STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175184	A. Building B. Wing	07/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pinnacle Park Nursing & Rehab Center	2936 Georgia Avenue Salina, KS 67401

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 45668 The facility had a census of 56 residents. The sample included 14 residents. Based on observation, record review, and interview, the facility failed to revise Resident (R)5's Care Plan to reflect her Hoyer lift (total body mechanical lift) transfer requirements. This deficient practice placed R5 at risk for impaired care due to uncommunicated care needs. Findings Including: - The Medical Diagnosis section within R5's Electronic Medical Records (EMR) included diagnoses of heart failure, cerebrovascular disease, major depression (major mood disorder), cognitive-communication disorder, abnormalities of gait, muscle weakness, and unsteadiness of her feet. R5's Quarterly Minimum Data Set (MDS) completed 06/21/24 noted a Brief Interview for Mental Status (BIMS) score of 13 indicating mild cognitive impairment. The MDS indicated she was dependent on staff for bed mobility, transfers, toileting, dressing, bathing, and personal hygiene. The MDS indicated she was at risk for falls. The MDS noted she had two non-injury and one minor injury fall since her last assessment. R5's Functional Abilities Care Area Assessment (CAA) completed 09/26/23 indicated she required staff assistance with most of her activities of daily living (ADLs). The CAA indicated the facility will provide care-planned interventions to reduce the risks related to ADL decline. R5's Falls CAA completed 09/26/23 indicated she was at risk for falls related to her medical diagnoses and impaired balance. The CAA indicated the facility will provide care-planned interventions to reduce the risks related to ADL decline. (continued on next page)

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

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R5's Care Plan initiated 11/12/23 indicated she required assistance with her ADLs related to her medical diagnoses and weakness. The plan indicated she required substantial to maximal assistance from staff for bathing, toileting, bed mobility, transfers, personal hygiene, and dressing. The plan indicated she used a high-back reclining wheelchair for mobility. The plan indicated she was at risk for falls. The plan instructed staff to anticipate her needs, ensure her call light was within reach, and ensure her environment remained free from spills or clutter. On 11/08/22 R5's plan indicated staff received education on transporting her in a shower chair related to a fall that occurred on 10/29/22. On 01/09/24 R5's plan was updated for fall interventions to show verbal education was provided to a bath aide to ensure R5's chair remained close while bathing for a fall that occurred on 12/28/23. On 06/03/24 R5's plan was updated to use two staff members if the resident needs to stand longer than a pivot. R5's plan lacked indication she required a Hoyer lift for transfers. On 07/23/24 at 08:00 AM R5 sat in her recliner in her room. Her call light was within reach. R5's wheelchair sat next to her bed. Her wheelchair had an auto-lock mechanism installed on it. R5 had bruising around her eyebrows and upper nose. She stated it occurred during a fall. On 07/24/24 at 08:21 AM an inspection of R5's room revealed a Hoyer lift was left placed in her room directly in front of her bed. On 07/24/24 at 10:05 AM CNA MM stated R5 was a high fall risk related to her weakness and inability to know her limitations. She stated R5 required two staff and a Hoyer lift after falling multiple times during care. She stated all direct care staff had access to view the care plans. She stated R5's Hoyer lift transfer requirements should be listed in the care plan. On 07/24/24 at 10:30 AM LN G stated R5 required two staff and a Hoyer lift for transfers due to her recent decline. She stated the care plans indicate the levels of assistance and transfer type for each resident. On 07/24/24 at 11:19 AM Administrative Nurse D stated that R5's ability to assist during care recently declined due to her weakness and physical limitations. She stated R5 required a total mechanical lift due to her inability to safely transfer. She stated that R5's plan of care indicated she was a total mechanical lift. She stated the care plans could be updated by all staff by reviewed by the interdisciplinary team. She stated fall interventions should be implemented within 48 hours of a fall or incident and revised on the care plans. The facility's Care Plan Revisions policy implemented 01/2020 indicated the facility will ensure each resident's care plan will be initiated and revised to reflect the resident's comprehensive care needs. The policy indicated the facility's interdisciplinary team will review and collaborate to provide interventions that meet the resident's care needs. The facility failed to revise R5's care plan to reflect her Hoyer lift transfer requirements. This deficient practice placed R5 at risk for impaired care due to uncommunicated care needs.