05/23/24 at 11:47 AM, Administrative Nurse D the resident's choices and preferences should be listed on the care plan or on the Kardex. The facility's Comprehensive Care Plan policy dated 06/2023 documented an individualized comprehensive person-centered care plan that includes measurable objectives and time frames to meet the resident's medical, nursing, mental, cultural, and psychological needs is developed for each resident. Each resident's comprehensive care plan was designed to aid in preventing or reducing declines in the resident's functional status and/or functional levels. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility failed to revise R43's Care Plan to include direction to staff for the necessary assistance with personal hygiene. This deficient practice placed R43 at risk for impaired care due to uncommunicated care needs.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 41037 The facility identified a census of 93 residents. The sample included 22 residents with five residents reviewed for activities of daily living (ADLs). Based on observation, record review, and interviews, the facility failed to provide the necessary assistance with personal hygiene for Resident (R) 43. This deficient practice placed R43 at risk for poor hygiene, decreased self-esteem, and impaired dignity. Findings included: - R43's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of dementia (a progressive mental disorder characterized by failing memory, and confusion), coronary artery disease (CAD-abnormal condition that may affect the flow of oxygen to the heart), hemiparesis (muscular weakness of one half of the body), hemiplegia (paralysis of one side of the body), muscle weakness, and lack of coordination. The Significant Change Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of eight which indicated moderately impaired cognition. The MDS documented R43 had a limited range of motion (ROM- the full movement potential of a joint, usually its range of flexion and extension) on one side. The MDS documented R43 was dependent on staff assistance for transfers, toileting, personal hygiene, dressing, and bathing. The Quarterly MDS dated [DATE] documented a BIMS score of three which indicated severely impaired cognition. The MDS documented that R43 had limited ROM to one side. The MDS documented R43 was dependent on staff assistance for transfers, toileting, dressing, and bathing. The MDS documented R43 received hospice care during the observation period. The MDS documented R43 required substantial to maximum staff assistance for personal hygiene. R43's Functional Abilities Care Area Assessment (CAA) dated 12/07/23 documented he was dependent on staff assistance for activities of daily living (ADL) and was under hospice care. R43's Care Plan dated 04/19/24 documented he was dependent on two staff members for bathing and required supervision to set up assistance for personal hygiene. The plan of care lacked direction to staff for R43's choices for personal hygiene and shaving. On 05/20/24 at 08:42 AM R43 lay in bed. R43 had facial hair. R43 stated he did not get shaved every day and needed assistance with shaving. On 05/20/24 at 11:36 AM R43 sat reclined in a Broda chair (specialized wheelchair with the ability to tilt and recline) in the small north activity room. R43 was unable to let a staff member he needed assistance. R43 facial hair remained unshaven. On 05/21/24 at 12:25 PM, R43 sat reclined in a Broda chair in the north small activity room. R43's facial hair remained unshaven. A puddle of liquid was noted under R43's Broda chair. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/22/24 at 07:50 AM R43 sat upright in a Broda chair in the dining room. R43 facial hair remained unshaven. R43 stated no one had offered to assist him with shaving his facial hair. On 05/23/24 at 10:18 AM, Certified Nurse Aide (CNA) P stated everyone had access to the care plan or Kardex (a nursing tool that gives a brief overview of the care needs of each resident). CNA P stated the resident choices and preferences should be found on the care plan. CNA P stated R43 required assistance with personal hygiene and should be shaved at least on his bath days. On 05/23/24 at 10:59 AM, Licensed Nurse (LN) H stated everyone had access to each of the resident's care plans or Kardex which contained each resident's preferences. LN H stated R43's care plan should have his preferences or choices listed. LN H stated staff should offer and assist him with shaving daily or as he preferred. On 05/23/24 at 11:47 AM, Administrative Nurse D stated she would expect staff to assist R43 with shaving as he preferred. Administrative Nurse D stated she expected a resident's choices and preferences to be listed on the care plan or on the Kardex. The facility's Quality of Life- Activities of Daily Living policy dated 06/2023 documented that the community environment and staff behaviors are directed toward assisting the resident in maintaining and/or achieving independent functioning, dignity, and well-being. Residents who are unable to carry out activities of daily living receive the necessary care and services to maintain good nutrition, grooming, and personal and oral hygiene. Residents are provided with the appropriate care and services including hygiene, mobility, elimination, and dining, including meals and snacks, and communication. The facility failed to ensure R43 received assistance with trimming his facial hair. This deficient practice placed him at risk for poor hygiene, decreased self-esteem, and impaired 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** 50660 The facility identified a census of 93 residents. The sample included 22 residents with six residents sampled for pressure ulcer (a 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) prevention. Based on observation, record review, and interview, the facility failed to ensure Resident (R) 52 received pressure ulcer care consistent with the standards of practice when the facility failed to ensure he consistently received the ordered treatments and failed to ensure dressing orders were in place to followed. The facility further failed to ensure R52's low air loss mattress was set at the accurate weight setting for the resident. The facility additionally failed to ensure R45's low air loss mattress was set at the appropriate weight setting and failed to ensure his heels were floated as ordered. These deficient practices placed these residents at risk for complications related to skin breakdown and pressure ulcers. Findings included: - R52's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of sepsis (a life-threatening systemic reaction that develops due to infections that cause inflammation throughout the entire body), methicillin susceptible staphylococcus aureus infection (MRSA-a type of bacteria resistant to many antibiotics) and morbid obesity (excessive body fat). The Admission Minimum Data Set (MDS) dated [DATE] noted R52 had a Brief Interview for Mental Status (BIMS) score of 14 which documented no cognitive impairment. The MDS documented R52 was dependent for transfers and getting in and out of bed. He was dependent on staff for toileting hygiene and dressing. The MDS documented R52 was dependent on staff assistance for wheelchair mobility; he used a manual wheelchair. The MDS documented he was admitted to facility with an unstageable pressure wound (depth of the wound is unknown due to the wound bed being covered by a thick layer of other tissue and pus) and a Stage 3 (full-thickness pressure injury extending through the skin into the tissue below) wound. The MDS documented he had pressure-reducing devices for his wheelchair and a low air loss mattress for his bed. R52 was also on a turn and reposition program and received pressure ulcer care. The MDS recorded R52 weighed 235 pounds. The Quarterly MDS dated [DATE] noted R52 had a BIMS score of 14 which documented no cognitive impairment. The MDS documented R52 was dependent for transfers and getting in and out of bed. He was dependent on staff for toileting hygiene and max to moderate assist with dressing. The MDS documented R52 was able to propel himself in a manual wheelchair. The MDS documented he had a Stage 4 (a deep pressure wound that reaches the muscles, ligaments, or even bone) wound. R52 was also on a turn and reposition program and received pressure ulcer care. The MDS recorded R52 weighed 240 pounds. R52's Pressure Ulcer Care Area Assessment (CAA) completed 01/04/24 documented he had a Stage 3 pressure ulcer and an unstageable pressure ulcer, present on admission. R52 was frequently Incontinent of urine and always Incontinent of bowel. R52 required substantial to maximum assist with rolling left to right and returning to his back. R52 was dependent with sitting to lying and lying to sitting on side of bed. R52 was being treated for wound infection. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R52's Care Plan initiated on 01/05/24 documented he had a wound on his sacrum. The plan documented that the nursing staff administered antibiotics as ordered by the physician. The plan documented the staff followed policy and procedure for listing, summarizing, and reporting infections. The plan documented that a low air loss mattress and a wheelchair cushion were in place for pressure reduction and pressure relieving boots would be on while the resident was in bed and as tolerated. The plan documented that R52 may refuse to have his wound care performed. On 01/24/24 the plan was updated to include that the wound consultant company was to evaluate and provide treatment of wounds as the physician recommends. The plan documented that staff were to communicate to the nurse when and if needed, and the nurse would report to the physician when and if needed. On 01/24/24 the plan documented that a wound vac (a vacuum-assisted wound treatment that applies gentle suction to a wound to help it heal) was ordered for the sacral wound and the wound vac was to be changed three times per week as ordered by the physician. The plan documented the vac was discontinued on 02/09/24. The plan documented that R52 had limited physical mobility due to weakness because of morbid obesity. R52's EMR recorded a Physician's Order to cleanse the sacral wound, apply Thera Honey (medical grade honey used to promote wound healing) and Optifoam dressing. Change daily. This order was discontinued on 01/17/24. Review of R52's January 2024 Treatment Administration Record (TAR) lacked evidence the dressing was changed on 01/05/24, 01/14/24 and 01/17/24. The TAR recorded to see progress note on 01/16/24. Review of the notes lacked a related entry for 01/16/24. R52's EMR recorded A Physician's Order dated 01/06/24 for a wet-to-wet dressing to the coccyx for five days one time a day for the Stage 3 pressure ulcer. This order was discontinued on 01/16/24. Review of R52's January 2024 TAR revealed the dressing was not changed on 01/09/24, was held on 01/11/24, documented to see progress note on 01/15/24 and was not completed on 01/14/14 and 01/16/24. The TAR lacked documentation of any order or dressing placed to the wound on 01/18/24. A Skilled Note dated 01/18/24 at 11:29 PM recorded the resident received daily wound care and a consult was ordered because the wound was getting worse. The note recorded the resident was on antibiotics for a wound infection. The notes for 01/18/24 lacked any indication if a dressing was placed to the sacral wound and if so, what kind of dressing. R52's EMR recorded a Physician's Order dated 01/18/24 which ordered for a wound vac to start on 01/19/24 to the coccyx with negative pressure set at 125 millimeters (mm) of Mercury (Hg) and changed three times weekly on Monday, Wednesday, and Friday. This order was discontinued on 01/24/24. A Skilled Note dated 01/21/24 documented the resident's dressing was clean, dry, and intact. The note documented the resident was waiting on a wound vac. R52's EMR recorded a Physician's Order dated 01/24/24 which ordered for a wound vac to the coccyx with negative pressure set at 125 millimeters mmHg and changed three times weekly on Tuesday, Thursday, and Saturday. This order was discontinued on 02/08/24. R52's January 2024 TAR revealed the wound vac dressing was not changed on 01/27/24 as ordered. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Late Entry Nurse Note dated 01/28/24 documented a Certified Nurse Aide (CNA) requested the nurse to look at R52's wound vac to be sure that it was properly running and upon assessment of the wound vac and placement, nurse noted the resident did not have a wound vac intact but had a bordered foam covering the coccyx wound with gauze packing in the wound. The wound vac had slipped to the hip and was not in place or properly doing its job. The note recorded the nurse placed a wet to dry dressing until the wound was reevaluated. A Skilled Note dated 01/28/24 documented R52 had a wound vac in place. A Nurse Note dated 01/31/24 documented the battery alarm on the wound vac was on. Staff attempted to plug-in the cord to the machine, but the prong was bent and was unable to connect or straighten prong. The staff notified Administrative Nurse D who contacted the company to request a replacement wound vac. The vac dressing was removed, and a wet-to-wet dressing put in its place. R42's February 2024 TAR revealed the wound vac was charted as held on 02/01/24, see progress note on 02/06/24 and lacked evidence of a dressing change on 02/03/24 and 02/08/24. R52's EMR listed an order dated 02/01/24 which directed to monitor the wound vac for proper functioning every shift. R52's February 2024 TAR revealed this this was completed on three of 14 opportunities. The other dates and shifts ere all noted as see progress note or lacked any documentation. A Skilled Note on 02/02/24 documented a wound vac was in place. A Late Entry Skilled Note on 02/03/24 documented the resident had a wet-to-dry dressing to the coccyx wound because the wound vac was not working; staff awaited delivery of a new wound vac. R52's EMR listed an order dated 02/07/24 that directed if the wound vac was not working or for unscheduled removal without an immediate replacement, staff were to cleanse the wound with hypochlorous acid (wound cleanser) apply Santyl (prescription ointment is used to remove damaged tissue from skin ulcers) to wound bed, calcium alginate rope (type of dressing) and cover with a foam dressing. This order was discontinued on 02/08/24. R52's February 2024 TAR lacked evidence this dressing was completed on 02/07/24 or 02/08/24. The TAR further lacked evidence of any dressing applied to the wound on 02/08/24. A Physicians Progress Note dated 02/08/24 documented the resident had a Stage 4 pressure ulcer and recorded the plan was to continue the wound vac. On 05/20/24 at 10:25 AM R52 laid in bed on a low air loss mattress. The weight stetting on the mattress pump was set to 450 pounds. On 05/22/24 at 11:21 AM Licensed Nurse (LN) H stated if there were difficulties with a wound vac or a replacement was needed, she would notify the wound nurse. LN H was unsure if there were vacs in the facility available or if it needed to be ordered. LN H stated she did know how to place a wound vac and dressing. LN H stated if waiting on the wound vac, she would make sure there were temporary dressing orders in place. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/22/24 at 11:23 PM LN K stated if a wound vac needed to be replaced or ordered, staff would call the physician and get orders on how to do for the wound care. The policy Pressure Injury Prevention and Management dated 2023 documented: The facility shall establish and utilize a systematic approach for pressure injury prevention and management, including prompt assessment and treatment; intervening to stabilize, reduce or remove underlying risk factors; monitoring the impact of the interventions; and modifying the interventions as appropriate. The facility policy Prevention of Pressure Injuries Guidelines dated June 2023 documented: identify specific risk factors. Establish goals and prevention interventions with the residents and physician's input. The policy lacked specific direction regarding wound vac use. The facility failed to ensure staff obtained and consistently followed orders and provided treatment for R52's Stage 4 pressure ulcer. This placed the resident at risk for delayed healing and or wound worsening. 49634 - R45's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of multiple sclerosis (MS- progressive disease of the nerve fibers of the brain and spinal cord), dementia (a progressive mental disorder characterized by failing memory, confusion), hypertension (HTN-elevated blood pressure), edema (swelling resulting from an excessive (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and muscle weakness. The Significant Change Minimum Data Set (MDS) for R45 dated 02/13/24 recorded a Brief Interview for Mental Status (BIMS) score of nine which indicated moderately impaired cognition. The MDS recorded R45 had an unhealed Stage 2 (partial-thickness skin loss into but no deeper than the dermis including intact or ruptured blisters) pressure wound. The MDS documented R45 was dependent on staff for bed mobility. R45's Pressure Ulcer/Injury Care Assessment (CAA) dated 02/13/24 documented R45 required dependent assistance from staff with bed mobility. R45 was frequently incontinent of bowel and bladder. R45's Functional Abilities CAA dated 02/13/24 documented R45 was at an increased risk of decline due to her need for assistance with activities of daily living (ADLs). Nursing should continue to assist with ADLs to reduce decline. R45's Care Plan dated 07/07/24 documented R45 had skin impairment related to a history of pressure injury and impaired mobility. The plan of care documented R45 had a low air loss mattress and a wheelchair cushion in place for pressure reduction. R45's EMR under the Orders tab recorded an order dated 02/22/24 which ordered staff to encourage boots. Boots were to be worn day and night if they were tolerated. R45's Orders tab recorded an order dated 03/19/24 which directed right heel prep every three days and as needed (PRN) if soiled or unscheduled, nursing to apply foam dressing for protection of area. R45's EMR under the Vitals tab documented her weight on 05/14/24 was 160 pounds. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/20/24 at 09:35 AM R45 laid flat in bed with her head directly on the mattress. R45's low air loss mattress was set at 350 pounds. R45's heels rested directly on her mattress. R45 was not wearing pressure-relieving boots. On 04/21/24 at 08:20 AM R45 laid flat in her bed on her back, with her head directly on the mattress. R45's low air loss mattress was set at 350 pounds. R45's heels rested directly on her mattress, and she was not wearing any pressure-relieving boots. On 05/23/24 at 10:17 AM Certified Nursing Aide (CNA) P stated all nursing staff were responsible for ensuring pressure relieving boots were on, and pillows were put under heels if the resident's Kardex (nursing tool that gives a brief overview of the care needs of each resident) indicated the resident should receive that care. On 05/23/24 at 10:59 AM Licensed Nurse (LN) H stated it was the nurse's duty to ensure low air loss mattresses were set at the proper weight for the individual resident. LN H stated ensuring low air loss mattresses were set and functioning properly was on the nurse's EMR under the treatment administration record. LN H stated it was all staff's responsibility to ensure the residents' heels were floated or boots were on if it was on the Kardex. On 05/23/24 at 11:46 AM Administrative Nurse D stated all nursing staff were responsible for ensuring the resident's heels were floated if required. She stated the settings for low air loss mattresses should be documented in the EMR under the treatment administration record (TAR) and checked as a nursing duty. The facility's Pressure Injury/Prevention and Management policy documented the facility was committed to the prevention of avoidable pressure injuries, unless clinically unavoidable, and to provide treatment and services to heal the pressure ulcer/injury, prevent infection and the development of additional pressure ulcers/injuries. The facility shall establish and utilize a systematic approach for pressure injury prevention and management, including prompt assessment and treatment; intervening to stabilize, reduce, or remove underlying risk factors; monitoring the impact of the interventions; and modifying the interventions as appropriate. The facility failed to ensure the pressure-reducing measures were implemented for R45, who was at risk for pressure injuries. This placed R45 at increased risk for pressure ulcers and pressure/skin injuries.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45668 The facility reported a census of 93 residents. The sample included 22 residents with seven reviewed for accidents. Based on record review, interviews, and observations, the facility failed to ensure an environment free from potential hazards related to Resident (R)33's bed rails. The facility failed to ensure R7 was safe to use her electronic recliner. The facility additionally failed to follow care-planned fall interventions for R32 and R49. These deficient practices placed the residents at risk for preventable accidents and injuries. Findings Included: -The Medical Diagnosis section within R33's Electronic Medical Records (EMR) included diagnoses of dementia (progressive mental disorder characterized by failing memory, and confusion), muscle weakness, urinary incontinence, major depressive disorder (major mood disorder), 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), and repeated falls. A review of R33's Annual Minimum Data Set (MDS) completed 02/09/24 noted a Brief Interview for Mental Status (BIMS) score of three indicating severe cognitive impairment. The MDS indicated he had no functional limitations with his upper and lower extremities. The MDS indicated he used a manual wheelchair for mobility. The MDS indicated he required partial to moderate assistance from staff for bed mobility, transfers, dressing, toileting, and bathing. The MDS indicated he was occasionally incontinent of bowel and bladder. The MDS indicated he had two non-injury falls since his prior assessment. The MDS indicated he had a pressure-reducing device for his bed. R33's Fall Care Area Assessment (CAA) completed 02/16/24 indicated he was at risk for falls related to his cognitive impairment and fall history. R33's Urinary Incontinence CAA completed 02/16/24 indicated he was at risk for skin breakdown and urinary tract infections (UTIs). The CAA indicated toileting and care interventions would be implemented to maintain or improve his incontinence. R33's EMR under Miscellaneous revealed a Side-Rail/Device Consent Form dated 10/30/20 indicating he had a one-quarter transfer bar added to his bed to assist with repositioning and transferring. The form did not acknowledge R33's pressure-reducing mattress. R33's Care Plan created on 09/16/19 indicated he required assistance from one staff for bed mobility, hygiene, transfers, dressing, bathing, and grooming. The plan indicated he had urinary incontinence and required a timed toileting schedule. The plan indicated he had a history of falls. The plan documented fall interventions added included a floor fall mat (added 06/19/23), a perimeter mattress (added 11/13/23), a portable urinal (added 12/05/23), and a night light (added 04/03/24). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/22/24 at 06:50 AM R33 lay in his bed awake. R33 called for help twice but did not activate his call light. R33 shifted himself to his left side and sat up on the side of his bed. R33 attempted to pull his wheelchair closer to his bed but the wheel was stuck on the lip of the fall mat on the floor. R33 stood up and attempted to pull his pants down but lost balance and sat back down. R33 called out for help again but did not use the call light. He pulled his pants and incontinence briefs down to his ankles. R33 ripped off his incontinence briefs from around his legs and pulled his red boxer shorts up. R33 attempted to move his wheelchair close to the bed but was unable. R33 stated he needed to use the bathroom and needed help. An inspection of R33's room revealed no portable urinal available for him to use. At 07:03 AM Licensed Nurse UU entered the room and assisted R33 to the restroom. On 05/23/24 at 08:10 AM an inspection of R33 room revealed his bed was positioned close to the wall. A five-to-six-inch gap was identified between the wall and his bed. R33 had a pressure-reducing bariatric-sized mattress. R33 had a three-quarter bed rail attached to the left outside of his bed. The railing had a five-to-six-inch gap between his pressure-reducing mattress and his bed. LN VV stated she was not sure how often the bed rails were assessed but verified the gaps for the railing and the wall. She stated she would notify Administrative Nurse D. She was unable to locate a portable urinal in R33's room. On 05/23/24 at 11:47 AM Administrative Nurse D stated the bed rails should be assessed each time the nurse enters to room for safety and reported if concerns were found. She stated R33 often attempted to self-transfer and was a high fall risk. She stated staff were to anticipate his needs and ensure he had assistance upon waking up. She verified he should have a urinal in his room to prevent him from attempting to take himself to the restroom without assistance. She stated bed rails assessments were completed when the devices were added. She was not sure if the assessments identified special mattresses. The facility's Accidents policy created 06/2023 indicated the facility will assess environmental hazards and safety risks to ensure ongoing safety reviews to reduce the risks of potential accidents and hazards. The policy noted all equipment will be appropriately utilized and monitored to ensure proper function and conditioning. The policy indicates the facility will provide ongoing education, assessments, and review from the interdisciplinary team. The facility failed to ensure an environment free from potential hazards related to R33's bed rails and his care-planned portable urinal. These deficient practices placed R33 at risk for preventable accidents and injuries. -The Medical Diagnosis section within R7's Electronic Medical Records (EMR) included diagnoses of dysphagia (difficulty swallowing), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), muscle weakness, morbid obesity (severe overweight), and dementia (a progressive mental disorder characterized by failing memory, confusion). R7's Annual Minimum Data Set (MDS) completed 05/01/24 noted a Brief Interview for Mental Status (BIMS) score of four indicating severe cognitive impairment. The MDS indicated she had no upper extremity impairments but had lower extremity impairments. The MDS indicated she required substantial to maximal assistance for bed mobility, transfers, dressing, personal hygiene, toileting, and bathing. The MDS indicated she had no falls since her last assessment. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R7's Cognitive Loss Care Area Assessment (CAA) completed 05/01/24 indicated she had problems related to short and long-term memory loss. The CAA noted she required substantial to maximal assistance for her activities of daily living (ADLs). R7's Care Plan initiated on 12/18/24 indicated she was at risk for falls and a decline in her ADLs related to her impaired balance, muscle weakness, and lack of coordination. The plan indicated she required limited assistance with transfers and slept in a recliner. The plan noted R7 preferred a recliner over sleeping in a bed. The plan noted she used a seated four-wheeled walker for mobility. The plan instructed staff to ensure her call light remained within reach and for staff to anticipate her need for fall prevention. R7's EMR lacked documentation related to R7's ability to safely operate the electric recliner in her room. On 05/21/24 at 01:34 PM, R7 wheeled herself to her room and awaited to be transferred to her recliner by staff. R7 was confused and was not able to operate the chair's remote control. Certified Nurse Aide (CNA) LL assisted R7 into her electric recliner with assistance using a gait belt transfer. CNA LL stated R7 had a major cognitive and physical decline within the last three weeks and required more staff assistance. CNA LL stated R7 will start working with therapy services to return to walking. She stated she was not sure if R7 had been assessed to safely use the electric recliner but R7 has had the recliner for a long time. CNA LL placed R7's remote on the left side of the recliner within R7's reach. R7's recliner still functioned. On 05/23/24 at 09:00 AM Consultant GG stated R7 was never assessed for safety related to her electric recliner. She stated R7 preferred the recliner over her bed. She stated R7 recently had a cognitive decline and verified she was not sure if R7 could safely transfer herself or operate the buttons. She stated staff would need to ensure R7 safely entered and exited the recliner. On 05/23/24 at 11:47 AM Administrative Nurse D stated R7 had not been assessed for safe use of the electric reclining chair. She stated R7 preferred the electric recliner over her bed but stated R7 could not safely operate the controls due to her cognitive decline. The facility's Accidents policy created 06/2023 indicated the facility will assess environmental hazards and safety risks to ensure ongoing safety reviews to reduce the risks of potential accidents and hazards. The policy noted all equipment will be appropriately utilized and monitored to ensure proper function and conditioning. The policy indicates the facility will provide ongoing education, assessments, and review from the interdisciplinary team. The facility failed to assess R7's ability to safely operate her electric reclining chair. This deficient practice placed R7 at risk for preventable falls and injuries. 49634 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- R49's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of transient ischemic attack (TIA- temporary episode of inadequate blood supply to the brain), dysphagia (swallowing difficulty), chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and hemiparesis/hemiplegia (weakness and paralysis on one side of the body). The Quarterly Minimum Data Set (MDS) dated [DATE] for R49 documented a Brief Interview of Mental Status (BIMS) score of zero which indicated severe cognitive impairment. The MDS indicated R49 was rarely or never understood. The MDS documented R49 had falls since admission or before admission. The MDS documented R49 needed cues for eating and required partial to moderate staff assistance for toileting, showering, and oral hygiene. The MDS documented R49 needed substantial to maximal assistance for lying to sitting position in bed, sit-to-stand, and stand and chair transfers. The Falls Care Area Assessment (CAA) dated 05 /07/23 documented R49 had a fall since the last assessment. The Cognitive Loss/Dementia CAA dated 05/07/23 documented R49 had a diagnosis of dementia and had a low-scoring BIMS. R49's Care Plan dated 05/11/23 documented that R49 was at risk for falls. He had an actual fall related to gait and balance problems and had a history of falls. Staff was to place a sign in R49's bathroom directing the resident to pull the call light for help. The plan of care stated staff was to place a sign stating Call don't fall by R49's bed. A Nursing Progress Note dated 03/26/24 documented R49 was found on the ground by his bed and chair, close to his closet. R49 was attempting to get dressed for the day. There was no injury noted. On 05/21/ 24 at 02:30 PM, observation of R49's bathroom and bedroom walls revealed there were no signs for prompting R49 to use the call light. On 05/21/24 at 08:41 AM R49 sat by the dining room door. He stated he was waiting for breakfast. On 05/23/24 at 10:17 AM Certified Nurse's Aide (CNA) P stated all nursing staff know what each resident's needs were by looking at their Kardex (nursing tool that gives a brief overview of the care needs of each resident). She stated nursing staff would know if the resident needed signs or the call light placed in a specific place. On 05/23/24 at 10:59 AM Licensed Nurse (LN) H stated she was unsure if R49 should have signs to prevent falls on his walls. LN H stated she seldom worked the North Hall. On 05/23/24 at 11:46 AM Administrative Nurse D stated if a resident was a fall risk, nursing would know that the resident needed visual prompts like signs by looking at the resident's Kardex. Administrative Nurse D stated the unit manager would be responsible for ensuring interventions such as signs were posted appropriately. She stated there were extra signs in the nurse's station, and all nursing staff could put the preventative signs back up if the sign fell . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's Accidents policy dated 06/23 documented the facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. The facility-oriented and resident-oriented approaches to safety are used to implement a system approach to safety, which considers the hazards identified in the environment and individual resident risk factors, and then adjusts interventions accordingly. The facility failed to ensure staff provided the visual cues such as signs in R49's bathroom and bedroom walls to prompt him to use his call light to prevent falls. This deficient practice placed R49 at risk of falls. - R32's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of the acquired absence of right leg below the knee, muscle weakness, hypertension (HTN-elevated blood pressure), chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing, altered mental status, artificial opening of urinary tract, kidney disease, dysphagia (swallowing difficulty), depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), Stage 3 (full thickness pressure injury extending through the skin into the tissue below) pressure ulcer of right buttocks, and a contracture (abnormal permanent fixation of a joint or muscle) of the right hand. The Significant Change in Status Minimum Data Set (MDS) dated [DATE] recorded that a Brief Interview for Mental Status (BIMS) was unable to be performed and a staff assessment should be conducted. The MDS documented R32 was severely impaired and never or rarely made decisions. The MDS recorded R32 required extensive assistance for all activities of daily living (ADLs) except eating, for which he needed set up and cues. R32 had no behaviors. The MDS documented R32 was dependent on staff for bed of daily living (ADLs) except eating, for which he needed set up and cues. R32 had no behaviors. R32's Cognitive Loss Care Area Assessment (CAA) dated 05/03/24 documented R32 was at increased safety risk due to his cognitive impairment and memory loss. Nursing should coordinate R32's care with social services. R32's Falls CAA dated 05/03/24 documented R32 was at an increased risk of falls due to his medications. Nursing should continue to monitor for adverse reactions to reduce fall risk. R32's Care Plan revised 07/11/23 directed staff to ensure R32's bed was in a low position. The plan of care for R32 directed staff to ensure he lay in the middle of the bed. On 05/20/24 at 08:23 AM R32 lay in the bed on his back, R32's bed was in a high position. R32's call light was between his wall and his bed on the floor. On 05/22/24 at 07:20 AM R32 laid on the bed on his back. R32's bed was in a high position. On 05/23/24 at 10:17 AM Certified Nurse's Aide (CNA) P stated she does not normally work on the North side of the building. She stated if R32's bed was supposed to be in the lowest position due to falls, the nursing staff taking care of him would know by the Kardex (a nursing tool that gives a brief overview of the care needs of each resident). On 05/23/24 at 10:59 AM Licensed Nurse (LN) H stated she was unfamiliar with R32, but she would be able to find out what he needed for fall prevention from the plan of care. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/23/24 at 11:46 AM Administrative Nurse D stated if R32's bed was to be in the lowest position. Administrative Nurse D would expect the staff to follow care interventions for a resident with a history of falls, and nursing staff would find that information in the Kardex. The facility's Accidents policy dated 06/23 documented the facility strives to make the environment as free from accident hazards as possible. Resident safety supervision and assistance to prevent accidents were facility-wide priorities. The facility-oriented and resident-oriented approaches to safety were used to implement a system approach to safety, which considers the hazards identified in the environment and individual resident risk factors, and then adjusts interventions accordingly. The facility failed to ensure R32's bed remained in the lowest position to prevent falls. This deficient practice placed the resident at risk of falls.

