STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175183	A. Building B. Wing	07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa St Joseph	11901 Rosewood Overland Park, KS 66209

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 45668 The facility identified a census of 83 residents. The sample included 18 residents with one reviewed for self-administration of medications. Based on observation, record review, and interviews, the facility failed to ensure Resident (R)53 was safe to self-administer her medications. This deficient practice placed R53 at risk for unidentified medication complications and administration errors. Findings Included: -The Medical Diagnosis section within R53's Electronic Medical Records (EMR) included diagnoses of multiple sclerosis (MS- progressive disease of the nerve fibers of the brain and spinal cord), paraplegia (paralysis characterized by motor or sensory loss in the lower limbs and trunk), and obstructive uropathy (structural blockage within the urinary tract blocking urine flow). R53's Quarterly Minimum Data Set (MDS) completed 06/07/24 noted a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. The MDS indicated she was dependent on staff assistance for toileting, bathing, transfers, bed mobility, dressing, and personal hygiene. The MDS indicated she had an indwelling urinary catheter (a tube inserted into the bladder to drain urine). R53's Urinary Catheter Care Area Assessment (CAA) completed 08/17/23 indicated she had a suprapubic urinary catheter (a catheter that enters the bladder through a surgically created hole in the abdomen) related to obstructive uropathy. The plan noted she required staff monitoring for the catheter ostomy site. The CAA instructed staff to provide catheter care and monitor her for urinary tract infections. R53's Functional Abilities CAA completed 08/17/23 revealed she required total staff assistance for bathing, dressing, grooming, personal hygiene, toileting, transfers, and bed mobility. R53's Care Plan initiated 06/04/24 indicated she required assistance with her daily activities of daily living (ADLs). The plan indicated she required staff assistance for toileting, bathing, transfers, bed mobility, and dressing. The plan indicated she had impaired memory, decision-making, and comprehension. The plan lacked documentation indicating she could self-administer her medication safely. R53's EMR under Physician's Orders lacked an order related to medication self-administration. (continued on next page)

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/17/24 at 11:30 AM, upon request, the facility provided a Medication Self-Administration Evaluation completed on 04/09/24. The evaluation noted R53 was deemed unable to safely self-administer her medications. On 07/15/24 at 08:01 AM, R53 sat upward in her bed. Her bed was elevated to the highest position. R53's bedside table was pulled over her lap. Her table contained a cup of water, and two small plastic pill cups filled with numerous medications. She stated she was taking her morning pills. Staff were not present in the room. On 07/17/24 at 10:20 AM Licensed Nurse (LN) J stated R53 should not be taking her medications unsupervised. She stated some residents prefer to eat their meals before taking the medications, but the medication should not left in the room unsupervised. On 07/17/24 at 12:20 PM Administrative Nurse D stated no residents in the facility were currently able to self-administer their own medications. She stated R53 needed supervision while taking her medications and staff were expected to remove the medication from the room upon leaving. The facility's Self-Administration of Medications policy revised 12/2017 indicated the facility will ensure each resident's safety related to the administration of medication. The policy indicated the facility will complete ongoing assessments of individuals identified as safe for self-administration. The policy indicated care planned interventions will be provided to identify the appropriate education and supervision for the administration. The facility failed to ensure R53 was safe to self-administer her medications. This deficient practice placed R53 at risk for unidentified medication complications and administration errors.

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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. 49634 The facility identified a census of 83 residents. The sample included 18 residents with four residents sampled for reasonable accommodations of resident needs and preferences. Based on observation, record review, and interview, the facility failed to ensure that Resident (R)11, R43, and R80 had call lights to call for assistance. The facility further failed to provide footrests for R72's wheelchair. This deficient practice left these residents at risk for impaired care due to unmet care needs. Findings included: - On 07/15/24 at 09:33 AM, R80's call light lay in the middle of her bed. R80 sat in her recliner and the call light was out of her reach. On 07/15/24 at 09:45 AM R43's call light was wrapped around her bed rail, R43 was in her Broda chair (specialized wheelchair with the ability to tilt and recline). R43's call light was out of her reach. On 07/16/24 at 12:09 PM, R11's call light was wrapped around his bed rail. R11 was in his wheelchair eating lunch. R11's call light was out of his reach. On 07/15/24 at 11:48 AM R72 was pushed to the dining room without foot pedals, R72 was pushed fast and her heels hit the floor and bounced back up before staff parked her wheelchair at the dining room table. On 07/16/24 at 11:05 PM, Certified Nurse's Aide (CNA) N stated pedals should be placed on wheelchairs if staff is going to propel the chairs. CNA N stated all call lights should be either on the resident or within the resident's reach. On 07/17/24 at 11:15 PM, Licensed Nurse (LN) I stated all residents should have their pedals on their wheelchairs if staff were pushing them. LN I stated all staff were responsible for call lights being placed where the residents can reach them. On 07/10/24 at 12:29 PM in an interview, Administrative Nurse D stated staff should never push residents without pedals, and call lights should always be within the residents' reach. The facility's Accommodation of Needs policy revised on 12/2017 documented the community's environment and staff behaviors are directed toward assisting the resident in maintaining and or achieving independent functioning, dignity, and well-being. The facility failed to ensure R11, R43, and R80 had call lights for use and failed to provide footrests for R72's wheelchair. This deficient practice placed the residents at risk for impaired care due to unmet care needs.

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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. 41037 The facility identified a census of 83 residents with 18 residents included in the sample. Based on interview and record review the facility failed to issue Center for Medicare/Medicaid Services (CMS) Notification of Medicare Non-Coverage Form 10123 (NOMNC- the form used to notify Medicare A participants of their rights to appeal and the last covered date of participants of potential financial liability when a Medicare Part A episode ends) with the required information for Resident (R)139. This failure placed the resident at risk for decreased autonomy and impaired decision-making. Findings included: - A review of R139's Electronic Medical Record (EMR) documented that the Medicare Part A episode began on 04/10/24 and ended on 04/27/24. R139 did not remain in the facility for custodial care. R139's clinical record lacked evidence of a NOMNC issued for this Medicare Part A episode. On 07/16/24 at 11:40 AM AM Administrative Staff A stated the facility was unable to find the NOMNC issued to R139. The facility did not provide a policy for beneficiary notification. The facility failed to ensure a NOMNC was provided at the end of skilled services for R139. This failure placed the residents at risk for decreased autonomy and impaired decision-making.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41713 The facility identified a census of 83 residents. The sample included 18 residents with four residents sampled for transfer and discharge. Based on observations, record review, and interview the facility failed to provide a written notice of transfer as soon as practicable to Resident (R) 13 and R56 or their representative for their facility-initiated transfers. This deficient practice had the risk of miscommunication between the facility and resident/family and possible missed opportunities for healthcare service for R13 and R56. Findings included: - The electronic medical record (EMR) for R13 documented diagnoses of congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), and dementia (progressive mental disorder characterized by failing memory, confusion). The Significant Change Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of five which indicated severely impaired cognition. R13 required extensive assistance from two staff for activities of daily living (ADLs). The Quarterly MDS dated [DATE] for R13 documented a BIMS score of eight that indicated moderately impaired cognition. R13 utilized a walker and a wheelchair for mobility. R13 required partial to moderate assistance with upper body dressing and substantial to maximal assistance with toileting, bathing, lower body dressing, and personal hygiene. The Discharge MDS dated [DATE] for R13 documented a discharge to an acute hospital with a return anticipated. An Entry MDS dated [DATE] for R13 documented a reentry from an acute hospital. The Discharge MDS dated [DATE] for R13 documented a discharge to an acute hospital with a return anticipated. The Entry MDS dated [DATE] documented a reentry to the facility from an acute hospital. The Discharge MDS dated [DATE] for R13 documented a discharge to an acute hospital with a return anticipated. The Entry MDS dated [DATE] for R13 documented a reentry to the facility from an acute hospital. The ADL Care Area assessment dated [DATE] for R13 documented he was alert and oriented with episodes of confusion. R13 was able to communicate his needs. R13 needed assistance with ADLs. R13 was able to walk with a walker but would forget it at times. R13 had lower extremity weakness and was at risk for falls. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R13's Care Plan dated 04/19/24 directed staff would support R13's plan to stay long term. Staff was directed to assist R13 with adjustments to the facility and routines. A Nursing Note dated 08/18/23 at 03:28 PM for R13 documented him having increased thirst and shortness of air. Staff called R13's physician who ordered the resident to be sent out to the hospital for evaluation. R13's Nurse's Progress Note dated 03/09/24 at 05:27 PM documented R13 was observed in the recliner shaking and trembling. R13 stated he was cold. R13 stated he was not hungry. R13 was noted to be responding to staff inappropriately to questions. Staff called R13's physician and notified him of R13's symptoms and received orders to send R13 to the hospital for evaluation. R13's family was called and notified of the transfer. R13's Nurse's Progress Note dated 04/16/24 at 05:32 PM documented R13 was noted to be shaking. The nurse obtained his vital signs with a noted oxygen saturation of 87 percent (%). At 05:00 PM R13 was noted to be vomiting. R13's physician was notified, and an order was received to send the resident out for evaluation at the hospital. R13's family was notified. R13's Nurse's Progress Note dated 04/16/24 at 07:09 PM documented R13 was admitted to the hospital for aspiration pneumonia (an inflammatory condition of the lungs caused by inhaling foreign material or vomit). The facility was unable to provide, as requested, the required written notification of transfer or discharge for R13's facility-initiated discharge to the hospital on 08/18/23, 03/09/24, or 04/16/23. On 07/15/24 at 11:50 AM R13 propelled himself in his wheelchair to the dining area and visited with other residents in the area. On 07/16/24 at 01:41 PM, R13 rested in a recliner in the commons area with a blanket covering his body and head. On 07/16/24 at 03:22 PM Administrative Staff A stated that only nursing notes had documentation of the discharge. Administrative Staff A stated that the nurses were responsible for notifying the family when a resident was sent out the to hospital but could not state for fact if a written notification or transfer was sent to the resident's representative. On 07/17/24 at 12:27 PM Administrative Nurse D stated that the floor nurses were responsible for notifying the family representative when a resident was sent to the hospital. Administrative Nurse D stated to her knowledge a formal written notification of transfer was not sent to the representative and that the representative would only receive a phone call when a resident was sent out to the hospital. The facility did not have a policy regarding written notification of transfer and or discharge. The facility failed to provide written notice of transfer as soon as practicable to R13 or their representative for their facility-initiated transfers. This deficient practice had the risk of miscommunication between the facility and resident/family and possible missed opportunity for healthcare service for R13. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- The electronic medical record (EMR) for R56 documented diagnoses of diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), dementia (progressive mental disorder characterized by failing memory, confusion), atrial fibrillation (a rapid, irregular heartbeat), and 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). The Significant Change Minimum Data Set (MDS) for R56 dated 05/23/24 documented a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. R56 had impairment on one side of his upper and lower extremities. R56 used a walker to assist with mobility. R56 required partial to moderate assistance from staff for functional abilities. R56 had a history of falls. The Discharge MDS dated [DATE] for R56 documented a discharge to an acute hospital with a return anticipated. The Discharge MDS dated [DATE] for R56 documented a discharge to an acute hospital with a return anticipated. The Entry MDS dated [DATE] for R56 documented a reentry to the facility from an acute hospital. The Discharge MDS dated [DATE] for R56 documented a discharge to an acute hospital with a return anticipated. The Discharge MDS dated [DATE] for R56 documented a discharge to an acute hospital with a return anticipated. The Entry MDS dated [DATE] for R56 documented a reentry to the facility from an acute hospital. The Discharge MDS dated [DATE] for R56 documented a discharge to an acute hospital with a return anticipated. The Entry MDS dated [DATE] for R56 documented a reentry to the facility from an acute hospital. R56's Functional Abilities Care Area Assessment (CAA) dated 05/28/24 documented R56 sustained recent fractures to the face and leg and required assistance with activities of daily living (ADLS). R56 was able to feed himself with setup assistance. R56 was at risk for future falls. R56's Care Plan dated 05/16/24 directed staff that R56 planned to make the community a long-term home through the next review period. Staff was to support R56's plan to stay long-term. Staff was directed to assist R56 with referrals, as needed, to meet goals for discharge. R56's Nurse's Progress Note dated 11/25/23 at 11:03 AM documented the resident was assessed by the physician in the facility at that time due to tremors and delayed responses. R56's physician ordered R56 to be sent out to the hospital for evaluation. Staff called R56's daughter to notify her of the transfer. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R56's Nurse's Progress Note dated 01/15/24 at 12:02 PM documented R56 complained of a headache and requested Imitrex (a medication used to treat migraines and cluster headaches). Staff notified R56's physician of his condition. R56 requested staff to call his daughter to notify her of his condition, and R56's daughter requested that R56 go to the hospital to be evaluated. R56's physician was notified, and the resident was transferred to the hospital. R56's Nurse's Progress Note dated 02/18/24 at 02:44 PM documented that staff noted R56 presented with some confusion and had put his shirt on inside out and on backward. Staff was called by R56's daughter and she requested that the nurse see R56 due to him being confused when she had called him. Staff checked on R56 again noting R56 with his arms and leg frequently jerking. R56 was unaware of the time. Staff called the on-call practitioner, and an order was received to send the resident to be evaluated at the hospital. R56's daughter was called and notified of the transfer. R56's 04/06/24 at 05:16 PM Nurse's Progress Note documented staff noted R56 to be confused and very disoriented. R56's family requested resident be sent out to the hospital. Staff called the on-call doctor, and an order was received to send the resident out to the hospital. R56's 05/02/24 at 06:04 PM Nurse's Progress Note documented R56's daughter had called the facility to notify staff that R56 was on the floor. Staff went to R56's and entered his room and found the resident on the floor in front of his dresser. R56 had noted blood coming from his nose and around his head. Staff immediately called 911. R56 stated he had turned his call light on for the staff to come get his dinner tray. R56 stated he got up from his recliner when the call light had not been answered and walked with the tray to a chair, then walked back to his recliner and attempted to turn around and fell . Emergency medical services (EMS)personnel arrived at the facility and assessed R56. R56 was transported out to the hospital. The facility was unable to provide as requested the required written notification of transfer/discharge for R56's discharges on 11/25/23, 01/15/24, 02/18/24, 04/06/24, and 05/02/24. On 07/16/24 at 08:45 AM R56 sat in the main lobby of the facility with his walker in front of him. R56 stated he was just waiting to go to his appointment this morning. On 07/16/24 at 03:22 PM Administrative Staff A stated that only nursing notes had documentation of the discharge. Administrative Staff A stated that the nurses were responsible for notifying the family when a resident was sent out to the hospital but could not state for fact if a written notification or transfer was sent to the resident's representative. On 07/17/24 at 12:27 PM Administrative Nurse D stated that the floor nurses were responsible for notifying the family representative when a resident was sent to the hospital. Administrative Nurse D stated to her knowledge a formal written notification of transfer was not sent to the representative and that the representative would only receive a phone call when a resident was sent out to the hospital. The facility did not have a policy regarding written notification of transfer and or discharge. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility failed to provide written notice of transfer as soon as practicable to R56 or their representative for their facility-initiated transfers. This deficient practice had the risk of miscommunication between the facility and resident/family and possible missed opportunity for healthcare service for R56.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41713 The facility identified a census of 83 residents. The sample included 18 residents with four residents sampled for transfer and discharge. Based on observations, record review, and interview the facility failed to provide a bed hold notice with the required information to Resident (R) 13 and R56 and/or to their family representative when transferred to the hospital. This deficient practice placed R13 and R56 at risk for impaired ability to return to the facility or his same room. Findings included: - The electronic medical record (EMR) for R13 documented diagnoses of congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), and dementia (progressive mental disorder characterized by failing memory, confusion). The Significant Change Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of five which indicated severely impaired cognition. R13 required extensive assistance from two staff for activities of daily living (ADLs). The Quarterly MDS dated [DATE] for R13 documented a BIMS score of eight that indicated moderately impaired cognition. R13 utilized a walker and a wheelchair for mobility. R13 required partial to moderate assistance with upper body dressing and substantial to maximal assistance with toileting, bathing, lower body dressing, and personal hygiene. The Discharge MDS dated [DATE] for R13 documented a discharge to an acute hospital with a return anticipated. An Entry MDS dated [DATE] for R13 documented a reentry from an acute hospital. The Discharge MDS dated [DATE] for R13 documented a discharge to an acute hospital with a return anticipated. The Entry MDS dated [DATE] documented a reentry to the facility from an acute hospital. The Discharge MDS dated [DATE] for R13 documented a discharge to an acute hospital with a return anticipated. The Entry MDS dated [DATE] for R13 documented a reentry to the facility from an acute hospital. The ADL Care Area assessment dated [DATE] for R13 documented he was alert and oriented with episodes of confusion. R13 was able to communicate his needs. R13 needed assistance with ADLs. R13 was able to walk with a walker but would forget it at times. R13 had lower extremity weakness and was at risk for falls. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R13's Care Plan dated 04/19/24 directed staff would support R13's plan to stay long term. Staff was directed to assist R13 with adjustments to the facility and routines. A Nursing Note dated 08/18/23 at 03:28 PM for R13 documented him having increased thirst and shortness of air. Staff called R13's physician who ordered the resident to be sent out to the hospital for evaluation. R13's Nurse's Progress Note dated 03/09/24 at 05:27 PM documented R13 was observed in the recliner shaking and trembling. R13 stated he was cold. R13 stated he was not hungry. R13 was noted to be responding to staff inappropriately to questions. Staff called R13's physician and notified him of R13's symptoms and received orders to send R13 to the hospital for evaluation. R13's family was called and notified of the transfer. R13's Nurse's Progress Note dated 04/16/24 at 05:32 PM documented R13 was noted to be shaking. The nurse obtained his vital signs with a noted oxygen saturation of 87 percent (%). At 05:00 PM R13 was noted to be vomiting. R13's physician was notified, and an order was received to send the resident out for evaluation at the hospital. R13's family was notified. R13's Nurse's Progress Note dated 04/16/24 at 07:09 PM documented R13 was admitted to the hospital for aspiration pneumonia (an inflammatory condition of the lungs caused by inhaling foreign material or vomit). The facility was unable to provide, as requested, evidence a bed hold notice was provided to R13 when he was discharged to the hospital on 08/18/23, 03/09/24, or 04/16/23. On 07/15/24 at 11:50 AM R13 propelled himself in his wheelchair to the dining area and visited with other residents in the area. On 07/16/24 at 01:41 PM, R13 rested in a recliner in the commons area with a blanket covering his body and head. On 07/16/24 at 03:22 PM Administrative Staff A stated that the social worker had been typically responsible for providing the bed hold to the resident and the representative. Administrative Staff A stated that the facility had not had a social worker for nearly a month, but he had not been able to find any record of bed holds for R13's hospitalization s. The facility policy Bed- Holds and Returns last revised in December 2017 documented at the time of transfer for hospitalization , the nursing facility must provide to the residents and or resident representatives a written notice which specifies the duration for the bed hold. Residents may return to and resume residence in the community after hospitalization . Prior to a transfer, written information would be given to the residents and the resident's representative that explained in detail the duration of the bed hold. The reserve bed payment policy as indicated by the state plan and the details of the transfer (per the Notice of Transfer). The facility failed to provide a bed hold notice to R13 and his representative when transferred to the hospital. This deficient practice placed R13 at risk for impaired ability to return to the facility or his same room. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- The electronic medical record (EMR) for R56 documented diagnoses of diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), dementia (progressive mental disorder characterized by failing memory, confusion), atrial fibrillation (a rapid, irregular heartbeat), and 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). The Significant Change Minimum Data Set (MDS) for R56 dated 05/23/24 documented a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. R56 had impairment on one side of his upper and lower extremities. R56 used a walker to assist with mobility. R56 required partial to moderate assistance from staff for functional abilities. R56 had a history of falls. The Discharge MDS dated [DATE] for R56 documented a discharge to an acute hospital with a return anticipated. The Discharge MDS dated [DATE] for R56 documented a discharge to an acute hospital with a return anticipated. The Entry MDS dated [DATE] for R56 documented a reentry to the facility from an acute hospital. The Discharge MDS dated [DATE] for R56 documented a discharge to an acute hospital with a return anticipated. The Discharge MDS dated [DATE] for R56 documented a discharge to an acute hospital with a return anticipated. The Entry MDS dated [DATE] for R56 documented a reentry to the facility from an acute hospital. The Discharge MDS dated [DATE] for R56 documented a discharge to an acute hospital with a return anticipated. The Entry MDS dated [DATE] for R56 documented a reentry to the facility from an acute hospital. R56's Functional Abilities Care Area Assessment (CAA) dated 05/28/24 documented R56 sustained recent fractures to the face and leg and required assistance with activities of daily living (ADLS). R56 was able to feed himself with setup assistance. R56 was at risk for future falls. R56's Care Plan dated 05/16/24 directed staff that R56 planned to make the community a long-term home through the next review period. Staff was to support R56's plan to stay long-term. Staff was directed to assist R56 with referrals, as needed, to meet goals for discharge. R56's Nurse's Progress Note dated 11/25/23 at 11:03 AM documented the resident was assessed by the physician in the facility at that time due to tremors and delayed responses. R56's physician ordered R56 to be sent out to the hospital for evaluation. Staff called R56's daughter to notify her of the transfer. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R56's Nurse's Progress Note dated 01/15/24 at 12:02 PM documented R56 complained of a headache and requested Imitrex (a medication used to treat migraines and cluster headaches). Staff notified R56's physician of his condition. R56 requested staff to call his daughter to notify her of his condition, and R56's daughter requested that R56 go to the hospital to be evaluated. R56's physician was notified, and the resident was transferred to the hospital. R56's Nurse's Progress Note dated 02/18/24 at 02:44 PM documented that staff noted R56 presented with some confusion and had put his shirt on inside out and on backward. Staff was called by R56's daughter and she requested that the nurse see R56 due to him being confused when she had called him. Staff checked on R56 again noting R56 with his arms and leg frequently jerking. R56 was unaware of the time. Staff called the on-call practitioner, and an order was received to send the resident to be evaluated at the hospital. R56's daughter was called and notified of the transfer. R56's 04/06/24 at 05:16 PM Nurse's Progress Note documented staff noted R56 to be confused and very disoriented. R56's family requested resident be sent out to the hospital. Staff called the on-call doctor, and an order was received to send the resident out to the hospital. R56's 05/02/24 at 06:04 PM Nurse's Progress Note documented R56's daughter had called the facility to notify staff that R56 was on the floor. Staff entered R56's room and found the resident on the floor in front of his dresser. R56 had noted blood coming from his nose and around his head. Staff immediately called 911. R56 stated he had turned his call light on for the staff to come get his dinner tray. R56 stated he got up from his recliner when the call light had not been answered and walked with the tray to a chair, then walked back to his recliner and attempted to turn around and fell . Emergency medical services (EMS)personnel arrived at the facility and assessed R56. R56 was transported out to the hospital. The facility was unable to provide, as requested, evidence a bed hold notice was provided to R56 when he was discharged to the hospital on 11/25/23, 01/15/24, 02/18/24, 04/06/24, and 05/02/24. On 07/16/24 at 08:45 AM R56 sat in the main lobby of the facility with his walker in front of him. R56 stated he was just waiting to go to his appointment this morning. On 07/16/24 at 03:22 PM Administrative Staff A stated that the social worker had been typically responsible for providing the bed hold to the resident and the representative. Administrative Staff A stated that the facility had not had a social worker for nearly a month, but he had not been able to find any record of bed holds for R5613's hospitalization s. The facility policy Bed- Holds and Returns last revised in December 2017 documented at the time of transfer for hospitalization , the nursing facility must provide to the residents and or resident representatives a written notice which specifies the duration for the bed hold. Residents may return to and resume residence in the community after hospitalization . Prior to a transfer, written information would be given to the residents and the resident's representative that explained in detail the duration of the bed hold. The reserve bed payment policy as indicated by the state plan and the details of the transfer (per the Notice of Transfer). The facility failed to provide a bed hold notice to R56 and his representative when transferred to the hospital. This deficient practice placed R56 at risk for impaired ability to return to the facility or his same room.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45668 The facility identified a census of 83 residents. The sample included 18 residents with five reviewed for activities of daily living (ADLs). Based on observation, record review, and interviews, the facility failed to provide assistance for Resident (R)10 and R11 during mealtimes to promote and maintain their highest practicable abilities. This deficient practice placed both residents at risk for impaired nutrition and a decline in their ADLs. Findings Included: - The Medical Diagnosis section within R10's Electronic Medical Records (EMR) included diagnoses of dementia (a progressive mental disorder characterized by failing memory, and confusion), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), left-sided hemiparesis (weakness and paralysis on one side of the body), and insomnia (difficulty sleeping). R10's Quarterly Minimum Data Set (MDS) completed 06/05/24 noted a Brief Interview for Mental Status (BIMS) score of eight indicating moderate cognitive impairment. The MDS indicated she had one-sided impairment of her upper and lower extremities. The MDS indicated she required substantial to maximal assistance for transfers, bed mobility, dressing, toileting, bathing, and personal hygiene. The MDS indicated she required set-up and clean-up assistance for meals. R10's Functional Abilities Care Area Assessment completed 09/29/23 indicated she was at risk for a decline in her ADLs related to her medical diagnoses. The CAA indicated she required extensive assistance with dressing, bathing, toileting, bed mobility, transfers, and grooming. The CAA noted she required set-up assistance for meals. The CAA noted she used a wheelchair for mobility. The CAA noted she used her right arm and right leg to propel herself. R10's Care Plan initiated on 12/27/23 indicated she had impaired memory, decision, and comprehension related to her dementia diagnosis. The plan indicated she required assistance with her ADLs related to her left-sided hemiparesis. The plan indicated she couldn't walk and used her wheelchair for ambulation. The plan indicated she couldn't use her left arm due to weakness and staff were to place all needed items, food utensils, drinks, and food towards her right side for easier reach so she could feed herself. The plan instructed staff to provide finger foods and cut her food up before serving. On 07/15/24 at 12:01 PM, R10 sat in the E Hall dining room. R10 sat in her wheelchair with her left arm draped across her chest. Two other residents at the table were served their meals but R10 had no food or drink. R10's food and drink were served to her 20 minutes after her peers' meals. R10's peers left the dining room, and she was left alone at the table. R10 sat at the table for 20 minutes alone with no staff or peer interaction. Staff failed to engage and provide interaction throughout R10's meal. R10's drink was not touched during her meal. The staff did not cue her to drink during her meal. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/16/24 at 12:05 PM R10 arrived in the dining room and awaited her lunch. At 12:20 PM R10 was served a whole hamburger on a bun and fries. R10 stared at her burger and fries but did not eat it. At 12:44 PM Dietary Staff CC entered the dining hall and asked R10 why she was not eating her meal. Dietary Staff CC then cut up R10's burger for her and she began to eat her meal. R10's water was placed on the left side of her table. R10 attempted several times to reach her water with her right arm but could not. R10 repositioned her wheelchair and stretched outward to finally get her water. On 07/17/24 at 10:20 AM Certified Nurse's Aide (CNA) O stated she felt a lot of the residents had to wait longer for assistance with ADLs because some of the residents with higher acuity (requiring more assistance for care) often took priority. She stated that R10 did require more prompting and cueing due to her dementia. She stated that R10 had left-sided weakness and required items to be placed on her right side. On 07/17/24 at 10:35 AM Licensed Nurse (LN) J stated the resident should be served at the same time but some of the meals were required to come out later depending on what the residents ordered. She stated staff should remain in the dining room to assist the residents with eating. She stated staff should engage with the residents and ensure their needs were met during meal service. On 07/17/24 at 12:32 AM Administrative Nurse D stated staff were expected to provide assistance to all the residents who need it during meal service. She stated the residents should not be left in the dining room to eat alone. She stated all staff had access to the care plan and should know what level of assistance was needed. She stated R10's meal and drinks should be placed toward her right side due to her left-sided weakness. The facility's Assistance with Meals policy revised 11/2019 indicated all residents were encouraged to eat in the dining room for socialization. The policy indicated residents that who required assistance with meals should be provided help as needed. The policy indicated staff will maintain supervision of the residents, engage in cueing, and provide guidance during meals. The facility failed to provide ADL assistance for eating for R10 during mealtime to promote R10s highest practicable ability and independence. This deficient practice placed R10 at risk for impaired nutrition and a decline in ADLs. 49634 - R11's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of hemiparesis (muscular weakness of one half of the body) with cerebrovascular accident (CVA-stroke- sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), hypertension (HTN-elevated blood pressure, and obesity. The Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of nine which indicated moderately impaired cognition. The MDS documented R11 had an impairment of the extremities on one side. The MDS documented R11 needed set-up and clean-up assistance with eating. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R11's ADL Functional/Rehabilitation potential Care Area Assessment (CAA) dated 11/29/23 documented that R11 had a history of right-sided hemiparesis. R11 required extensive to total staff assistance with dressing, bathing, grooming, personal hygiene, and oral care. The MDS documented R11 could feed himself most of the time after the meal was set up. R11's Care Plan date 05/01/24 documented that nursing staff was to assist R11 with meals, placing utensils and cups to the left side for easier reach. R11's plan of care documented nursing staff were to assist R11 with eating if he needed help. On 07/16/24 at 08:34 AM R11 sat in a reclined wheelchair. R11 was eating breakfast that consisted of hot cereal and mandarin oranges. During the observation, R11's spoon was on the floor so R11 was eating his mandarin oranges and hot cereal with his fingers. The nursing staff did not check on R11, who ate in his room by himself. On 07/16/24 at 11:05 PM, Certified Nurse's Aide (CNA) N stated all the nursing staff could check on R11. CNA N stated she would change R11's shirt and ensure he had enough to eat. On 07/16/24 at 12:06 PM Licensed Nurse (LN) H stated nursing should check on R11 more often while he was eating and help him if needed. On 07/17/24 at 12:29 PM, Administrative Nurse D stated staff should check on the residents who eat in their rooms and help if they need assistance. The facility's Assistance with Meals policy revised 11/2019 documented it was the facility's policy that residents shall receive assistance with meals in a manner that meets the individual needs of each resident. The facility failed to ensure R11 received supportive care and services to promote and maintain his quality of life and highest practicable ADL ability when the facility did not ensure R11 had assistance and monitoring while eating. This deficient practice placed the resident at risk for decreased abilities and independence.