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 45668 The facility had a census of 56 residents. The sample included 14 residents with seven residents reviewed for accidents and/or hazards. Based on observation, record review, and interview, the facility failed to ensure safe care practices were followed during staff-assisted care resulting in multiple preventable falls for Resident (R)5. This deficient practice placed R5 at risk for further falls and injuries. Findings Including: - The Medical Diagnosis section within R5's Electronic Medical Records (EMR) included diagnoses of heart failure, cerebrovascular disease, major depression (major mood disorder), cognitive-communication disorder, abnormalities of gait, muscle weakness, and unsteadiness of her feet. R5's Quarterly Minimum Data Set (MDS) completed 06/21/24 noted a Brief Interview for Mental Status (BIMS) score of 13 indicating mild cognitive impairment. The MDS indicated she was dependent on staff for bed mobility, transfers, toileting, dressing, bathing, and personal hygiene. The MDS indicated she was at risk for falls. The MDS noted she had two non-injury and one minor injury fall since her last assessment. R5's Functional Abilities Care Area Assessment (CAA) completed 09/26/23 indicated she required staff assistance with most of her activities of daily living (ADLs). The CAA indicated the facility will provide care-planned interventions to reduce the risks related to ADL decline. R5's Falls CAA completed 09/26/23 indicated she was at risk for falls related to her medical diagnoses and impaired balance. The CAA indicated the facility will provide care-planned interventions to reduce the risks related to ADL decline. R5's Care Plan initiated 11/12/23 indicated she required assistance with her ADLs related to her medical diagnoses and weakness. The plan indicated she required substantial to maximal assistance from staff for bathing, toileting, bed mobility, transfers, personal hygiene, and dressing. The plan indicated she used a high-back reclining wheelchair for mobility. The plan indicated she was at risk for falls. The plan instructed staff to anticipate her needs, ensure her call light was within reach, and ensure her environment remained free from spills or clutter. On 11/08/22 R5's plan indicated staff received education on transporting her in a shower chair related to a fall that occurred on 10/29/22. On 01/09/24 R5's plan was updated for fall interventions to show verbal education was provided to a bath aide to ensure R5's chair remained close while bathing for a fall that occurred on 12/28/23. On 06/03/24 R5's plan was updated to use two staff members if the resident needs to stand longer than a pivot. R5's Fall During Staff Assist report completed 10/29/22 indicated R5 fell while Certified Nurses Aid (CNA) LL assisted her in the shower room. The report indicated R5's shower chair had tipped while a CNA LL attempted to provide her with a shower resulting in R5 falling to the floor. The report indicated no injuries occurred during the fall episode. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R5's Fall During Staff Assist report completed 12/28/23 indicated R5 fell while CNA KK assisted with undressing her in the shower room. The report indicated R5 reported she needed to sit and could no longer stand. The report indicated the shower chair was not in reach and R5 had to be assisted to the ground. The report indicated R5 had to be laid flat on the grab and lifted with a full lift (Hoyer lift- total body mechanical lift). R5's Fall During Staff Assist report completed 05/30/24 indicated R5 fell during staff bathroom care. The report indicated R5 was standing in the bathroom holding onto the railing. The note indicated CNA T was performing care on her and R5 began to fall. The report indicated that CNA T was unable to hold R5 up and she fell backward against the staff member and then lowered to the ground. The report indicated no injuries occurred during the fall episode. R5's Fall During Staff Assist report completed 07/02/24 indicated R5 fell during staff-assisted toileting. The report indicated R5 stood and held onto the handrail in her bathroom as CNA T unfastened her brief. The report indicated R5 fell against the CNA T and then to the floor. The report indicated CNA T attempted to lift R5 back up to a standing position resulting in a second fall to the floor landing on her bottom and then right side. The note indicated R5 received a bump and bruise around her right eyebrow. No interventions were implemented related to this fall episode. R5's EMR under Progress Notes revealed a nursing note completed on 07/06/24. The note indicated the nurse walked into R5's room and found her on the floor in front of her recliner. The note indicated two direct care staff had attempted to change her incontinence brief and she slid down to the floor. The note indicated no injuries occurred during the fall episode. The report indicated R5 had to be laid flat on the ground and lifted with a full lift. The facility could not provide a fall investigation for this fall incident as requested. R5's Fall During Staff Assist report completed 07/14/24 indicated R5 fell while in her room. The report indicated R5 was pushed in