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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** 45668 The facility reported a census of 93 residents. The sample included 22 residents with three reviewed for oxygen therapy. Based on record review, interviews, and observations, the facility failed to administer Resident (R)87's supplemental oxygen per her physician's order. The facility additionally failed to store R23's oxygen nebulizer mask (a device that changes liquid medication into a mist easily inhaled into the lungs) in a sanitary manner. These deficient practices placed both residents at risk for respiratory complications. Findings Included: - The Medical Diagnosis section within R87's Electronic Medical Records (EMR) included diagnoses of acute respiratory failure, anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), morbid obesity (severely overweight), asthma (a disorder of narrowed airways that caused wheezing and shortness of breath), and chronic obstructive pulmonary disorder (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing). R87's Annual Minimum Data Set (MDS) completed 02/08/24 noted a Brief Interview for Mental Status (BIMS) score of four indicating severe cognitive impairment. The MDS indicated she required substantial to maximal assistance from one staff for transfers, bathing, dressing, personal hygiene, and bed mobility. The MDS indicated she had shortness of breath but did not indicate she smoked. The MDS indicated she had oxygen therapy. R87's Fall Care Area Assessment (CAA) completed 02/14/24 indicated she was at risk for falls and accidents related to her severe cognitive impairment, limited mobility, and need for assistance with her activities of daily living (ADLs). The CAA indicated a care plan will address her safety risks. R87's Care Plan initiated on 02/06/24 indicated she required extensive assistance from one staff for transfers, bed mobility, personal hygiene, toileting, and mobility with her wheelchair. The plan indicated she received oxygen therapy related to her medical diagnosis. The plan instructed staff to provide oxygen as needed, position her to promote improved ventilation and breathing and provide frequent reminders to wear her oxygen nasal cannula (oxygen mask supplying air to both nostrils). The plan lacked interventions related to smoking. R87's EMR under Physician Orders indicated she received two liters of continuous supplemental oxygen via a nasal cannula every shift for her COPD. On 05/22/24 at 06:20 AM R87 slept in her wheelchair in the small south hall dining room. R87's supplemental oxygen tank meter indicated it was empty. R87's nasal cannula lay below her mouth on her neck. At 06:50 AM R87 continued to sleep in her chair. Her oxygen cylinder remained empty and her nasal cannula rested on her chin. On 05/22/24 at 06:50 AM Certified Nurse Aid (CNA) Q stated R87's oxygen should be checked each shift and switched out when in the red section of the meter. She stated R87's tank was switched out the previous evening and she would let the charge nurse know it was empty. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/22/24 at 06:55 AM Licensed Nurse (LN) UU assessed R87. R87's oxygen saturation level (SpO2 - the amount of oxygen bound to hemoglobin in your red blood cells) was 87 percent (%) indicating the need for supplemental oxygen. LN UU stated the tanks were being switched out and that should help raise her oxygen levels. She stated the oxygen cylinders were monitored each shift and changed out when needed. On 05/23/24 at 11:47 AM Administrative Nurse D stated staff were expected to check R87's oxygen cylinder throughout the shift and replace it before it became empty. She stated R87 needed frequent reminders to wear her nasal cannula and staff were expected to prompt her to wear it appropriately. The facility's Oxygen Administration policy (undated) indicated staff will administer oxygen per the physician's order. The facility failed to administer R87's supplemental oxygen per her physician's order. This deficient practice placed R87 at risk for complications related to shortness of breath. 41037 - R23's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing) and asthma (a disorder of narrowed airways that caused wheezing and shortness of breath). 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 R23 received oxygen therapy during the observation period. R23's Functional Abilities Care Area Assessment (CAA) dated 04/01/24 documented that R23 required varying levels of assistance with her activities of daily living. R23's Care Plan dated 09/18/22 documented staff would administer treatments and medications as ordered by the physician. R23's EMR under the Orders tab revealed the following physician orders: Change and date nebulizer kit and storage bag weekly at bedtime every Wednesday for maintenance dated 04/03/24. On 05/20/24 at 07:59 AM R23 sat in a wheelchair beside her bed. R23's nebulizer laid unbagged in the top drawer of the bedside cabinet next to R23's bed. On 05/23/24 at 10:18 AM, Certified Nurse Aide (CNA) P stated oxygen equipment should not touch the floor and should be stored in a plastic bag when not in use. On 05/23/24 at 10:59 AM, Licensed Nurse (LN) H stated respiratory equipment was changed weekly and was stored in a clear plastic bag when not in use. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/23/24 at 11:47 AM, Administrative Nurse D stated all respiratory equipment should be changed as per facility policy. Administrative Nurse D stated respiratory equipment should be stored in a clean plastic bag when not in use. The facility was unable to provide a policy related to sanitary storage of respiratory equipment. The facility failed to ensure R23's nebulizer was stored in a sanitary manner to decrease exposure and contamination. This deficient practice placed R23 at an increased risk of developing respiratory infection.

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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 93 residents. The sample included 22 residents with two reviewed for siderails. Based on observations, record review, and interviews, the facility failed to identify Resident (R) 33's individual risks on R33's side rail assessment. The facility additionally failed to assess R31's side rails for safety prior to use. This deficient practice placed the residents at risk for siderail-related injuries and accidents due to unidentified risks. Findings Included: -The Medical Diagnosis section within R33's Electronic Medical Records (EMR) included diagnoses of dementia (progressive mental disorder characterized by failing memory, and confusion), muscle weakness, urinary incontinence, major depressive disorder (major mood disorder), 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), and repeated falls. A review of R33's Annual Minimum Data Set (MDS) completed 02/09/24 noted a Brief Interview for Mental Status (BIMS) score of three indicating severe cognitive impairment. The MDS indicated he had no functional limitations with his upper and lower extremities. The MDS indicated he used a manual wheelchair for mobility. The MDS indicated he required partial to moderate assistance from staff for bed mobility, transfers, dressing, toileting, and bathing. The MDS indicated he was occasionally incontinent of bowel and bladder. The MDS indicated he had two non-injury falls since his prior assessment. The MDS indicated he had a pressure-reducing device for his bed. T R33's Fall Care Area Assessment (CAA) completed 02/16/24 indicated he was at risk for falls related to his cognitive impairment and fall history. R33's Urinary Incontinence CAA completed 02/16/24 indicated he was at risk for skin breakdown and urinary tract infections (UTIs). The CAA indicated toileting and care interventions would be implemented to maintain or improve his incontinence. R33's EMR under Miscellaneous revealed a Side-Rail/Device Consent Form dated 10/30/20 indicating he had a one-quarter transfer bar added to his bed to assist with repositioning and transferring. The form did not acknowledge R33's pressure-reducing mattress or bolstered overlay. R33's Care Plan created on 09/16/19 indicated he required assistance from one staff for bed mobility, hygiene, transfers, dressing, bathing, and grooming. The plan indicated he had urinary incontinence and required a timed toileting schedule. The plan indicated he had a history of falls. The plan documented fall interventions including a perimeter mattress (added on 11/13/23). (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/23/24 at 08:10 AM an inspection of R33 room revealed his bed was positioned close to the wall. A five-to-six-inch gap was identified between the wall and his bed. R33 had a pressure-reducing bariatric-sized mattress. R33 had a three-quarter-sized bed rail attached to the left outside of his bed. The railing had a five-to-six-inch gap between his pressure-reducing mattress and his bed. LN VV stated she was not sure how often the bed rails were assessed but verified the gaps for the railing and the wall. She stated she would notify Administrative Nurse D. On 05/23/24 at 08:10 AM Licensed Nurse (LN) VV stated she was not sure how often the bed rails were assessed. She stated the rails should be assessed frequently to ensure there were no gaps or holes in the mattresses to prevent entrapment or suffocation. She stated staff should check the position of the railing each shift for holes or gaps. On 05/23/24 at 11:47 AM Administrative Nurse D stated the bed rails should be assessed each time the nurse enters to room for safety and reported if concerns were found. She stated bed rails assessments were completed when the devices were added. She was not sure if the assessments identified special mattresses. The facility's Accidents policy dated 06/2023 indicated the facility strived to make the environment as free from accidents as possible. The policy indicated staff would inspect the risk factors related to bed safety, positioning, lifting, transfers, wandering, and environmental hazards to reduce the risks of accidents occurring. The facility failed to provide a policy related to side rails safety as requested on 05/23/24. The facility failed to identify R33's pressure-reducing mattress and bolstered overlay as possible risks on R33's side rail assessment. This deficient practice placed R33 at risk for preventable accidents related to the use of side rails. 41037 - R31's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of intellectual disabilities, quadriplegia (inability to move the arms, legs, and trunk of the body below the level of an associated injury to the spinal cord), muscle weakness, dysphagia (swallowing difficulty), hemiparesis (muscular weakness of one half of the body), and hemiplegia (paralysis of one side of the body). 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 no staff interview was needed. The Quarterly MDS dated [DATE] documented a BIMS score of one which indicated severely impaired cognition. The MDS documented that R31 required set-up or clean-up assistance with meals. The MDS documented R31 received a mechanically altered diet during the observation period. The MDS documented R31 was dependent on staff assistance for the ability to roll from side to side. R31's Cognitive Loss/Dementia Care Area Assessment (CAA) dated 07/19/23 documented a diagnosis of intellectual disabilities. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R31's Care Plan revised on 04/ 19/24 documented R31 was dependent on one staff member for assistance with bed mobility. R31's Care Plan lacked direction to staff for side rails. R31's EMR under the Assessments tab revealed no risk assessment was completed for side rail use prior to side rails being added to R31's bed. A Nursing: Quarterly or Annual Evaluation dated 04/09/24 revealed a Falls/Bedrails/Restraints assessment that documented no new side rails had been added to R31's bed since the last assessment. The facility was unable to provide any alternatives tried prior to installation of bedrails, a risk for entrapment assessment and documentation of the risk, a documented consent, or risk versus benefit was reviewed by the resident or the resident representative. On 05/21/24 at 08:55 AM R31 lay on her bed with her body leaned to the left side close to the side rails attached to her bed. R31's head of her bed was elevated, and the bedside table was pulled across the bed in front of R31. R31's breakfast tray was on the bedside table with her butter and jelly packages unopened. R31's fingers on both hands had a limited range of motion (ROM- the full movement potential of a joint, usually its range of flexion and extension). On 05/23/24 at 10:00 AM, Administrative Nurse D stated she was unable to locate a risk assessment for the side rails on R31's bed. Administrative Nurse D stated she had learned that maintenance had received a work order to apply side rails to R31's bed on 02/24/24. Administrative Nurse D stated maintenance installed the side rails onto R31's bed on 02/26/24. Administrative Nurse D stated there should have been an assessment prior to the installation of the bedrails. The facility's Accidents policy dated 06/2023 documented the facility would assess environmental hazards and safety risks to ensure ongoing safety reviews to reduce the risks of potential accidents and hazards. The policy noted all equipment would be appropriately utilized and monitored to ensure proper function and conditioning. The policy indicated the facility would provide ongoing education, assessments, and review from the interdisciplinary team. The facility failed to ensure that R31 had a documented risk assessment, a consent for the use of the side rails, and failed to ensure the resident and/or responsible party were advised of the risks and/or benefits of the use of the side rails. This placed the resident at risk for uninformed decisions and impaired safety related to the risks associated with the use of side rails.