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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** 49634 The facility identified a census of 83 residents. The sample included 18 residents with three residents reviewed for treatment/services to prevent/heal pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, because of pressure, or pressure in combination with shear and/or friction). Based on observation, record review, and interviews, the facility failed to ensure pressure-reducing measures were placed on Resident (R) 11 and R80's bilateral lower extremities to prevent pressure ulcers. This placed R11 and R80 at increased risk for pressure ulcer development. Findings Included: -R11's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of hemiparesis (muscular weakness of one half of the body) with cerebrovascular accident (CVA-stroke- sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), hypertension (HTN-elevated blood pressure, obesity, and lymphedema (swelling caused by accumulation of lymph) The Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of nine which indicated moderately impaired cognition. The MDS documented R11 had an impairment to one side. The MDS documented R11 had a Stage 1 (pressure wound which appears reddened, does not blanche, and may be painful but is not open) or greater pressure area or scar over a bony prominence or non-removable dressing or device. The MDS documented R11 was at risk for pressure ulcers. The MDS documented R11 needed substantial to maximal assistance to roll from right to left. R11's Pressure Ulcer/Injury Care Area Assessment (CAA) dated 11/29/23 documented R11 required staff to assist with turning and repositioning every two hours while in his bed and wheelchair. R11 had a pressure-reducing mattress and a pressure-reducing wheelchair cushion. R11 had no skin breakdown noted. The CAA documented R11 had lymphedema in his bilateral extremities. R11's Care Plan dated 05/01/24 documented that staff was to keep pressure off his left elbow and bilateral heels as much as possible. Staff were to monitor for any signs of pressure injury, and report to the physician. R11's plan of care documented that staff were to observe R11's skin for redness; staff were to use pillows to float R11's heels while he was in bed. The Braden Scale (a scale for predicting pressure sore risk) dated 01/29/24 documented a score of thirteen which indicated a moderate risk for pressure wounds. On 07/16/24 at 07:34 AM R11 lay on his bed on his back. R11's heels were directly on the mattress. R11 did not have a pillow to float his heels. On 07/17/24 at 07:01 AM R11 laid on his bed on his back. R11's heels were directly on his mattress. R11 did not have a pillow to float his heels. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/16/24 at 07:55 AM Certified Nursing Aide (CNA) N stated she had noticed R11's heels were not floated She stated she was going to give him a bed bath and get him up for breakfast. CNA N stated she was aware his heels were to be placed on a pillow; she was able to see each resident's information on R11's plan of care. On 07/16/24 at 08:33 Licensed Nurse (LN) H stated she was aware R11's heel should be floated, but she was not assigned to that hall. LN H stated all nursing staff have access to the care plan and can see what is needed for each resident. On 07/17/24 at 12:29 PM Administrative Nurse D stated nursing should follow the care plan, Medication Administration Record (MAR), and the Treatment Administration Record (TAR). She stated if heels should be floated nursing was responsible for ensuring the task was done. The facility's Prevention of Pressure Injuries Protocol revised on 01/2018 documented that pressure injury was usually formed when a resident remains in the same position for an extended period causing increased pressure or a decrease of circulation (blood flow) to that area and subsequent destruction of tissue. The facility failed to ensure that pressure-reducing measures were placed on R11 to prevent pressure ulcers. This placed R11 at increased risk for pressure ulcer development. - R80's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of hemiparesis (muscular weakness of one half of the body) with cerebrovascular accident (CVA-stroke- the sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), hypertension (HTN-elevated blood pressure, dysphagia (swallowing difficulty), weakness, depression (a mood disorder that causes a persistent depression feeling of sadness and loss of interest), and renal failure (inability of the kidneys to excrete wastes, concentrate urine and conserve electrolytes) The Quarterly Minimum Data Set (MDS) dated 06//19/24 R80 documented a Brief Interview of Mental Status (BIMS) score of five which indicated severely impaired cognition. The MDS documented R80 was at risk for developing pressure ulcers. The MDS documented R80 was dependent on staff for all activities of daily living (ADLs). The MDS documented R80 has a pressure-reducing chair and bed. R80's Care Plan dated 07/10/24 documented R80 was at risk for pressure ulcers and other related injuries. R80's plan of care documented staff was to help her keep her heels off the mattress using pillows as R80 would allow. R80's plan of care documented staff to apply heel protectors as ordered. R80's Braden Scale for Prediction Pressure Sore Risk dated 07/10/24 was not complete. R80's EMR under the Orders tab dated 11/12/23 revealed the following physician orders: nursing was to apply Tubi-grips (elasticated tubular bandage designed to provide tissue support in treating strains, sprains, soft tissue injuries, general edema, and tissue protection) to her right lower extremity for swelling. R80's EMR under the Orders tab dated 02/24/24 revealed the following physician's order: Boot to the right lower extremity for heel protector. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/15/24 at 011:44 AM R80 sat in her recliner, R80's flat call light, and her arm splint laid on her bed out of reach. R80's boot was not applied to R80's right lower extremity. R80's boot laid on the floor by R80's bed. On 07/16/24 at 07:01 AM R80 laid in her bed on her back. R80's heels lay directly on her mattress. R80's heels were not floating, and there were no pillows under her feet. R80's EMR under nursing Treatments documented no refusals. On 07/17/24 at 010:50 AM Certified Nurse's Aide (CNA) M stated she was unsure if R80 needed Tubi-grips and a boot or brace. She stated she would assume the resident needed the boot since it was lying on the floor. CNA M stated she was not able to see the plan of care, she did not have a login for the computer system. On 07/17/24 at 10:55 Licensed Nurse (LN) I stated if there was an order for boots and Tubi-grips they should be applied as ordered. LN I stated, nursing was responsible for the Tubi-grips and the boots for R80. On 07/17/24 at 12:09 PM, Administrative Nurse D stated if the care plan or Medication Administration Record or the Treatment Administration Record directed to apply boots or Tubi-grips, the devices should be applied. The facility's Prevention of Pressure Injuries Protocol revised on 01/2018 documented that pressure injury was usually formed when a resident remains in the same position for an extended period causing increased pressure or a decrease of circulation (blood flow) to that area and subsequent destruction of tissue. The facility failed to ensure pressure-reducing measures were placed on R80 to prevent pressure ulcers. This placed R80 at increased risk for pressure ulcer development.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45668 The facility identified a census of 83 residents. The sample included 18 residents with five reviewed for range of motion (ROM) and positioning. Based on observation, record review, and interviews, the facility failed to ensure Residents(R)73 and R44's care planned arm bolsters (specialized devices used for positioning and support) were utilized on their Broda chairs (specialized wheelchair with the ability to tilt and recline). The facility additionally failed to ensure R75 and R11's hand splints were implemented as ordered. This deficient practice placed the residents at risk for a decline in ROM and contractures (abnormal permanent fixation of a joint). Findings Included: -The Medical Diagnosis section within R73's Electronic Medical Records (EMR) included diagnoses of major depressive disorder (major mood disorder), osteoporosis (abnormal loss of bone density and deterioration of bone tissue with an increased fracture risk), hypertension (high blood pressure), and dementia (a progressive mental disorder characterized by failing memory, confusion). A review of R73's Annual Minimum Data Set (MDS) completed 05/08/24 noted a Brief Interview for Mental Status (BIMS) score of four indicating severe cognitive impairment. The MDS indicated she was dependent on staff assistance for toileting, bathing, transfers, bed mobility, dressing, and personal hygiene. The MDS indicated she required staff assistance with meal set-up and clean up. R73's Dementia Care Area Assessment (CAA) completed 05/16/24 indicated she had memory impairment related to her cognitive loss. The CAA noted she had difficulty hearing but could make her needs known. R73's Pressure Injury CAA completed 05/16/24 indicated she was at risk for skin breakdown. The CAA noted she required turning and repositioning every two hours. The CAA noted she used a pressure reduction mattress and wheelchair seat cushion. R73's Care Plan initiated on 06/04/24 indicated she had impaired memory, decision-making, and comprehension related to her dementia diagnoses. The plan indicated she required a Hoyer lift (full-body mechanical lift) and two staff for transfers. The plan noted she required staff assistance with bed mobility, toileting, dressing, and personal hygiene. The plan indicated she used a Broda chair for comfort and positioning. The plan indicated her Broda chair had arm bolsters for positioning. The plan indicated R73 had fragile skin and bruised easily. R73's EMR under Physician's Order revealed no orders related to her arm bolsters. R73's EMR under physical or occupational therapy notes lacked documentation related to her arm bolsters. On 07/15/24 at 07:13 AM R73 was wheeled into the E Hall dining room. R73 was positioned at the rear table facing the empty kitchenette. R73 had geri-sleeves (sleeves placed over arms and legs to protect from injuries) on but her Broda lacked the arm bolsters. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/17/24 at 10:03 AM R73 sat in her Broda chair. R73's Broda chair lacked the arm bolsters. On 07/17/24 at 10:05 AM Certified Nurse's Aide (CNA) O stated she had been in the facility for almost a year and R73's chairs had been switched out. She stated she was not sure what arm bolsters were. She stated didn't remember her having arm bolsters attached to her chair. She stated all staff had access to the care plans and could review the preventative interventions. She stated she would report issues or concerns to the nurse for clarification. She stated she would place pillows, cushions, or apply splints if she was aware that the resident required the supportive devices. On 07/17/24 at 10:25 AM Licensed Nurse (LN) J stated the direct care staff or nurses could apply the bolster directly to the chairs based on the orders from the Treatment Administration Report (TAR). She stated she was not sure about R73's arm bolsters. On 07/17/24 at 12:28 PM, Administrative Nurse D stated she expected supportive devices to be listed on the Medication Administration Record (MAR) or the Treatment Administration Record (TAR) for the nurse to sign off and be responsible for the application or placement of the devices. The facility's Accommodation of Needs policy the facility will ensure the availability and appropriate placement of assistive devices that promote positioning, safety, independence, and dignity. The policy indicated the individual needs and preferences of each resident will be accommodated while maintaining health and safety. The facility failed to implement R73's arm bolsters to her Broda chair as care planned. This deficient practice placed R73 at risk for a decline in ROM and contractures. 41037 - R44's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of cerebral infarction (stroke - the 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), dysphagia (swallowing difficulty), Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), major depressive disorder (major mood disorder which causes persistent feelings of sadness), and severe protein-calorie malnutrition. The Significant Change Minimum Data Set (MDS) dated [DATE] documented R44 had severely impaired cognition. The MDS documented R44 was dependent on staff assistance for positioning. The Quarterly MDS dated [DATE] documented R44 had severely impaired cognition. The MDS documented that R44 was dependent on staff assistance for positioning. R44's Pressure Ulcer Care Area Assessment (CAA) dated 01/09/24 documented she required repositioning. R44's Care Plan dated 12/13/23 documented that staff would reposition R44 as needed when up in her Broda chair (specialized wheelchair with the ability to tilt and recline). The plan of care documented that staff would place arm bolsters (specialized devices used for positioning and support) in her Broda chair for positioning. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/15/24 at 08:10 AM R44 sat upright in her Broda chair. R44's chair did not have arm bolsters. On 07/15/24 at 11:48 AM Certified Nurse Aide (CNA) O pushed R44 into the dining room in her Broda chair. The chair did not have arm bolsters in place. On 07/16/24 at 07:50 AM R44 sat in her Broda chair at the dining room table. R44 did not have arm bolsters on her Broda chair. On 07/17/24 at 10:05 AM, Certified Nurse Aide (CNA) O stated she would place pillows, cushions, or apply splints if she was aware that the resident required supportive devices. CNA O stated she was not sure what arm bolsters were. CNA O stated she was not aware of R44's need for arm bolsters. CNA O stated she had not seen any bolsters for R44 in the past four months that she had taken care of R44. On 07/17/24 at 10:16 AM, agency Licensed Nurse (LN) J stated she was not aware that R44 was care planned to have an arm bolster in her Broda chair for support and positioning. On 07/17/24 at 12:28 PM, Administrative Nurse D stated she expected supportive devices to be listed on the Medication Administration Record (MAR) or the Treatment Administration Record (TAR) for the nurse to sign off and be responsible for the application or placement of the devices. The facility's Accommodation of Needs policy last revised 12/2017 documented the facility would ensure the availability and appropriate placement of assistive devices that promote positioning, safety, independence, and dignity. The policy indicated the individual needs and preferences of each resident would be accommodated while maintaining health and safety. The facility failed to ensure R44's supportive devices were provided for positioning. This deficient practice left R44 at risk for discomfort and a decrease in mobility. - R75's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of hemiplegia (paralysis of one side of the body) affecting the right side, chronic pain, and lack of coordination. The Significant Change Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of one which indicated severely impaired cognition. The MDS documented R75 was dependent on staff assistant for dressing, transfers, and mobility. The MDS documented R75 had functional limitations of range of motion (ROM- the full movement potential of a joint, usually its range of flexion and extension) of her upper and lower extremities on one side. The Quarterly MDS dated ,d+[DATE] documented a BIMS score of four which indicated severely impaired cognition. The MDS documented that R75 had functional limitations of ROM of her upper and lower extremities on one side. The MDS documented R75 was dependent on staff assistance for her activities of daily living. R75's Pressure Ulcer Care Area Assessment (CAA) dated 12/29/23 documented she required the assistance of the staff for repositioning. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R75's Care Plan dated 03/26/24 documented that staff would ensure the hand splint was on her right hand at all times except for showers and hand hygiene for contractures. R75's EMR under the Orders tab revealed the following physician orders: Right-hand splint on at all times, except for shower and hand hygiene per therapy dated 03/26/24. A review of R75's Treatment Administration Record from 07/01/24 to 07/15/24 documented she had her right-hand splint in place 27 out of 30 opportunities including the morning and evening of 07/15/24. On 07/15/24 at 11:13 AM R75 sat in her high back wheelchair asleep in the common area. R75's right lacked a right-hand splint, her right-hand fingers were bent inward, and her right arm rested tightly across her chest area. On 07/16/24 at 07:24 AM R75 sat in her high-back wheelchair in the common area asleep. R75's right hand lacked her hand splint. On 07/16/24 at 01:00 PM, Certified Nurse Aide (CNA) P stated R75 had not worn her right-hand splint at least for the past three months. CNA P stated the splint had caused bruises and discomfort for R75. On 07/16/24 at 01:06 PM, Licensed Nurse (LN) G stated R75 had refused her right-hand splint a few times in the past two or three weeks. LN G stated therapy was aware that R75 had refused to wear her splint. On 07/17/24 at 12:29 PM, Administrative Nurse D stated the splints or device should be on the Medication Administration Record (MAR), or the Treatment Administration Record (TAR), and nursing staff were responsible for ensuring they were applied as ordered or care planned. The facility's Restorative Nursing-Range of Motion Program policy revised 12/17 documented the residents who have or were at risk of having difficulty with ROM were assessed by nursing or therapy for a restorative nursing range of motion program to promote independence and quality of life by improving or maintaining functional ROM. The facility failed to ensure R75 received services and treatment for her multiple contractures to prevent an avoidable reduction of ROM and/or mobility. This deficient practice left R75 at risk for further decline and decreased ROM. 49634 - R11's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of hemiparesis (muscular weakness of one half of the body) with cerebrovascular accident (CVA-stroke- sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), hypertension (HTN-elevated blood pressure, and obesity. The Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of nine which indicated moderately impaired cognition. The MDS documented R11had an impairment to one side. The MDS indicated R11 had therapy during the observation period. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R11's Functional/Rehabilitation Potential Care Area Assessment (CAA) dated 11/29/23 documented R11 had right-sided hemiparesis. R11 required extensive to total staff assistance with dressing, bathing, grooming, personal hygiene, and oral care. R11's Care Plan dated 05/01/24 documented staff to keep R11's fingernails trimmed and the palm of his right hand clean. The plan of care documented staff was to apply a rolled washcloth in R11's right hand as needed. R11's plan of care dated 06/06/24 documented that staff was to apply the right resting hand splint in the morning for approximately eight hours, staff may remove the splint for showers and hand hygiene, then reapply at nighttime. On 07/16/24 at 08:34 AM R11 was sitting up in a reclined wheelchair. R11 was eating breakfast with his left hand, which consisted of hot cereal and mandarin oranges. R11 did not have a splint on his right hand or a rolled washcloth in his right hand. On 07/17/24 at 08:22 AM R11 sat in his reclined wheelchair watching TV. R11 did not have a rolled washcloth in his right hand, or a splint on his right hand. On 07/17/24 at 11:05 AM, Certified Nurse's Aide (CNA) M stated she was not able to see what the plan of care for R11 was and said she was trained by a staff CNA. CNA M stated she was an agency and had been logged out of the facility's system. CNA M stated she had not taken the time to get a new login. CNA M stated she would put the rolled washcloth in R11's right hand. On 07/17/24 at 11:36 AM Licensed Nurse (LN) I stated she was able to see the plan of care for all residents. LN I stated all splints should be applied. On 07/17/24 at 12:29 PM, Administrative Nurse D stated the splints or devise should be on the Medication Administration Record (MAR), or the Treatment Administration Record (TAR), and nursing staff were responsible for ensuring they were applied as ordered or care planned. The facility's Restorative Nursing-Range of Motion Program policy revised 12/17 documented the residents who have or were at risk of having difficulty with ROM were assessed by nursing or therapy for a restorative nursing range of motion program to promote independence and quality of life by improving or maintaining functional ROM. The facility failed to ensure R11's right hand splint or a rolled washcloth was placed in R11's right hand, to prevent his contractures from worsening. This deficient practice left R11 at risk for further decline and decreased range of motion ROM or mobility.