her wheelchair by CNA NN and parked next to her recliner. The report indicated CNA NN left the room to get a bed pad for R5's recliner. The report indicated R5 stood up as CNA NN reentered the room. The report indicated CNA NN attempted to assist but R5 fell face-first into the recliner. The note indicated CNA NN attempted to lift R5 to a standing position but resulted in an assisted fall to the ground. The report indicated R5 had to be lowered to a lying position and transferred to the bed with a full mechanical lift. The report indicated no injuries occurred during the fall episode. No fall interventions were implemented. On 07/23/24 at 08:00 AM R5 sat in her recliner in her room. Her call light was within reach. R5's wheelchair sat next to her bed. Her wheelchair had an auto-lock mechanism installed on it. R5 had bruising around her eyebrows and upper nose. She stated it occurred during a fall. On 07/24/24 at 10:05 AM CNA MM stated R5 was a high fall risk related to her weakness and inability to know her limitations. She stated R5 required two staff and a Hoyer lift after falling multiple times during care. She stated R5 would often fall and had to be supervised closely during transfers and care. She stated R5 had weakness standing up and should not be left standing for long periods of time. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/24/24 at 10:30 AM LN G stated R5 required two staff and a Hoyer lift for transfers due to her recent decline. She stated R5 was at a risk for falls and was to be watched closely for care and attempts at standing from her wheelchair. She stated staff were to provide reminders and redirection for her to wait for staff assistance during transfers. On 07/24/24 at 11:19 AM Administrative Nurse D stated that R5's ability to assist during care recently declined due to her weakness and physical limitations. She stated R5 required a total mechanical lift due to her inability to safely transfer. She stated staff should be closely monitoring her during care and attempt to intervene during fall episodes. She stated the facility attempted to promote independence during care, but R5's functional abilities had gotten progressively worse. The facility's Accidents and Supervision (undated) indicated the facility would ensure each resident will be comprehensively assessed for safety and falls. The policy indicated the facility will provide sufficient staff and supervision to reduce the risks of falls and accidents. The facility failed to ensure safe care practices were followed during assisted care resulting in multiple falls for R5. This deficient practice placed R5 at risk for further falls and injuries.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45668 The facility reported a census of 56 residents. The sample included 14 residents with two reviewed for bowel and bladder incontinence. Based on record review, observations, and interviews, the facility failed to implement individualized toileting interventions to improve Resident (R)17's bowel and bladder incontinence or prevent worsening based on his incontinence evaluation. This deficient practice placed R17 at risk for complications related to incontinence. Findings Included: - The Medical Diagnosis section within R17's Electronic Medical Records (EMR) included diagnoses of legal blindness, muscle weakness, stiffness to his right knee, unsteadiness on his feet, and lack of coordination. A review of R17's Quarterly Minimum Data Set (MDS) completed 05/20/24 noted a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. The MDS indicated he required partial to moderate assistance with personal hygiene, toileting, and dressing. The MDS indicated his vision was severely impaired. The MDS indicated he was frequently incontinent of bladder and occasionally incontinent of bowel with no toileting program. The MDS indicated he was at risk for skin breakdown and pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction). The MDS noted he had pressure-reducing devices for his bed and chair. R17's Functional Abilities Care Area Assessment (CAA) completed 09/15/23 indicated he required assistance from staff for his activities of daily living (ADLs) related to his impaired gait, muscle weakness, and visual impairment. The CAA indicated the facility will provide care-planned interventions to reduce the risks related to ADL decline. R17 Urinary Incontinence CAA was not triggered for incontinence. R17's Care Plan initiated on 11/12/23 indicated he required assistance with his ADLs. The plan indicated he required assistance with toileting transfers. The plan indicated he was at risk for skin impairment related to bowel and bladder incontinence. The plan instructed staff to provide checks and changes to maintain dignity for urinary incontinence. The plan lacked interventions related to R17's occasional bowel incontinence. The plan instructed staff to provide peri-care after incontinence episodes. The plan lacked individualized interventions to maintain and promote R17's highest level of functioning related to incontinence. R17's EMR revealed a Bowel and Bladder assessment dated [DATE]. The assessment indicated he was incontinent of both bladder and bowel. The assessment indicated he could communicate his needs. The assessment indicated his urinary incontinence was new. The assessment noted he could void correctly without incontinence but was incontinent at least once daily. The assessment indicated he was appropriate for a toileting program and a good candidate for self-toileting. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R17's EMR under Tasks revealed he had numerous episodes of bowel and bladder incontinence throughout the month of July 2024. On 07/22/24 at 10:23 AM R17 sat in his recliner in his room. R17's sensory cane rested on his television dresser across the room from him. R17 stated he received staff assistance during care but often would take himself to the restroom. He was not sure if he was placed on a toileting program but stated he often had incontinence. On 07/24/24 at 10:20 AM Certified Nurse Aide (CNA) R said most of the residents were toileted upon request or asked during care interactions. She stated the care plan should include individualized toileting interventions for some residents with incontinence. She stated she was not sure if R17 required a toileting program or interventions. She stated R17 could take himself or he asked to be taken to the restroom. On 07/24/24 at 10:31 AM Licensed Nurse (LN) G stated all residents were screened upon admission for bowel and bladder. She stated toileting interventions should be implemented on residents noted to be appropriate. She stated the care plan should be updated to reflect the toileting interventions. She stated she was not sure if R17 was provided toileting interventions or on a toileting program. On 07/24/24 at 11:19 AM Administrative Nurse D stated each resident was screened for incontinence upon admission, quarterly, annually, and anytime a change of condition occurred related to bowel and bladder. She stated the admission nurse would report the evaluation findings to the interdisciplinary team and individualized interventions would be implemented as needed. She stated each resident should be offered toileting frequently throughout the day and provided preventative skin care. The facility's Incontinence policy revised 09/09/20 indicated all residents assessed for bowel and bladder incontinence will be provided the appropriate treatment and services to prevent infections and improve incontinence to the highest extent possible. The facility failed to implement individualized toileting interventions to improve and/or maintain R17's bowel and bladder function based on his incontinence evaluation. This deficient practice placed R17 at risk for complications related to incontinence.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. 41037 The facility identified a census of 56 residents. The sample included 14 residents and five Certified Nurse Aides (CNA) were reviewed for performance evaluations and the associated in-service training. Based on record review and interview, the facility failed to ensure five of the five CNA staff reviewed had the required yearly performance evaluations completed. This placed the residents at risk for inadequate care. Findings included: - A review of the facility's staffing list revealed the following CNAs were employed with the facility for more than 12 months: CNA 0, hired on 08/27/21, had no yearly performance evaluations upon request. CNA P, hired on 08/04/20, had no yearly performance evaluations upon request. CNA Q, hired on 12/12/22, had no yearly performance evaluations upon request. CNA R, hired on 02/21/22, had no yearly performance evaluations upon request. CNA S, hired on 05/27/23, had no yearly performance evaluations upon request. On 07/23/24 at 04:04 PM, Administrative Nurse D stated the facility was not currently up to date on performance evaluations for CNAs and said a performance plan was implemented recently to address the situation. The facility's Evaluation Process policy dated 12/01/19 documented it was the policy of the facility to review the work performance of employees with a formal written evaluation annually. The facility failed to ensure the five CNA staff reviewed had the required yearly performance evaluations completed. This placed the residents at risk for inadequate care.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 49634 The facility identified a census of 56 residents. The facility identified two residents on contact-based precautions and six on Enhanced Barrier Precautions (EBP-infection control interventions designed to reduce transmission of resistant organisms that 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, hand hygiene, storage of oxygen tubing while not in use, and disinfecting of shared equipment. These deficient practices placed the residents at risk for infectious diseases. Included Findings: - On 07/22/24 at 08:00 AM an electric razor with brown shavings was laid on an EBP cart outside of Resident (R)22's room. The soiled razor was not in a container. On 07/22/24 at 08:10 AM, Certified Nursing Aide (CNA) M pushed the Hoyer (total body mechanical lift) from Resident (R)22's room into R49's room without sanitizing the Hoyer lift. CNA M did not perform hand hygiene upon leaving R22's room and before