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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 93 residents. Based on observation, record review, and interviews, the facility failed to ensure that posted nursing hours included the required information for residents or visitors. Findings included: - A review of the 18 months of posted nursing staffing information provided by the facility lacked evidence of the nursing hours on the following dates: 04/06/24 and 04/07/24. The following dates lacked evidence of the daily census on 05/20/24, 05/21/24, and 05/22/21. On 05/23/24 at 11:47 AM Administrative Nurse D stated that human resources was responsible for posting the daily nursing hours. Administrative Nurse D stated she was not aware the daily posted nursing hours did not include the daily census. The undated facility's Nurse Staffing Posting Information policy is documented it is the policy of this facility to make nurse staffing information readily available in a readable format to residents and visitors at any given time. The Nurse Staffing Sheet would be posted on a daily basis and would contain the following information: facility name, the current date, the facility's current resident census, and the total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift. The facility failed to include required posted nursing staffing information that included the daily census and nursing hours.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. 45668 The facility identified a census of 93 residents. The sample included 22 with one reviewed for dementia care. Based on interviews, record review, and observations, the facility failed to implement effective person-centered dementia (a progressive mental disorder characterized by failing memory, and confusion) care interventions related to Resident (R)1's wandering behaviors. This deficient practice placed R1 at risk for unmet care needs and inability to maintain his highest practicable level of functioning. Findings Included: - The Medical Diagnosis section within R1's Electronic Medical Records (EMR) included diagnoses of dementia, type two diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made or the body cannot respond to the insulin), muscle weakness, major depressive disorder (major mood disorder), and heart failure. R1's Annual Minimum Data Set (MDS) completed 05/01/24 noted a Brief Interview for Mental Status (BIMS) score of three indicating severe cognitive impairment. The MDS noted he had no upper extremity impairments but had lower extremity impairments. The MDS indicated he used a wheelchair and was independent in mobility. The MDS indicated he had a history of physically and verbally aggressive behaviors. The MDS indicated he had wandering behaviors one to three days a week. R1's Dementia Care Area Assessment (CAA) completed 05/01/24 indicated he was at risk for cognitive decline related to his secure cognitive impairment related to his medical diagnoses and memory loss. The CAA noted he had a history of wandering behaviors The CAA indicated a care plan will be implemented to address his cognitive loss. R1's Behavioral CAA completed 05/01/24 indicated he had a history of behaviors including hitting, yelling, kicking, threatening, and cursing. The CAA indicated a care plan will be implemented to address his behaviors. R1's Falls CAA completed 05/01/24 indicated he was at risk for falls related to his needs for assistance and wandering. The CAA instructed staff to monitor him while following current interventions for safety and fall prevention. The CAA indicated a care plan will be implemented to address his safety risks. R1's Care Plan initiated on 04/29/19 indicated he was at risk for falls and behaviors. The plan noted he required extensive assistance from staff for bed mobility, personal hygiene, dressing, transferring, and bathing. The plan noted he used a manual wheelchair and could propel himself. The plan indicated he had a history of behaviors toward other residents. The plan instructed staff to monitor and document his behaviors (05/17/23), provide diversional activities for aggressive behaviors (05/17/23), separate him from his victim (06/26/23), remove environmental triggers 05/17/23), and provide one-to-one supervision upon aggressive episodes (05/17/24). The plan lacked interventions related to R1 wandering into other resident's rooms. The plan did not address wandering behaviors reported in March and April 2024. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's EMR under Progress Notes revealed on 03/20/24 indicated R1 required frequent redirection for wandering, refusal of care, and behavioral concerns while wandering onto different units of the building. The note lacked other behavioral interventions attempted outside of redirection. R1's EMR under Progress Notes revealed on 04/15/23 during the morning time R1 entered another resident's room and was struck in the leg by the other resident's cane. The note lacked attempted behavioral interventions. R1's EMR under Social Service Note revealed on 04/15/23 at 05:13 PM multiple reports from other residents that R1 was attempting to enter other resident's rooms. The note indicated R1 was hit in the shin with another resident's cane during the attempts. R1's EMR under Progress Note revealed on 05/06/24 R1 wandered to the north unit and got into a physical altercation with another resident. The note indicated R1 was placed on one-to-one supervision for the evening. On 05/21/24 at 08:21 AM R1 was wheeled into the dining room for breakfast by his one-to-one staff. R1's wheelchair had a non-slip pad and pressure-reducing cushion. On 05/22/24 at 11:45 AM R28 stated that R1 had a habit of wandering into her room in the evening times. She stated he was confused and believed the room was his and that she would have to call staff to reorient him to his room. She stated he was never aggressive or threatening to her. On 05/23/24 at 10:39 AM Certified Nurse Aide (CNA) P stated R1 currently was on a one-to-one due to his behaviors. She stated that R1 had been known to wander into other resident rooms from time to time. She stated staff would provide redirection for him. She stated R1 had good and bad days. On 05/23/24 at 11:20 AM Licensed Nurse (LN) H stated R1 liked to wander around the building and to the north unit. She stated he would occasionally wander into other resident's rooms when looking for his room. She stated staff were expected to redirect him, offer bathroom breaks, and reorient him to his room. On 05/23/24 at 12:45 PM Administrative Nurse D stated R1 had increased behaviors and the facility was looking into a secured facility for him to transfer. She stated staff were expected to provide supervision, toileting assistance, and redirect him away from other residents he had past issues with. She stated he was on one-to-one supervision due to increased aggressive behaviors. The facility's Dementia Care created 06/2023 indicated residents with dementia will receive the care and services to maintain or attain the highest practicable physical, mental, and psychosocial wellbeing. The policy indicated individualized plans of care will be developed to provide interventions that address cognitive functioning, behavioral symptoms, and physical impairments. The facility failed to implement effective person-centered dementia interventions related to R1's wandering behaviors which provided staff with information on techniques to divert and redirect specific to R1's current or history of interests. This deficient practice placed R1 at risk for unmet care needs to maintain his highest practicable level of functioning.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 41037 The facility identified a census of 93 residents. The sample included 22 residents, four medication carts, and two medication rooms. Based on observation, record review, and interviews, the facility failed to properly label and store medications in two of four medication carts. This placed the residents at risk for adverse outcomes or ineffective medication regimens. Findings included: - On 05/20/24 at 07:14 AM the medication cart on the north unit contained two opened, undated insulin (a hormone that lowers the level of glucose in the blood) pens. On 05/21/24 at 07:01 AM a medication cart on the south unit was unlocked and unattended in the hallway. On 05/20/24 at 07:14 AM, Licensed Nurse (LN) J stated all insulin pens should have an open date listed on the pen once the pen was placed in the medication cart. On 05/23/24 at 11:47 AM, Administrative Nurse D stated all medication carts should be locked when staff walked away from the cart. Administrative Nurse D stated all insulin pens needed to be labeled and dated once the pens had been removed from the refrigerator and placed into the medication cart. The facility's Medication Storage policy dated 06/2023 documented the facility would store all drugs and biologicals in a safe, secure, and orderly manner. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes.) containing drugs and biologicals would be locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others. The facility failed to properly store and label medications which could potentially cause adverse consequences or ineffective treatment to the affected residents.

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F 0775 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep complete, dated laboratory records in the resident's record. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49634 The facility identified a census of 93 residents. The sample included 22 residents. Based on observation, record review, and interviews, the facility failed to ensure that physician-ordered laboratory test results for Resident (R) 26 were included in the clinical record. This deficient practice could result in unnecessary tests and delayed treatment. Findings included: - R26's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of hypertension (HTN-elevated blood pressure), malignant neoplasm of the prostate (cancer that occurs in the prostate), combined systolic and diastolic heart failure (the heart cannot effectively contract with each heartbeat in diastolic heart failure your heart cannot relax between heartbeats), hypertension (HTN-elevated blood pressure), anxiety (an emotion characterized by feelings of tension, worried thoughts, and physical changes), transient ischemic attack (TIA- temporary episode of inadequate blood supply to the brain), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin and urine retention. R26's Significant Change Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) of one, which indicated severely impaired cognition. The MDS documented R26 was dependent on staff for all activities of daily living (ADLs), except eating, R26 needed setup only. R26's Cognitive Loss / Dementia Care Area assessment dated [DATE] documented R26 had a diagnosis of dementia. R26 also had a diagnosis of depression and anxiety. R26 was on hospice for a terminal diagnosis of malignant neoplasm of the prostate. R26 required extra time to answer staff, and he did better with yes or no questions, and simple interactions. R26's Care Plan revised on 02/23/24 documented R26 was admitted to hospice with a diagnosis of malignant neoplasm of the prostate. R26's comfort would be maintained. Staff were to adjust the provision of ADLs to compensate for R26's changing of abilities. Staff were to encourage R26 to participate to the extent he wishes to participate. R26's EMR under the Orders tab revealed the physician order: Check prothrombin time test (PT/INR: a blood test sample to check how fast blood clots blood test), completed by the hospice provider on the day shift every two weeks. R26's clinical record lacked evidence of the results of the physician-ordered laboratory tests. Upon request, the facility was unable to provide PT/INR results from 02/14/24 through 05/23/24. On 05/22/24 at 11:43 AM observation of the hospice book revealed hospice staff drew the blood for the PT/INR and signed off, but the lab results were not in the book. On 05/23/24 at 10:59 AM, Licensed Nurse (LN) H stated the laboratory results would be found in the hospice binder after they were reviewed by the physician. (continued on next page)