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	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** 39752 The facility identified a census of 93 residents. The sample included five residents reviewed for abuse. Based on record review, interviews, and observations, the facility failed to ensure an environment free from avoidable accidents for Resident (R) 72 when staff failed to apply wheelchair pedals to her chair when propelled by staff and failed to use the required amount of staff assistance for transfers to ensure safety. Subsequently, R72 sustained a comminuted (a type of broken bone that is broken in at least two places and are usually caused by severe trauma) distal (away from the farthest point of origin or attachment) left femur (the thigh bone) fracture. This also placed R72 at risk for increased pain and impaired well-being. Findings included: - R72's Electronic Medical Record (EMR), under the Diagnosis tab, recorded diagnoses of need for continuous supervision, aphasia (condition with disordered or absent language function) following cerebral infarction (CVA-stroke- sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain), gastroesophageal reflux (GERD-backflow of stomach contents to the esophagus), hypertension (HTN-high blood pressure), hyperlipidemia (HLD-high cholesterol), atrial fibrillation (Afib-condition with disordered or absent language function), malignant neoplasm (tumor) of skin, and anemia (an inadequate number of healthy red blood cells to carry adequate oxygen to body tissues). The Annual Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of zero which indicated severely impaired cognition. The MDS documented R72 had no impairment of upper and lower body extremities. R72 used a manual wheelchair and required substantial to maximal assistance where the staff did more than half the effort for lower body dressing, upper body dressing, putting on and taking off footwear, personal hygiene, toileting hygiene, and showering or bathing self. R72 was dependent on staff to assist with all transfers. The Activities of Daily Living [ADL] Functional/Rehabilitation Potential Care Area Assessment (CAA) dated 06/12/24 did not trigger. R72's Care Plan documented interventions dated 07/17/23 directing staff that R72 could not walk and needed a wheelchair to help her get around. R72 could propel her wheelchair but might need help with longer distances. An intervention dated 08/01/23 directed staff to ensure R72's bad foot was on the footrest as needed but lacked clarification as to which foot. The intervention dated 08/30/24 directed staff to use a sit-to-stand lift for transfers with the assistance of two staff members. R72's Care Plan dated 09/09/24 documented the resident had a diagnosis of CVA and a fracture of the left distal femur. The plan directed staff R72 could not walk and needed a Broda chair (specialized wheelchair with the ability to tilt and recline) to get around; staff were to assist with the Broda chair. The plan directed R72 required the assistance of two staff using a Hoyer (a full-body mechanical lift) for transfers. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The undated Nursing Report A Hall document described R72's room location, how R72 was transferred, her toileting needs, her route of communication and understanding, and if R72 would use her call light. The document recorded R72 used the sit-to-stand lift for transfers but lacked the number of staff needed to provide this. R72's History and Physical dated 10/30/23 documented an assessment of Afib, GERD, anemia, HTN, HLD, major depressive disorder (MDD), and stroke with aphasia. The plan documented to continue the same medications, monitor for changes, infection, and weight, and provide a supportive environment for the resident. The document was electronically signed on 11/30/23 by Consultant GG. R72's Skin Observation dated 08/29/24 documented that R72 had a scabbed area on her forehead and no other concerns. R72's Nurse's Note dated 08/31/24 at 06:34 PM documented that at approximately 04:45 PM R72's representative arrived and stated that R72 was not lifting her leg to allow the representative to push R72 in her wheelchair. Staff notified Consultant GG who gave orders to send R72 out to the emergency room for evaluation and treatment. R72's Encounter Summary from the hospital documented H&P Notes dated 08/31/24 at 08:36 PM that recorded R72 admitted with a chief complaint of left leg weakness. The Physical Exam section noted R72 had + [positive] edema of the left knee. The summary listed an X-ray Knee 3-View Left section which documented a complete fracture was identified involving the distal femur. There was mild to moderate comminution. There was moderate needle displacement of the distal fracture fragment. There was displacement of approximately 2.5 centimeters (cm); the fracture extended to the knee arthroplasty (a surgical procedure that repairs or replaces a join), a joint effusion (presence of increased fluid in the joint), total knee arthroplasty was identified and vascular calcification (a condition where calcium deposits form in the walls of blood vessels). This was electronically signed by Physician II. The encounter documented an X-ray Femur Left section dated 08/31/24 that documented a distal fracture; no comparison was able to be done. The findings recorded an oblique fracture (a complete break in a bone at an angle) was noted in the distal femoral diaphysis (main or midsection of a long bone) above the knee prosthesis. There was cephalad an anatomical direction that refers to movement towards the head. It is often used in medical terminology to describe the location of body parts) overriding of the distal femur and medial (towards the middle or center) displacement. The section documented a finding of overriding medially displaced oblique fracture of the distal femoral diaphysis above the prosthetic (artificial body part) knee and was signed by Physician JJ. The encounter noted a section CT [computed tomography-a test that uses X-ray technology to make multiple cross-sectional views of organs, bone, soft tissue, and blood vessels] Knee Left without Contrast dated 08/31/24. The section noted the indication for the CT was a fracture. The findings documented there was a complete fracture identified involving the distal femur. The fracture demonstrated mild to moderate comminution. The fracture extended to a knee prosthesis. There was approximately 11 millimeters (mm) overriding of the fracture fragments. There was medial displacement of the distal fracture fragment. A left knee arthroplasty was present. The proximal (nearer to the center or point of attachment) tibia (larger of two bones of the lower leg) and fibula (smaller of two bones of the lower leg) were unremarkable for acute abnormality and there was a joint effusion. This was signed by Physician II. No other issues or abnormalities were documented on the left knee X-ray or CT findings. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R72's Referral/Response Letter from Consultant GG's office documented an encounter dated 09/04/24. The documents recorded R72 was seen by Consultant Nurse Practitioner (NP) KK. The encounter recorded R72 returned from the hospital with a left femur fracture and a hospice consult. The assessment noted R72's left leg was in a brace. R72 had no skin tears, ecchymosis (redness), abrasions, hematomas (collection of blood outside of the blood vessels) or evidence of trauma on the knee or left and right lower extremities. The assessment recorded a left leg closed comminuted intra-articular (in the joint) fracture involving the distal femur extending to the knee prosthesis consistent with an osteoporotic fracture (fractures due to weakened bone density). The encounter listed other diagnoses of Afib, GERD, anemia, HTN, HLD, MDD, and stroke with aphasia. The assessment noted that Consultant NP KK discussed with staff R72's fracture was due to osteoporosis (a disease-causing bones to become porous and weak) because there was no history of a fall or trauma, no evidence of trauma on or fall based on the physical assessment and a history of osteoporosis. The plan directed to monitor for pain and reposition for comfort. The document noted the encounter had not yet been electronically signed. Review of additional Referral/Response Letter from Consultant GG's office documented encounters dated 09/10/24, 09/13/24, and 09/18/24. The assessment on all three encounters noted a left leg closed comminuted intra-articular fracture involving the distal femur extending to the knee prosthesis consistent with an osteoporotic fracture. The encounter listed other diagnoses of Afib, GERD, anemia, HTN, HLD, MDD, and stroke with aphasia. The assessment noted that Consultant NP KK discussed with staff R72's fracture was due to osteoporosis because there was no history of a fall or trauma, no evidence of trauma on or fall based on the physical assessment, and a history of osteoporosis. The plan on 09/10/24 directed to continue current care, monitor for swelling in the leg, and encouraged the family not to sit the resident in an upright position due to pressure on the femur. The plan for 09/13/24 directed to continue current care and monitor for swelling in the leg. The plan for 09/18/24 directed to continue to monitor for comfort, pain, and repositioning and continue with the plan of care. All three encounter visits noted the document had not yet been electronically signed. Licensed Nurse (LN) G's Notarized Witness Statement dated 09/06/24 documented on 08/31/24 at approximately 04:45 PM R72's representative approached the nurses' station and stated concerns related to R72 not lifting her left leg so she could be pushed in the wheelchair. LN G went to assess R72. R72 was wearing shorts and would not lift her left leg. R72's representative had placed a gait belt on R72's leg to attempt to lift R72's leg while a second family member attempted to push R72 in her wheelchair but was unable to. LN G documented that R72 had no visible injuries at that time as there was no bruising or swelling. Certified Nurse Aide (CNA) M's typed interview via phone call dated 09/09/24 at 12:35 PM documented CNA M assisted R72 out of bed and R72 ate breakfast in the dining room and then she went back to her room. R72 then had lunch in the dining room and R72's representative reported R72's leg was not acting normal. R72 was taken to her room and CNA M assisted in changing her clothes and then R72 was sent out [to the hospital]. The Facility's Investigation dated 09/10/24 documented that facility leadership was notified on 09/03/24 by the hospital that R72 had sustained a fracture to her left femur. R72 had no previous falls or incidents reported or noted in the resident's clinical record nor reported by initial staff interviews. The investigation documented the facility concluded the care plan was followed and no abuse had occurred. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an observation on 09/16/24 at 10:10 AM, R72 laid in her bed with her blanket pulled up to her chest. R72 manipulated her blankets but did not respond when her name was called. During an observation on 09/16/24 at 01:10 PM, R72 sat in her Broda chair (specialized wheelchair with the ability to tilt and recline), with her feet raised on the foot pedal, R72's back tilted back and a blanket covered her lap. R72 had her call light pad in her lap within reach. R72 fidgeted during interaction but was not vocal at all. R72 appeared sad and moved her right leg up and down on the foot pedal. During an interview on 09/16/24 at 12:45 PM, CNA N stated when she worked on 08/30/24, R72 appeared to have no concerns with her leg nor had any events that could have caused injury. CNA N stated that if a resident had a concern or if she had noticed R72's leg would not raise and was not acting normally, she would report it to the charge nurse. CNA N stated R72 had no foot pedals for her wheelchair, and when she propelled her on 08/30/24 to the dining room, no foot pedals were used. During an interview on 09/16/24 at 12:54 PM Licenses Nurse (LN) G reported that R72 never had wheelchair pedals for her wheelchair. LN G stated that R72's family reported a concern with her leg when her family arrived to visit R72. LN G further revealed that she received training in July of this year that directed staff that if a resident was going to be pushed by staff, foot pedals needed to be placed on the resident's wheelchair. During an interview on 09/16/24 at 02:27 PM, R72's representative stated R72 was seated in her wheelchair when she arrived to visit with R72. R72's representative stated foot pedals would have been helpful to move R72 safely, as typically R72 had to be asked to raise her feet when anyone pushed R72 in the wheelchair. R72's representative reported that at times R72 would act like her foot would not work and drop it to the floor. R72's representative stated when R72 did that, she would have to stop and talk to R72, and then R72 would raise her foot again. R72's representative stated on 08/31/24 that R72's foot was very strange. R72's representative described R72's left foot as turned in and like a limp wet noodle when she attempted to raise R72's leg. R72's representative revealed that R72's knee was also very swollen and R72's capri pants were not pulled down due to this and it looked like R72 had shorts on. R72's representative stated that R72 never had foot pedals for her wheelchair and R72's family representative had asked for some foot pedal multiple times, but none had ever been found that would fit. R72's representative stated in the past she told the facility when R72 was self-propelling, putting foot pedals on R72's wheelchair would hinder R72 from being mobile she had asked for foot pedals to be used when they visited and would propel R72 on walks outside and in the facility. R72's representative said foot pedals would have been very beneficial for R72. During an interview on 09/16/24 at 03:08 PM, CNA M stated that she worked on 08/31/24 with R72. CNA M reported that she got R72 up that day with the sit-to-stand lift by herself to go to breakfast. CNA M stated she noticed R72's leg did not work when she used the sit-to-stand lift but said had not received anything in report to know if anything had happened with R72 or if this was normal behavior. CNA M stated that R72 did not use foot pedals when R72 was in her wheelchair. CNA M could not recall R72's feet or legs getting caught up when she propelled R72 and said if that happened, she would have reported it to the nurse. CNA M revealed that 08/31/24 was the first day she worked at the facility and that when she came on duty, she was provided a nursing report sheet that told her who to get up and what care each resident needed. CNA M reported she worked on R72's hall by herself, which is why she did not have a second person with her when transferring R72 with the sit-to-stand lift. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 09/16/24 at 03:27 PM, LN H stated that the sit-to-stand transfer should be performed with two staff members, and if a second staff member is not present for the transfer, staff are to locate another staff member or get the nurse for the second staff member to safely perform the transfer. During an interview on 09/16/24 at 03:30 PM CNA O stated the sit-to-stand lift required two staff members for use and if he did not have someone present, CNA O would locate a second staff member to safely transfer the resident. During an interview on 09/16/24 at 03:35 PM Administrative Staff A stated if the resident's care plan called for two staff members for R72's transfer with the sit-to-stand lift, the transfer via lift should have been conducted with two staff members. Administrative Staff A stated CNA M should have had a second staff member present. Administrative Staff A stated if staff pushed a resident and the resident could hold up his or her legs, no foot pedals were needed. Administrative Staff A confirmed the facility had conducted recent audits as part of the corrective actions for the deficiency cited on the annual survey for the lack of foot pedals for R72. The facility's policy Incidents - Accidents dated November 18 documented all staff would be trained upon hire on proper usage of facility equipment. The policy directed that the facility would monitor the effectiveness of the interventions including adequate supervision consistent with the resident's needs, goals, plan of care, and current standards of practice to reduce the risk of an accident. The facility failed to ensure an environment free from avoidable accidents for R72 when staff failed to apply wheelchair pedals to her chair when propelled by staff and failed to use the required amount of staff assistance for transfers to ensure safety. Subsequently, R72 sustained a comminuted distal left femur fracture. This also placed R72 at risk for increased pain and impaired well-being.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa St Joseph	11901 Rosewood Overland Park, KS 66209

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49634 The facility identified a census of 83 residents. The sample included 18 residents with two residents reviewed for catheters (a flexible tube inserted through a narrow opening into a body cavity, particularly the bladder, for removing fluid) and urinary tract infection (UTI-an infection in any part of the urinary system). Based on observation, record review, and interviews, the facility failed to provide appropriate treatment for Resident (R) 11 with an indwelling catheter (a tube inserted into the bladder to drain urine into a collection bag) when the facility failed to prevent the drainage bag tubing from resting on the floor and failed to practice good hand hygiene during catheter care. These deficient practices placed R11 at risk for catheter-related complications. Findings included: - R11's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of hemiparesis (muscular weakness of one half of the body) with cerebrovascular accident (CVA-stroke- sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), hypertension (HTN-elevated blood pressure, and obesity. The Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of nine which indicated moderately impaired cognition. The MDS documented R11 had an impairment of the extremities on one side. The MDS documented R11 was dependent on staff for all toileting hygiene. R11's Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA) dated 11/29/23 documented R11 had bilateral nephrostomy (a passage maintained by a tube or splint) with a diagnosis of kidney stones and obstructive uropathy (a disorder of the urinary tract that occurs due to obstructed urinary flow and can be either structural or functional). R11 was being treated for UTI with intravenous (IV-administered directly into the vein) antibiotics. The CAA documented that staff would help with emptying urine from nephrostomy collection bags. R11 was encouraged to drink fluids. R11's Care Plan date 05/01/24 documented that R11 had an indwelling Foley catheter and a history of UTIs. R11 had a healing surgical wound where his nephrostomy tubes were removed. R11's plan of care documented nursing staff was to empty urine from the drainage bag every shift and as needed (PRN). R11's plan of care documented nursing staff was to keep the drainage bag below the level of his bladder and off the floor. Staff were to secure tubing to R11's leg using a catheter strap. R11's EMR under the Orders tab revealed the following physician's order: Cranberry extract 200 milligrams (mg) capsule, give one capsule by mouth every day for UTI prophylactic dated 05/02/24. R11's EMR under the Orders tab revealed the following physician's order for catheter care: empty the Foley bag every shift, record output, and report any urine abnormalities dated 05/02/24. R11's EMR under the Orders tab revealed the following physician's order: 16 French Foley catheter for obstructive uropathy, dated 05/09/24. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R11's EMR under the Orders tab revealed the following physician's order: Flush the catheter with 60 milliliters (ml) of normal saline everyday shift to prevent catheter complications dated 06/18/24. R11's EMR under the Orders tab revealed the following physician's order: Omnicef (antibiotic) give 300 mg cap twice daily, morning and evening for seven days for UTI dated 07/11/24. On 07/16/24 at 08:34 AM R11 sat in a reclined wheelchair. R11 was eating breakfast that consisted of hot cereal and mandarin oranges. R11's catheter tubing laid on the floor under his wheelchair. 0n 07/17/24 at 08:15AM R11 laid in his bed. CNA M donned gloves, preparing to get R11 up in his wheelchair for breakfast. CNA M placed R11's catheter bag and tubing on his bed. CNA M did not don her personal protective equipment (PPE) or perform any hand hygiene. R11 was on enhanced barrier precautions (EBP). CNA M rolled R11 to the wall, she removed his brief, R11's brief had bowel movement in it. CNA M wiped cleaned R11's backside with wipes, CNA M used a wet soapy washcloth to finish cleaning R11, and dried R11's backside with a towel. CNA M doffed her gloves, did not perform hand hygiene, and doffed her gloves. CNA M washed R11's front peri area with a wipe and used the same towel to try R11's front peri/catheter area. CNA rolled R11 from side-to-side securing clothing and Hoyer (total body mechanical lift) sling. Administrative Nurse E came to R11's room to help with the transfer of Hoyer. Administrative Nurse E and CNA M donned gloves but Administrative Nurse E and CNA M did not perform hand hygiene or don gowns for EHB precautions. Administrative Nurse E held R11's catheter bag, and CNA M transferred R 11. CNA M pushed Hoyer to the hallway and walked away. On 07/16/24 at 11:05 PM, Certified Nurse's Aide (CNA) N stated there should be no part of the catheter tubing touching the floor. CNA stated she was able to search each person's plan of care when she logged into her computer to document. On 07/16/24 at 12:06 PM, Licensed Nurse (LN) G stated R11's catheter tubing should never touch the floor; it could add to complications of UTI. On 07/17/24 at 12:29 PM, Administrative Nurse D stated staff should ensure catheter tubing was off the floor; staff should practice good hand hygiene during catheter and peri-care. The facility's Catheter Care, Urinary policy revised 12/2017 documented that staff should use standard precautions when handling or manipulating the drainage system. The facility failed to provide appropriate treatment for R11 with an indwelling catheter when the facility failed to prevent the drainage bag tubing from resting on the floor and failed to practice good hand hygiene during catheter care. These deficient practices placed these residents at risk for catheter-related complications and further UTIs.