entering R49's room. On 07/22/23 at 01:28 PM, R18's oxygen cannula was wrapped around her wheelchair and was not in a sanitary container. On 07/23/24 at 08:07 AM CNA M placed R22's soiled linens directly on the floor while changing R22's bed. R22 was on EBP. CNA M did not sanitize the floor immediately after the soiled linens were picked up. On 07/23/24 at 07:08 AM two commercial washers were filled with wet clothing left from the 10:00 PM to 12:00 AM shift. Two commercial dryers had lint in the lint traps. An inspection of the soiled area of the laundry room revealed there was no personal protective equipment (PPE-gloves and gowns used in transmission-based precautions) available. On 07/24/24 at 07:51 AM CNA T pushed a resident down the 200 hall; CNA T had a dirty unbagged hospital gown in her right hand. On 07/24/24 at 07:57 AM, CNA M and CNA N donned two pairs of gloves each, and donned gowns. Neither CNA performed hand hygiene. R18, who was on contact precautions for Methicillin-resistant Staphylococcus aureus (MRSA-a type of bacteria resistant to many antibiotics), laid on her bed on her back. CNA N fastened R18's brief. CNA N and CNA M rolled R18 from left to right, putting her sling underneath her. CNA M and CNA N doffed both sets of gloves. Without performing hand hygiene, CNA M and CNA N each donned clean gloves and put R18 in her wheelchair using the Hoyer lift. Wearing the same gloves, CNA N placed R18's oxygen nasal cannula into R18's nares. CNA M placed R18's urinary catheter bag underneath her wheelchair. Wearing the same gloves, CNA N brushed R18's hair and put her boots on her heels. CNA N doffed her gloves and gown and then performed hand hygiene. CNA M doffed her gloves and gown and then pushed the Hoyer lift to the hallway without sanitizing the Hoyer lift or performing hand hygiene. CNA M proceeded to walk into another room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 07/23/24 at 07:50 AM Housekeeping Staff V stated she was unaware that laundry could not sit in the washers overnight. She stated the night laundry worker puts a load in the washers before she leaves at 12:00 AM. She stated red red-bagged laundry (indicating transmission-based precautions) was washed separately but she did not do anything different for the red-bagged laundry. She stated gloves were available to the laundry staff. Housekeeping Staff V stated there were gowns on the washer in the clean area if the gowns were needed. She stated she did assess water temperatures for any laundry including the red bagged laundry and said the temperatures were assessed by a supervisor. Housekeeping Staff V said she was unaware if the washers were monitored by temperature or by chemicals. On 07/24/24 at 08:10 AM Housekeeping Staff U stated she was unaware laundry could not sit in the washer overnight and stated that she was told laundry could sit in the washer if the seal on the washing machine wasn't broken. She stated the overnight staff did all the red-bagged laundry, and she had been trained to wear PPE when handling red-bagged laundry. On 07/24/24 at 08:16 AM CNA M stated she did not know she was supposed to clean equipment between residents or how to accomplish that but stated she would ask. CNA M stated she did forget to do hand hygiene before entering R49's room, and said she should have done hand hygiene when going from resident to resident, and when she left the residents' rooms. On 07/24/24 at 11:18 AM Administrative Nurse D stated shared equipment was to be cleaned after each resident's use. She stated oxygen tubing should always be stored in a container when not in use and each resident had their own bag on their canister and wheelchairs. Administrative D stated staff should do hand hygiene when going from resident to resident, dirty to clean, and when leaving a resident's room. The facility's Hand Hygiene, Cleaning and Disinfection of Resident -Care Equipment, Handling of Soiled Linen, Laundry, Transmission-Based Precautions policy documented the facility's undated Hand Hygiene policy documented all staff would perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applied to all staff working in all locations within the facility. The use of gloves did not replace hand hygiene. If the task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves. Aligning with principles of started precautions, staff shall consider all previously worn clothing and used linens as potentially contaminated. It was the policy of this facility to handle, store, process, and transport linen in a safe and sanitary method to prevent the spread of infection. Resident-care equipment can be a source of indirect transmission of pathogens. Reusable resident-care equipment will be cleaned and disinfected to break the chain of infection. The facility staff will apply Transmission-Based Precautions (TBP), in addition to standard precautions, to residents who are known or suspected to be infected or colonized with certain infectious agents requiring additional controls to prevent transmission. 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, and disinfecting of shared equipment. These deficient practices placed the residents at risk for infectious diseases.