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F 0775 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/23/24 at 11:46 AM Administrative Nurse D stated the labs should be in R26's medical record. She stated the medical records personnel scanned the records after the laboratory record was reviewed by the physician. The facility's Laboratory Services policy documented that clinical lab and radiology services were to meet the needs of our residents and were provided by the community. Staff would promptly notify the practitioner of results that fall outside the clinical reference ranges. The facility will file all results in the medical record. The facility failed to ensure current physician-ordered laboratory test results for R26 were included in the clinical record. This deficient practice could result in unnecessary tests and delayed treatment.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 41713 The facility identified a census of 93 residents. The facility had one main kitchen and two dining areas. Based on observation, record review, and interview the facility failed to ensure the director of food and nutrition services had the required qualifications of a certified dietary manager (CDM). This placed residents at risk for unmet dietary and nutritional needs. Findings included: - On 05/21/24 at 11:53 AM Dietary Staff BB stated she had completed her course for a dietary manager and had her test scheduled to get her certification as a dietary manager. Dietary Staff BB stated the dietician used to be at the facility daily, but he moved to a corporate position so now he was only at the facility twice a week. The undated Dietary Services-Staffing policy documented the facility would employ a qualified dietician or other clinically qualified nutrition professionals on a full-time, part-time, or consultant basis. If a qualified dietician or other clinically qualified nutrition professional was not employed full-time, the facility would designate a person to serve as the director of food and nutrition services who: met the requirements as a certified dietary manager, a certified food service manager, or had a similar national certification for food service management and safety from a national certifying body. Had an associate's or higher degree in food service management or in hospitality, if the course of study included food service or restaurant management, from an accredited institution of higher learning. Had two or more years of experience in the position of director of food and nutrition services in a nursing facility setting and had completed a course of study in food safety and management by no later than October 1, 2023, that included topics integral to managing dietary operations including, but not limited, foodborne illness, sanitation procedures, and food purchasing/receiving. The facility failed to ensure the director of food and nutrition services had the required qualifications of a CDM. This placed residents at risk for unmet dietary and nutritional needs.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. 41713 The facility identified a census of 93 residents. The facility had one main kitchen and two dining rooms. Based on observation, record review, and interview, the facility failed to ensure that facility had sufficient staff with the appropriate competencies and skill sets to carry out the functions of the Food and Nutrition Services. This deficient practice resulted in residents' meal service being delayed and and potentially impaired nutrition Findings included: - On 05/20/24 at 06:58 AM Dietary Staff EE was the only dietary staff in the kitchen. Dietary Staff EE stated that the cook was sick or at the hospital and the dietary manager would not get to the facility until later in the morning. On 05/20/24 at 08:12 AM Administrative Nurse D, Dietary Staff EE, and two unidentified staff members were in the kitchen area preparing biscuits and gravy for the residents. On 05/20/24 at 08:15 AM Administrative Nurse D stated she had to step in and help prepare breakfast for the residents due to dietary staff not being available. Administrative Nurse D stated the dietary manager called in due to illness and the dietary cook had to take an ill child to the hospital. Administrative Nurse D stated that the dietary staffing was low and there was no extra staff available to help cover the call-ins. On 05/20/24 at 08:47 AM staff pushed the food cart with food trays that had covered plates on it out into the dining room. At 09:03 AM, the first breakfast meal was served to a resident. On 05/20/24 at 09:00 AM nursing staff came to the dining room and began passing trays out to the residents in the dining room. On 05/20/24 at 12:30 PM approximately 12 residents sat at the dining room tables in the north dining room without any drink available for them. At 12:50 PM, the residents continued to sit at the dining tables in the north dining room without any drinks offered or available for them. At 12:56 PM, dietary staff pushed the drink cart out of the kitchen into the dining room and at 01:00 PM staff entered the dining room to begin pouring and passing drinks out to the residents sitting at the dining tables On 05/20/24 at 01:01 PM, dietary staff pushed the food cart with the food trays on it out of the kitchen and into the dining room. On 05/202/24 at 01:21 PM, nursing staff entered the dining room and began passing food trays out to residents in the north dining room. The meal on the tray was pork loin, peas, and stuffing with gravy. Meal tickets for each resident were on their tray. A review of the facility's posted meal service times listed the following times: Breakfast 08:00 AM to 09:00 AM; Lunch- Noon to 01:00 PM; Dinner- 05:00 PM to 06:00 PM. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 05/22/24 at 02:45 Administrative Nurse D stated nursing staff was responsible for providing residents with drinks at meal times. Administrative Nurse D stated she would not expect the residents to have to sit and wait more than 15 minutes without being offered a drink. Administrative Nurse D stated that dietary staff had been short-staffed the last few days and meal service was delayed a bit due to the shortage. The undated Dietary Services-Staffing policy documented: The facility employs sufficient staff with the appropriate competencies and skill sets to carry out the functions of the Food and Nutrition Services, taking into consideration resident assessments, individual plans of care, and the number, acuity, and diagnoses of the facility's resident population in accordance with the facility assessment. The facility would provide sufficient support personnel to carry out the supportive functions of the Food and Nutrition Services safely and effectively. These functions included but were not limited to Safe and timely meal preparation. Maintaining a clean and sanitary environment. Providing meals and/or supplements in accordance with the resident's needs, preferences, and care plans. The facility failed to ensure sufficient dietary staff was available to carry out the functions of the Food and Nutritional Services. This deficient practice placed the residents at risk of delayed meal service and potentially impaired nutrition.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 41713 The facility identified a census of 93 residents. The facility had one main kitchen and two dining areas. Based on observation, record review, and interview the facility failed to ensure dietary staff prepared food that conserved the nutritive value, flavor, and appearance when preparing pureed foods. This placed two residents at risk of decreased nutritional food value and quality of food. Findings included: - On 05/21/24 at 11:08 AM Dietary Staff CC had the equipment ready for the preparation of the pureed foods. Dietary Staff CC obtained a pan of cooked burger patties from the oven and removed three of the patties and placed them into the Robo Coupe (a machine/food processor that finely chops foods) container. Dietary Staff CC added one cup of prepared cheese sauce to the burger patties. Dietary Staff CC stirred the mixture, poured the mixture into a clean metal container, covered the container with plastic wrap, and placed it into the warmer to keep warm. Dietary Staff CC obtained a clean Robo Coupe container and lid and the pan of green beans from the stove. Dietary Staff CC spooned out three servings and poured them into the container. Dietary Staff CC added an unmeasured amount of broth to the green beans to puree them. Dietary Staff CC scraped the container and poured the pureed green beans into a clean metal storage container and then covered it with plastic wrap and placed it into the warmer. On 05/21/24 at 11:08 AM Dietary Staff CC stated she did not have the recipes for the pureed foods available for this week's food menus as they were not sent with the Week at a Glance recipes and menus. Dietary Staff CC stated that when food was pureed, broth, butter, and milk were some of the things added to the foods when pureed to ensure the nutritive value of the food was not compromised. Dietary Staff CC stated the pureed food should have a smooth texture to it without any lumps so the food would be easily swallowed by someone who had difficulty swallowing solid foods. The Puree Food Preparation policy documented each resident must receive, and the facility must provide food that was prepared by methods that conserve nutritive value, flavor, and appearance. Pureed foods should be prepared in such a manner to prevent lumps or chunks. The goal was a smooth, soft consistency like soft mashed potatoes. Residents receiving puree diets should always receive portions equivalent to those served on the regular or therapeutic diet ordered per facility policy and procedure. Puree Food Preparation Guidelines per serving: For meats add one teaspoon (tsp) of beef broth or beef gravy; for Poultry -add one tsp of chicken broth or chicken gravy; for fish add one tsp of mayonnaise; for noodles add one tsp of margarine; vegetables (leaf, stem, flower) add two tsp of mashed potato flakes; vegetables (root, tuber) add one tsp margarine. The facility failed to ensure dietary staff prepared food that conserved the nutritive value, flavor, and appearance when preparing pureed foods. This placed the affected residents at risk of decreased nutritional food value and quality of food.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41037 The facility identified a census of 93 residents. The sample included 22 residents with five residents reviewed for nutrition. Based on observation, record review, and interviews, the facility failed to ensure Resident (R) 31 was provided with the appropriate textured diet. This deficient practice placed R31 at risk for aspiration (inhaling liquid or food into the lungs). Findings included: - R31's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of intellectual disabilities, quadriplegia (inability to move the arms, legs, and trunk of the body below the level of an associated injury to the spinal cord), muscle weakness, dysphagia (swallowing difficulty), hemiparesis (muscular weakness of one half of the body), and hemiplegia (paralysis of one side of the body). 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 no staff interview was needed. The Quarterly MDS dated [DATE] documented a BIMS score of one which indicated severely impaired cognition. The MDS documented that R31 required set-up or clean-up assistance with meals. The MDS documented R31 received a mechanically altered diet during the observation period. The MDS documented R31 was dependent on staff assistance for the ability to roll from side to side. R31's Nutritional Status Care Area Assessment (CAA) dated 07/19/23 documented that R31 was at risk for alteration in nutrition related to her diagnosis of obesity (excessive body fat). R31's Care Plan dated revised on 09/27/20 documented staff would observe R31 for chewing and swallowing problems. R31's Care Plan revised on 04/25/23 documented R31's diet was regular, mechanical soft with thin liquids. R31's EMR under the Orders tab revealed the following physician orders: Regular diet mechanical soft texture, with a regular thin liquid consistency and lactose-free milk with meals dated 10/01/21. On 05/20/24 at 01:35 PM, R31 lay on her bed with the head of her bed elevated. The bedside table was pulled across the bed in front of R31. R31's lunch tray rested on the bedside table. R31's lunch consisted of a pork cutlet. R31's pork cutlet was uncut and not ground. On 05/23/24 at 09:35 AM Dietary Staff BB stated it was the dietary staff's responsibility to serve the correct diet and food consistency to each of the residents. On 05/23/24 at 10:18 AM, Certified Nurse Aide (CNA) P stated the nursing staff who served a resident a room tray should check the resident's meal ticket to ensure that the diet order was correct. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/23/24 at 10:59 AM, Licensed Nurse (LN) H stated everyone was responsible for ensuring each of the residents received the correct diet. On 05/23/24 at 11:47 AM, Administrative Nurse D stated she expected everyone who delivered a room tray to a resident to review the meal ticket and ensure the resident received the correct diet. The undated facility's Therapeutic Diet Orders policy documented the facility provided all residents with foods in the appropriate form and/or the appropriate nutritive content as prescribed by a physician, and/or assessed by the interdisciplinary team to support the resident's treatment/plan of care, in accordance with his/her goals and preferences. Mechanically Altered Diet was one in which the texture or consistency of food was altered to facilitate oral intake. Examples include soft solids, pureed foods, ground meat, and thickened liquids. Therapeutic diets may be considered in certain situations, such as, but not limited to swallowing difficulty. Dietary and nursing staff are responsible for providing therapeutic diets in the appropriate form and/or the appropriate nutritive content as prescribed. The facility failed to provide the required mechanical soft-textured diet for R31. The deficient practice placed her at risk for aspiration or other adverse consequences.