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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 83 residents. The sample included 18 residents with one resident reviewed for dementia (a progressive mental disorder characterized by failing memory, and confusion) care services. Based on observation, record review, and interviews, the facility failed to provide Resident (R)73 with dementia-related care and practices during her mealtimes. This deficient practice placed the R73 at risk for impaired quality of life. Findings Included: - The Medical Diagnosis section within R73's Electronic Medical Records (EMR) included diagnoses of major depressive disorder (major mood disorder), osteoporosis (abnormal loss of bone density and deterioration of bone tissue with an increased fracture risk), hypertension (high blood pressure), and dementia. R73's Annual Minimum Data Set (MDS) completed 05/08/24 noted a Brief Interview for Mental Status (BIMS) score of four indicating severe cognitive impairment. The MDS indicated she was dependent on staff assistance for toileting, bathing, transfers, bed mobility, dressing, and personal hygiene. The MDS indicated she required staff assistance with meal set-up and clean-up. R73's Dementia Care Area Assessment (CAA) completed 05/16/24 indicated she had memory impairment related to her cognitive loss. The CAA noted she had difficulty hearing but could make her needs known. R73's Care Plan initiated on 06/04/24 indicated she had impaired memory, decision-making, and comprehension related to her dementia diagnoses. The plan indicated she required a Hoyer lift (full-body mechanical lift) and two staff for transfers. The plan noted she required staff assistance with bed mobility, toileting, dressing, and personal hygiene. The plan indicated she needed encouragement and cues to participate in groups and activities. The plan indicated she preferred to wake up at 07:00 AM and would need to be invited to group activities. The plan instructed staff to seat her near other residents to allow her to visit. The plan indicated she had depression. The plan noted R73 required set-up assistance and cueing from staff during meals. On 07/15/24 at 07:10 AM R73 was brought to the E Hall dining and positioned next to the rear table facing the unused kitchenette. R73 was alone in the dining room with no provided music or entertainment. R73 was not offered or provided a drink while she sat in the dining room. R73 repeatedly yelled out All right and okay but no staff or residents were in the area to engage with her. On 07/16/24 at 07:05 AM R73 was brought out to the E Hall dining room and positioned facing the unused kitchenette. R73 was alone in the dining room with no provided music or entertainment. R73 was not offered or provided a drink while she sat in the dining room alone. R73 repeatedly yelled out All right and okay but no staff or residents were in the area to engage with her. At 07:50 AM R44 (a severely cognitively impaired resident) was brought into the dining hall and positioned directly across from R73. Neither resident was offered food or drink as staff again left the dining room with both residents alone. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/16/24 at 12:03 AM R73 was wheeled into the dining room E Hall dining room and positioned at the rear table facing the unused kitchenette. R73 was not offered food or drink. R73 repeatedly yelled out All right and Okay but the staff did not talk to her. R73 sat in the dining room while other resident ate their meals. At 12:41 PM Certified Nurse's Aide (CNA) O entered the dining hall and placed R73 and R44's meal trays on the table. CNA O completed hand hygiene and sat down at the table. CNA O flipped the dome covers off both meal trays and prepped R44's meal for her to eat without talking to her. CNA O put a spoonful of R44's food and held it up to her mouth but did not ask her if she wanted a bite. CNA O continued to provide assisted bites without talking or explaining to R73 what she was doing or if she wanted a bite. At 12:50 PM CNA stopped feeding R44 and engaged in a personal conversation with Dietary Staff CC at the assisted table. Upon completion of R73's meal, CNA O briskly wheeled R73 to her room without talking to her. On 07/17/24 at 10:05 AM Certified Nurse's Aide (CNA) O stated the resident should be offered drinks and entertainment while waiting for their meals. She stated staff were expected to talk to the residents while assisting them. She stated the facility held annual in-services for dementia care. She stated residents should not be left unsupervised or alone. She stated the higher acuity residents sometimes take more time than others and often have staff running back and forth. On 07/17/24 at 12:20 PM Administrative Nurse D stated staff were expected to offer drinks, music, television, games, puzzles, and other activities to the residents. She stated the residents should never be left alone or with no one to socialize with. She stated staff should never discuss personal issues or hold conversations in front of the residents. She stated staff focus should be on the residents and what their care needs were. She stated the facility had annual training for dementia care exercises to familiarize staff with how to talk to residents with dementia. The facility's Memory Support' policy revised 05/2025 indicated staff will continue to provide supervision and supportive care to individuals with cognitive impairment. The policy indicated individualized interventions will be implemented and adjusted to address changes in each resident's condition. The facility failed to provide R73 with dementia-related care and practices during her mealtimes. This deficient practice placed the R73 at risk for unmet care needs to maintain their 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 83 residents. The sample included 18 residents with eight medication carts, four treatment carts, and three medication rooms. Based on observation, record review, and interviews, the facility failed to properly store medications in seven of the eight medication carts and four of the four treatment carts. This placed the residents at risk for adverse outcomes or ineffective medication regimens. Findings included: - On 07/15/24 at 07:12 AM the medication cart on C-hall was unlocked and unattended in the hallway. The medication cart contained plastic cups in the top drawer with unlabeled pills in the cups. On 07/15/24 at 07:16 AM the medication cart on B-hall was unlocked and unattended in the hallway. On 07/15/24 at 07:20 AM the treatment carts on F-hallway and G-hall were unlocked and unattended in the hallway. On 07/15/24 at 07:20 AM the medication cart on G-Hall was unlocked and unattended in the hallway. On 07/15/24 at 07:21 AM the treatment cart on E hall was unlocked and unattended in the hallway. On 07/15/24 at 07:22 AM the mediation cart on C-hall was unlocked and unattended in the hallway. On 07/16/24 at 07:12 AM the medication cart and the treatment cart on E-hall were unlocked and unattended in the hallway. On 07/16/24 at 07:34 AM the treatment cart on A-hall was unlocked and unattended in the hallway. On 07/16/24 at 06:50 AM the treatment cart on P-hall was unlocked and unattended in the hallway. On 07/17/24 at 07:37 AM the medication cart on A-hall was unlocked and unattended in the hallway. On 07/15/24 at 07:20 AM, agency Licensed Nurse (LN) K stated the medication carts should stay locked unless the cart was in view. On 07/15/24 at 07:22 AM LN H stated the carts should be locked at all times, and the computer should be off when not in use. On 07/16/24 at 07:12 AM LN J stated the medication cart and the treatment cart should always be locked when not in use. On 07/17/24 at 12:28 PM, Administrative Nurse D stated she expected the nurses to keep the medication carts and the treatment carts locked when not in use. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's Storage of Medications policy last reviewed 01/2024 documented the facility would store all drugs and biological 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 would not be left unattended if open or otherwise potentially available to others. The facility failed to properly store medications which could potentially cause adverse consequences or ineffective treatment to the affected residents.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 49634 The facility identified a census of 83 residents and 13 residents who were on Enhanced Barrier Precautions (EBP-infection control interventions designed to reduce transmission of resistant organisms which employ targeted gown and glove use during high contact care). Based on record review, observations, and interviews, the facility failed to follow sanitary infection control standards related to the handling of soiled laundry, storage of oxygen tubing while not in use, and hand hygiene during catheter (a tube inserted into the bladder to drain urine) care. The facility further failed to follow EBP. These deficient practices placed the residents at risk for infectious diseases. Included Findings: - On 07/15/ 24 at 07:40 AM Resident (R) 51 had a portable oxygen tank with a nasal cannula (a hollow tube used to deliver supplemental oxygen) that was not in use near the entrance of her room. The nasal cannula hung over the portable oxygen tank, there was not a sanitary container for storage of the cannula. On 07/15/24 at 09:07 AM R33's nasal cannula was wrapped around the arm of the wheelchair in her room. The nasal cannula was not stored in a sanitary container. On 07/15/24 at 09:46 AM, an unidentified staff member walked off the E-hallway with unbagged linens pressed up against her upper body. On 07/16/24 at 03:38 PM, a dirty tub of white clothing was in a yellow tub marked dirty laundry. The yellow tub of soiled clothing sat next to clean laundry that was hanging on a rack and hung partly into the soiled bin in the washing area of the laundry room. 0n 07/17/24 at 08:15 AM R11 laid in his bed. Certified Nurse Aid (CNA) M donned two pairs of gloves, preparing to get R11 up in his wheelchair for breakfast. CNA M placed R11's catheter bag and tubing on his bed. CNA M did not don her gown for the EBP nor perform any hand hygiene prior to donning the gloves. CNA M rolled R11 to the wall, removed his brief, and there was bowel movement in the brief. CNA M wiped R11's backside with wipes. Wearing the same gloves, CNA M used a wet soapy washcloth to finish cleaning R11 and dried R11's backside with a towel. CNA M doffed her gloves, did not perform hand hygiene, and donned a clean pair of gloves. CNA M washed R11's front peri area with a wipe and used the same towel to try R11's front peri/catheter area. CNA M rolled R11 from side to side, securing clothing and Hoyer (total body mechanical lift) sling. CNA M doffed her gloves and left the room to get help with R11s transfer. Administrative Nurse E arrived at R11's room to help with the transfer using the Hoyer. Administrative Nurse E and CNA M donned gloves but neither Administrative Nurse E nor CNA M performed hand hygiene before donning gloves and neither wore a gown for EBP. Administrative Nurse E held R11's catheter bag, and CNA M transferred R11. CNA M pushed the Hoyer to the hallway without sanitizing it and walked away. On 07/17/24 at 02:19 PM a laundry tub marked dirty laundry sat in the dirty part of the laundry room without a lid. There was clothing hanging on top of the basket. Dietary Staff BB stated the clothes hanging were clothing that was going to be given away. He stated the facility had nowhere else to store the clothing. Dietary Staff BB stated the dirty clothes tubs should have had lids. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/17/24 at 12:29 PM Administrative Nurse D stated staff are trained on hand hygiene when they are hired, and agency staff have a check-off sheet when they come aboard that includes hand hygiene. She stated oxygen tubing should always be stored in a container when not in use. Administrative D stated staff would know what PPE to wear when taking care of a resident, by the guide provided to them inside the resident's room, with the PPE. The facility's policy for Peri Care, Enhanced Barrier Precautions, and Laundry and Linen documented, that the facility was to provide cleanliness and comfort to the resident to prevent infections skin irritation, and to observe the resident's skin condition. The enhanced barrier precautions documented the community will fully implement the precautions during high-contact resident care activities when caring for residents at risk. The laundry and linen policy directs to separate soiled and clean linen and perform hand hygiene after handling soiled linen and before handling clean linen. The facility failed to follow sanitary infection control standards related to the handling of soiled laundry, hand hygiene storage of oxygen tubing while not in use, catheter care, and EBP. These deficient practices placed the residents at risk for infectious diseases.

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F 0908 Level of Harm - Potential for minimal harm Residents Affected - Many	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41713 The facility identified a census of 83 residents. The facility identified one main kitchen. Based on observation, record review, and interview, the facility failed to ensure the kitchen's walk-in refrigerator and freezer unit was in safe operating condition. Findings included: - Upon inspection of the main kitchen during the initial tour on [DATE] at 07:19 AM observation revealed a blanket and towels on the floor at the base of the walk-in refrigerator and freezer unit. Water was leaking from the unit onto the floor with a stream of water flowing to a drain on the floor. When the door to the walk-in freezer compartment was opened, the light in the unit did not work. A review of the facility's Work Orders Summary report from [DATE] to the present noted that a work order had been turned in on [DATE] by the kitchen for excessive water coming from the walk-in. On [DATE] another work order was submitted to look at the walk-in again due to it leaking water again. On [DATE] a work order was submitted for a leak on the main kitchen walk-in. On [DATE] at 09:45 Dietary Staff AA stated that there was a leak in the wall between the refrigerator compartment and the freezer compartment. Dietary Staff AA stated that he had been told by Administrative Staff A that a repairman would be at the facility to fix the leak sometime this week. Dietary Staff AA stated he had turned in a work order to maintenance about a month ago or so. On [DATE] at 10:33 AM Administrative Staff A stated he was aware that work orders had been submitted by the kitchen for the walk-in unit leaking. Administrative Staff A stated the current owner's corporate office had been notified as well but they had not yet remedied the situation due to the change of ownership coming at the end of this month. The facility, upon request, did not provide a preventative maintenance policy. The facility failed to maintain mechanical equipment in safe operating condition.