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 41713 The facility identified a census of 93 residents. The facility had one main kitchen. Based on observation, record review, and interview, the facility failed to ensure staff stored, prepared, and served food items with the professional standards for food service safety. This placed the residents at risk of foodborne illness and cross-contamination (the transfer of harmful substances to food). Findings included: - On the initial kitchen tour on 05/20/24 at 06:58 AM, the kitchen floor was dirty with food debris scattered about the floor. In the dishwashing area, there were piles of dirty dishes and kitchen equipment from the previous day that had not been washed. In the walk-in refrigerator area, there was a large plastic container that had approximately 90 bowls of food/fruit with lids on them that were not labeled or dated. The walk-in freezer condenser was iced over. On 05/20/24 at 07:02 AM the Low Dish Machine Temperature Log for May 2024 lacked evidence staff assessed the temperatures for the wash cycle, final rinse, and sanitizer on 05/04/24 both morning and midday, on 05/08/24 evening shift, 05/10/24 morning shift, and 05/11/24 both morning and midday shift. On 05/20/24 at 07:05 AM the clean plates were stored on the dish cart face up. On 05/20/24 at 08:15 AM a refrigerator contained an undated zip lock bag of red peppers and lettuce that had browned dated 05/16/24. On 05/20/24 at 08:58 AM an unidentified staff served a male resident in the North dining room. The staff member carried two coffee cups and a cup of juice to the resident. The staff member held the juice cup from the top, touching the drinking surface. On 05/21/24 at 07:15 AM, Dietary Staff DD did not wear a beard net to cover his facial hair in the food prep area. The walls by the beverage station and entrance had visible holes, The door frame at the wash station into the mop room had missing trim pieces close to the floor with bits of plaster pieces on the floor. The water holding tank under the dishwashing machine was leaking water into the dishwashing area floor and the metal containment around it was rusted. Glass bowls were stored face up on a rack by the serving area. The walk-in cooler door between the walk-in refrigerator and freezer was not latched and the floor was wet; there was an ice chunk formed around the bottom part of the door towards the doorframe. Ice crystals were noted on the condenser and there was ice on the vents and icicle formation on the condenser pipes where fluids were dripping. The walk-in refrigerator had a zip-lock bag of hard-boiled eggs that was not dated There was a peanut butter and jelly sandwich in a bag, dated 05/25/24 [sic]; the jelly had soaked through the bread and the crust was very hard. On 05/21/24 at 07:20 AM the plates in the kitchen area were stored face up in the plate rack. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 05/21/24 at 11:08 AM, Dietary Staff CC failed to perform hand hygiene prior to starting the food preparation of the pureed foods. On 05/21/24 at 11:53 AM, Dietary BB stated the kitchen had a cleaning schedule that was to be followed by each shift. Dietary BB stated she was sick on 05/20/24 as well as the cook so the kitchen was not cleaned up after the night shift on 05/19/24. Dietary Staff BB stated staff should be labeling and dating any food that had been opened. Dietary Staff BB stated staff should wear a hair net and/or beard net if applicable any time they were in the food prep area. Dietary Staff BB stated the facility was in the process of starting some remodeling in the kitchen area and the missing trim and walls were some of the areas to be fixed. Dietary Staff BB stated the facility was in the process of getting more dietary staff hired. The facility did not provide a policy related to food service, preparation, and storage as requested on 05/23/24. The facility failed to ensure staff stored, prepared, and served food items with the professional standards for food service safety. This placed the residents at risk of food-borne illness and cross-contamination.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49634 The facility identified a census of 93 residents. The sample included 22 residents with three reviewed for hospice services. Based on observation, record review, and interviews, the facility failed to ensure a communication process was implemented, which included how the communication would be documented between the facility and the hospice provider, and failed to provide a description of the services and equipment provided to Resident (R) 26 by hospice. This deficient practice created a risk for missed or delayed services and impaired end-of-life care for R26. Findings Included: - R26's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of hypertension (HTN-elevated blood pressure), malignant neoplasm of the prostate (cancer that occurs in the prostate), combined systolic and diastolic heart failure (the heart cannot effectively contract with each heartbeat in diastolic heart failure your heart cannot relax between heartbeats), hypertension (HTN-elevated blood pressure), anxiety (an emotion characterized by feelings of tension, worried thoughts, and physical changes), transient ischemic attack (TIA- temporary episode of inadequate blood supply to the brain), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin) and urine retention. R26's Significant Change Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) of one, which indicated severe cognitive impairment. The MDS documented R26 was dependent on staff for all activities of daily living (ADLs) except eating, R26 needed setup only. R26's Cognitive Loss / Dementia Care Area assessment dated [DATE] documented R26 had a diagnosis of dementia. R26 also had a diagnosis of depression and anxiety. R26 was on hospice for a terminal diagnosis of malignant neoplasm of the prostate. R26 required extra time to answer staff, he did better with yes or no questions, and simple interactions. R26 also took medications for cognition. R26's Care Plan revised on 02/23/24 documented R26 was admitted to hospice with a diagnosis of malignant neoplasm of the prostrate. R26's comfort would be maintained. Staff was to adjust the provision of ADLs to compensate for R26's changing of abilities. Staff were to encourage R26 to participate to the extent he wished to participate. R26's Care Plan lacked direction to staff for collaboration of care and services with the hospice provider which included the services, frequency of visits, medications, and equipment provided by hospice. A review of the communication book provided by the hospice revealed R26 was admitted to hospice services on 02/07/24. The hospice communication book lacked documentation of the services provided by the hospice. On 05/21/24 at 07:42 AM R26 lay in his bed. The bed was in the lowest position. R26 was awake and watching TV. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/22/24 at 08:02 AM R26 was up in his Broda chair (specialized wheelchair with the ability to tilt and recline) waiting for breakfast in the dining room. On 05/23/24 at 10:59 AM Licensed nurse (LN) H stated hospice provided a book and the order for hospice would be in the EMR. LN H said the nursing staff could find what hospice provided and when hospice would be in the facility for each resident in the hospice book. On 05/23/24 at 11:46 AM Administrative Nurse D stated R26's plan of care should include all the services and equipment provided by the hospice provider. Administrative Nurse D stated the hospice provider visits should be placed in the hospice communication for the facility staff to review if needed. The facility's Coordination of Hospice Services policy documents that when a resident chooses to receive hospice care and services the facility will coordinate and provide care in cooperation with hospice staff to promote the resident's highest practical, physical, mental, and psychological well-being. The facility failed to ensure collaboration between the facility and the hospice provider and failed to develop a care plan for both by hospice and the facility that included a description of the services, medication, and equipment provided to R26 by the facility. This deficient practice placed R26 at risk for delayed services or impaired end-of-life care.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Topeka Center for Rehabilitation and Healthcare	2515 SW Wanamaker Road Topeka, KS 66614

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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. 45668 The facility identified a census of 93 residents. The facility identified 21 residents on enhanced barrier precautions (EBP-infection control interventions designed to reduce transmission of resistant organisms which employs targeted gown and glove use during high contact care). Based on record review, observations, and interviews, the facility failed to follow sanitary infection control standards related to following enhanced barrier precautions, hand hygiene, cleaning medical equipment, supplemental oxygen equipment storage, and indwelling catheter maintenance (tube placed in the bladder to drain urine into a collection bag). The facility additionally failed to handle soiled trash in a sanitary manner. These deficient practices placed the residents at risk for infectious diseases. Findings Included: - On 05/20/24 at 07:23 AM an initial walkthrough of the facility was completed. An inspection of the hallway revealed trash bags filled with soiled incontinence products sat directly on the floor outside of Resident (R) 18, R77, and R79's rooms. On 05/20/24 at 07:59 AM R23's oxygen nebulizer mask (a device which changes liquid medication into a mist easily inhaled into the lungs) sat directly on top of her bedside table. No clean storage bag was present. On 05/20/24 at 10:03 AM R89's nebulizer mask and supplemental oxygen face mask rested directly on the floor next to his bed. No clean storage bag was present. On 05/20/24 at 11:19 AM a bag of soiled linens lay directly on the floor in the hallway between R77 and R5's room. On 05/20/24 at 11:23 AM Licensed Nurse (LN) WW checked R78's blood glucose (blood sugar) with a glucometer (instrument used to calculate blood glucose). LN WW donned gloves and entered the room where she placed the glucometer on the chair next to her without placing a clean barrier and prepped the resident. LN WW obtained a blood sample onto the strip in the glucometer and then told R78 the reading while she placed the glucometer on the floor. LN WW administered R78's medication injection into her abdomen then gathered the supplies and left the room. LN WW returned to the medication cart wearing the soiled gloves and placed the glucometer and the medication pen back in the resident's kit bag without sanitizing it. Wearing the same soiled gloves, LN WW opened the drawer to the cart and placed the kit containing the glucometer inside the cart. LN WW shut that drawer, opened another drawer then promptly shut that drawer, removed her soiled gloves, and performed hand hygiene. pen, and medication cart contents. On 05/20/24 at 11:39 AM R39's indwelling urinary catheter drainage bag hung from the back of his wheelchair. The drainage port of R39's urine collection bag lay directly on the floor under his wheelchair as he propelled himself to the physical therapy department. Multiple staff passed the resident in the hall but did not get the tubing and port off the floor. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/21/24 at 07:09 AM the ice machine off the north dining room had tape on the lip of the service area where ice was obtained for resident use. The tape was tattered and lifting in areas with the adhesive side showing. The adhesive side had collected debris and dirt and appeared black and dirty. The dirty surface would not wipe clean after attempts were made. On 05/22/24 at 08:03 AM LN I prepped R14's morning medications to be given enterally (administering medication directly into the gastrointestinal tract when the resident cannot ingest, chew, or swallow through a surgically inserted tube into the stomach). LN I completed hand hygiene and donned gloves but failed to wear a protective gown as required for R14's enhanced barrier precautions. R14's room had enhanced barrier precautions signage and a cart containing the appropriate personal protective equipment (PPE) posted outside her room. On 05/23/24 at 10:38 AM Certified Nurse Aide (CNA) P stated oxygen therapy masks should be stored in a clean bag and never allowed to touch contaminated surfaces. She stated if the tubing or oxygen mask became soiled, she would inform the nurse and change it out. She stated trash bags should be taken to the soiled linen area trash can and discarded. She stated soiled bags should never be left on the floor. She stated indwelling catheter collection bags were usually hung on the back of the resident's wheelchair. She stated the bag should not touch the floor due to the risk of spreading infections and contaminating the environment. CNA P stated that enhanced barrier precautions required staff to complete hand hygiene, put on gloves, and wear a gown when providing direct care for residents at risk. On 05/23/24 at 11:10 AM Licensed Nurse H stated staff were required to follow enhanced barrier precautions when providing direct care to residents with wounds, urinary catheters, stomas (surgical opening in the body), and residents with tube feeding. She stated staff were required to wear gloves and gowns when directly exposed to the exposed area of the body. She stated hand hygiene should be completed before touching, during, and after care. She stated glucometer should be cleaned before and after use. On 05/23/24 at 12:34 PM Administrative Nurse D stated staff were expected to ensure that oxygen therapy equipment, urinary catheters, and masks were stored properly and never placed on contaminated surfaces. She stated the facility should have enhanced barrier precaution signs and PPE bins outside the room of each resident on precautions. She stated the facility held recent in-service training related to enhanced barrier precautions and infection control. She stated staff were expected to follow the facility's posted precautions. She stated staff were expected to clean and sanitize equipment and complete hand hygiene upon contact with contaminated surfaces. A review of the facility's Infection Control and Prevention policy revised 04/2023 noted all resident care devices will be cleaned adequately to prevent the spread of pathogens from objects and in between persons. The policy indicated staff will complete hand hygiene before during and after contact with residents or potentially soiled surfaces. The policy indicated therapy equipment will be stored in a manner that prevents contamination. The policy indicated the facility would ensure clear signage and posted precautions were followed by staff. The policy indicated that shared equipment will be cleaned before and after use or when visibly soiled. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility failed to follow sanitary infection control standards related to enhanced barrier precautions, hand hygiene, cleaning medical equipment, supplemental oxygen equipment storage, and indwelling catheter maintenance. The facility additionally failed to handle soiled trash in a sanitary manner. These deficient practices placed the residents at risk for infectious diseases.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. 49634 The facility identified a census of 93 residents. Based on observation, record review, and interviews, the facility failed to provide Resident (R)30 with a functioning call light system to convey her needs to staff. This deficient practice placed the resident at risk for delayed care and decreased psychosocial well-being. Findings Included: - On 05/20/24 at 11:05 AM a call light check was performed. Inspection of the South hallway revealed no issues with the call light system. An inspection of the North hallway revealed R30's call light was not working in her room. R30's call light stayed on when the button was pushed. R30's call light box was taped with medical tape, and the wires were hanging out of the call light box. On 05/21/24 at 01:31 PM, the TELS (a web-based software for maintenance) work order created by staff on 05/06/24 documented that staff reported that R30's call light was not working. The TELS work order communication documented a priority of critical. On 05/20/24 at 09:59 AM R30 laid in her bed and ate her breakfast She stated her call light had not worked for a while, but she was unsure how long. She stated nursing gave her a cowbell, but she did not think nursing could hear the bell with her door shut. R30 stated nursing checked on her but it seemed like it took a long time. On 05/21/24 at 09:26 AM R30 laid in her bed. She stated she wanted orange juice, but the staff had not been in to check on her yet. R30 stated her call light was still broken, and she did not think the staff heard the cowbell with her door shut. On 05/21/24 at 09:55 Certified Nurse Aide (CNA)P stated R30's call light had not worked for a while. CNA P stated R30 had a cowbell in her room to summon nursing. CNA P stated nursing had been checking on R30 more often. On 05/21/24 at 02:07 PM Maintenance Staff U stated R30's call light was not working a few months ago, so the facility had a company come to the facility and fix all the call lights. Maintenance Staff U stated that R30's light stopped working again on 05/06/24. He stated the facility had called the company to order the part needed but had not received the part needed as of 05/21/24. Maintenance Staff U stated he called and checked up on the part on 05/20/24 and the company said they had not sent the part and had forgotten that they had talked to Maintenance Staff U. He stated the maintenance department had not placed the medical tape around the wires from the call light box. On 05/23/24 at 10:17 AM, CNA M stated R30's call light had not worked for a while. She stated nursing staff checked on her often and she had a cowbell to ring. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/23/24 at 10:59 AM Licensed Nurse (LN) H stated nursing puts a work order if the call lights quit working. LN H said if there were issues with a call light, nursing would check on the resident more often and the resident was given resident a cowbell. On 05/23/24 at 11:46 AM Administrative Nurse D stated if a call light was not working, nursing would put in a work order, and that order went to the maintenance department. Administrative Nurse D stated resident was given a cowbell. The facility was unable to provide a policy for call light systems. The facility failed to provide R30 with a functioning call light system to convey her needs to staff. This deficient practice placed the resident at risk for delayed care and decreased psychosocial well-being.

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F 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop, implement, and/or maintain an effective training program that includes effective communications for direct care staff members. 41037 The facility identified a census of 93 residents. Based on record review and interviews, the facility failed to ensure agency direct care staff had received the required communication training. This placed the residents at risk for impaired care and decreased quality of life. Finding included: - On 05/23/24 at 10:40 AM a review of the training provided by the facility for agency Certified Nurses Aid (CNA) NN, CNA QQ, and CNA RR revealed the following: CNA NN's facility-provided credentialing file lacked documented training completed for communication. The file noted she was provided abuse, neglect, and exploitation (ANE), resident rights, dementia, and infection control training. CNA QQ's facility-provided credentialing file lacked evidence of training completed for communication. CNA RR's facility-provided credentialing file lacked evidence of training completed for communication. On 03/27/24 at 11:47 AM Administrative Nurse D stated human resources or scheduling staff was responsible for ensuring the agency had the correct qualifications but was unsure who was responsible for verifying the agency staff had completed the required communication training. Administrative Nurse D stated some of their contracted agency staff training could be viewed online but with the other agency providers, she was not sure how the facility verified training and if the information was retained anywhere. The facility's Staff Competency policy dated 06/2023 documented all nurse aide personnel would participate in regularly scheduled in-service training classes. Nursing staff would demonstrate competency in skills and techniques necessary to care for the resident's needs, as identified through resident assessments, and resulting plans of care. At a minimum, there should be competency demonstrated, at the appropriate staff level on the following topics, through various tools, such as pre and post-tests, skills lists, and return demonstration for abuse, neglect and exploitation policies and procedures, dementia management, infection control, resident rights, person-centered care, effective communication, basic nursing skills, basic restorative services, skin and wound care, medication management, pain management, identification of changes in condition, and cultural competency. The facility failed to ensure the completion of the required communication training for all staff who provided care in the facility. This placed the residents at risk for impaired care and decreased quality of life.

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F 0942 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that staff members are educated on resident rights and facility responsibilities to properly care for its residents. 41037 The facility identified a census of 93 residents. Based on record review and interviews, the facility failed to ensure agency direct care staff had received the required resident rights training. This placed the residents at risk for impaired care and decreased quality of life. Finding included: - On 05/23/24 at 10:40 AM a review of the training provided by the facility for agency Certified Nurses Aid (CNA) QQ, and CNA RR revealed the following: CNA QQ's facility-provided credentialing file lacked evidence of training completed on resident rights. CNA RR's facility-provided credentialing file lacked evidence of training completed on resident rights. On 03/27/24 at 11:47 AM Administrative Nurse D stated human resources or scheduling staff was responsible for ensuring the agency had the correct qualifications but was unsure who was responsible for verifying the agency staff had completed the required training. Administrative Nurse D stated some of their contracted agency staff training could be viewed online but with the other agency providers, she was not sure how the facility verified training and if the information was retained anywhere. The facility's Staff Competency policy dated 06/2023 documented all nurse aide personnel would participate in regularly scheduled in-service training classes. Nursing staff would demonstrate competency in skills and techniques necessary to care for the resident's needs, as identified through resident assessments, and resulting plans of care. At a minimum, there should be competency demonstrated, at the appropriate staff level on the following topics, through various tools, such as pre and post-tests, skills lists, and return demonstration for abuse, neglect and exploitation policies and procedures, dementia management, infection control, resident rights, person-centered care, effective communication, basic nursing skills, basic restorative services, skin and wound care, medication management, pain management, identification of changes in condition, and cultural competency. The facility failed to ensure the completion of the required resident rights training for staff who provided care in the facility. This placed the residents at risk for impaired care and decreased quality of life.

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. 41037 The facility identified a census of 93 residents. Based on record review and interviews, the facility failed to ensure all direct care staff had received the required abuse, neglect, and exploitation (ANE) training. This placed the residents at risk for abuse, neglect, and exploitation. Finding included: - On 05/23/24 at 10:40 AM a review of the training provided by the facility for agency Certified Nurses Aid (CNA) QQ, and CNA RR revealed the following: CNA QQ's facility-provided credentialing file lacked evidence of training completed for ANE. CNA RR's facility-provided credentialing file lacked evidence of training completed for ANE. On 03/27/24 at 11:47 AM Administrative Nurse D stated human resources or scheduling staff was responsible for ensuring the agency had the correct qualifications but was unsure who was responsible for verifying the agency staff had completed the required training. Administrative Nurse D stated some of their contracted agency staff training could be viewed online but with the other agency providers, she was not sure how the facility verified training and if the information was retained anywhere. The facility's Staff Competency policy dated 06/2023 documented all nurse aide personnel would participate in regularly scheduled in-service training classes. Nursing staff would demonstrate competency in skills and techniques necessary to care for the resident's needs, as identified through resident assessments, and resulting plans of care. At a minimum, there should be competency demonstrated, at the appropriate staff level on the following topics, through various tools, such as pre and post-tests, skills lists, and return demonstration for abuse, neglect and exploitation policies and procedures, dementia management, infection control, resident rights, person-centered care, effective communication, basic nursing skills, basic restorative services, skin and wound care, medication management, pain management, identification of changes in condition, and cultural competency. The facility failed to ensure the completion of the required ANE training for staff who provided care in the facility. This placed the residents at risk for abuse, neglect, and exploitation.

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F 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Include as part of its infection prevention and control program, mandatory training that includes written standards, policies, and procedures for the program. 41037 The facility identified a census of 93 residents. Based on record review and interviews, the facility failed to ensure agency direct care staff had received the required infection control training. This placed the residents at risk for impaired care and decreased quality of life. Finding included: - On 05/23/24 at 10:40 AM a review of the training provided by the facility for agency Certified Nurses Aid (CNA) QQ, and CNA RR revealed the following: CNA QQ's facility-provided credentialing file lacked evidence of training completed for infection control. CNA RR's facility-provided credentialing file lacked evidence of training completed for infection control. On 03/27/24 at 11:47 AM Administrative Nurse D stated human resources or scheduling staff was responsible for ensuring the agency had the correct qualifications but was unsure who was responsible for verifying the agency staff had completed the required training. Administrative Nurse D stated some of their contracted agency staff training could be viewed online but with the other agency providers, she was not sure how the facility verified training and if the information was retained anywhere. The facility's Staff Competency policy dated 06/2023 documented all nurse aide personnel would participate in regularly scheduled in-service training classes. Nursing staff would demonstrate competency in skills and techniques necessary to care for the resident's needs, as identified through resident assessments, and resulting plans of care. At a minimum, there should be competency demonstrated, at the appropriate staff level on the following topics, through various tools, such as pre and post-tests, skills lists, and return demonstration for abuse, neglect and exploitation policies and procedures, dementia management, infection control, resident rights, person-centered care, effective communication, basic nursing skills, basic restorative services, skin and wound care, medication management, pain management, identification of changes in condition, and cultural competency. The facility failed to ensure the completion of the required infection control training for staff who provided care in the facility. This placed the residents at risk for impaired care and decreased quality of life.