STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175207	A. Building B. Wing	01/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunporch of Dodge City	501 W Beeson Road Dodge City, KS 67801

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50659 The facility reported a census of 32 residents with 12 residents selected for review. Based on observation, interview, and record review, the facility failed to accurately revise three residents care plans. The facility failed to revise the care plan after Resident (R)19 who had increased exiting behaviors, and actual elopements (when a cognitively impaired resident leaves the facility without the knowledge or supervision of staff) from facility on 10/12/23 and 02/14/24. AdditionallyThe facility failed to update and place appropriate fall interventions for R3 and R15 who had multiple falls. This failure placed the residents at risk for uncommunicated care needs. Findings included: - The Electronic Health Records (EHR) documented R19 had the following diagnosis of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure). The 012/23/24 Annual Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of three, indicating severely impaired cognition. R19 had no behaviors or depression. R19 required set up for showers and was independent with all other activities of daily living (ADLs). R19 had no falls, and she was administered anti-psychotic (class of medications used to treat major mental conditions which cause a break from reality) medication, and anti-depressant (class of medications used to treat mood disorders) medication. The 01/03/25 Cognitive Loss/Dementia Care Area Assessment (CAA) documented R19 had Alzheimer's and had severely impaired cognition. She was at risk for ADL declines, behaviors and communication deficiencies. Goal was to avoid decline or complications due to her cognitive impairment. The 10/01/24 Quarterly MDS documented a BIMS score of five, indicating severely impaired cognition. R19 had no depression and had behaviors one to three days with wandering. R19 was independent in all ADLs, she received anti-psychotic, and anti-depressant medications. She wore a Wander Guard (bracelet that sets off an alarm when residents wearing one attempt to exit the building without an escort). The Care Plan documented the following: (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	Staff were instructed to place a sign on the door for visitors to check with staff before allowing folks to leave facility, dated initiated 09/22/24. Staff provided a Wander Guard bracelet on R19. Staff instructed to check placement of Wander Guard each shift, date initiated 09/22/24. Staff instructed to check on R19 every 15 minutes to monitor my location for my safety, date imitated 09/22/24. Staff instructed to notify my family when R19 would come to the exit door frequently. Staff instructed to assist R19 away from the door. When weather permits, staff instructed to assist R19 outside in courtyard to walk with staff, date imitated 09/22/24. The 01/22/25 Physician Orders documented the following: Check placement of Wander Guard each shift. To use the tag reader, turn on the right button and right arrow. The press down arrow button until it stated tag test mode. Then press enter mode. Place reader near wander guard to receive the reading. Date ordered 09/22/24. Review of the Wandering Risk Scale for R19, dated 10/24/23 thru 12/20/24 documented R19 was a high risk to wander five out of the seven days. The 10/09/23 at 10:49 AM Progress Note revealed R19 punched the code on main entrance door and walked out of the facility and down the sidewalk. Staff observed R19 exiting and redirected R19 back into the facility. The 10/12/23 at 08:23 PM Progress Note revealed R19 entered the code to the exit door of hallway 300 and exited the facility witnessed by an unidentified nursing student. The nursing student immediately found the nurse to question if R19 was ok to be outside alone. The unidentified nurse and nursing student exited the facility and noted the property fence gait was open. R19 was located ambulating on the street. The 02/14/24 at 03:43 PM Progress Note revealed R19 exited the facility when a band member was leaving the facility. Unidentified band member alerted the staff. Two unidentified staff members immediately exited the facility and assisted R19 back into the facility. The 03/26/24 at 05:13 PM Progress Note revealed R19 had clothing in a mesh laundry bag, was in the main lobby near entrance door. R19 reported she would just follow them out when visitors attempted to leave facility. R19 was redirected away from the main entrance. The 04/14/24 at 01:53 Mood/Behavior Note revealed R19 had exiting seeking behaviors in front lobby. R19 would ask other residents and visitors to open the door for her. Review of Progress Notes from 04/15/24 thru 09/19/24 staff documented 15 exit seeking notes in EHR. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 09/22/24 at 07:08 PM 'Progress Note revealed R19 exited the facility at 03:48 PM when a visitor assisted R19 with the door so she could leave. An unidentified resident alerted staff that R19 was outside. Staff assisted R19 back into facility. During an observation on 01/22/25 at 10:00 AM, R19 had been wandering up and down the 300 hallway several times. R19 was well groomed, was wearing an outdoor vest, carried her black handbag and her walking cane under her arm. During an observation on 01/22/25 at 02:30 PM R19 wandered in hallway 300, she wore a burgundy coat and carried her black handbag. During an observation on 01/23/25 at 01:40 PM, R19 was seated in front lobby chair approximately 12 feet from the exit/entrance door. R19 watched the oxygen vendor man punch the code on the exit panel. During an interview on 01/23/25 at 02:00 PM, Certified Nurse Aide (CNA) R reported that R19 would exit seek all the time. CNA R reported that R19 wore a Wander Guard and that R19 would be looking for her family. CNA R reported that staff would re-direct R19 away from exit doors almost every day. CNA R reported that R19 would change her coat to different outdoor wear through out the day. During an interview on 01/27/25 at 04:06 AM, CNA H reported that R19 reported that she was told by the charge nurse not to check on R19 during the night as not to disturb R19. CNA H reported she would see R19 out of her room in the morning and that she was easy to redirect when needed. During an interview on 01/27/25 at 04:23 AM, Licensed Nurse (LN) K reported that she would check on R19 once at night and once in the morning, she reported that R19 would not like people coming into her room. LN K reported that R19 was an elopement risk and always wore a Wander Guard bracelet. LN K reported the Wander Guard bracelet would be checked each shift for placement and the alarm worked. LN K reported she would assist R19 toward the exit door to have the alarm sound to check for function. LN K reported there was a device to check the Wander Guard but was educated by other staff to use the exit door. During an observation on 01/27/25 at 05:06 AM noted an Explorer/ [NAME] Leaf binder in nurse's station. The binder contained R19's information and picture. During an interview on 01/27/25 at 03:31 PM, Administrative Nurse B reported that she would like to answer the surveyor's questions about R19's exit seeking behavior and the progress notes in the EHR that were noted prior to the facility state reportable # 0766 on 09/23/24 when Administrative Staff A could be present. During an interview 01/27/25 at 03:31 PM, Administrative Nurse B reported she expected the care plan interventions to be documented on the EHR in a timely manner and confirmed that did not always occur and expected the charge nurses to update the care plan in the EHR. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/27/25 at 04:07 PM, Administrative Staff A, reviewed the progress notes with surveyor, and Administrative Nurse B in regard to R19 exit seeking and elopement notes in EHR. Administrative Staff A reported she did not realize that R19 had an exit seeking note on 09/19/24 in EHR, she had an appalled look on her face. Administrative Staff A revealed she did not believe that R19 had a true elopement on 02/14/24. However, Administrative Staff A revealed she was not aware that R19 had exited the facility on 10/12/23 and she reported she would have done an investigation, and a report had she been aware. Administrative Staff reported that R19's care plan lacked interventions for exit seeking prior to 09/22/24 and reported that was unacceptable. The facility's undated Care Plans, Comprehensive Person-Centered documented a comprehensive person-centered care plan with measurable objectives and timetables would be developed and implemented for each resident and included revisions and updates if a desired outcome was not met The facility failed to review and revise R19's care plan prior to 09/22/24 for exit seeking and elopement behaviors. These deficient practices had the potential to lead to uncommunicated needs which could result in additional falls with the potential for injury or actual harm. - The Electronic Health Records (EHR) documented R3 had the following diagnoses that included dementia (progressive mental disorder characterized by failing memory, confusion), pain and anxiety. The 02/28/24 Annual Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of zero, which indicated severely impaired cognition. R3 had a total mood severity score of zero, which indicated no depression, and she had one wandering behavior noted. R3 required moderate assistance with activities of daily living (ADL) such as toileting hygiene, showering, personal hygiene, and dressing. R3 required supervision for ambulation and transfer and set-up for eating. R3 was occasionally incontinent of bladder, and she had no falls. The 03/11/24 Falls Care Area Assessment (CAA) documented R3 was at risk for injuries resulting from falls and ADL declines, goal was to continue to avoid falls and injuries to resident. The 03/11/24 Cognitive Loss/Dementia CAA documented R3 was at risk for ADL declines, communication deficiencies and falls due to her cognitive impairment. Goal was to maintain her cognitive functioning without complication or decline. The 11/12/24 Quarterly MDS lacked a BIMS and total mood severity score. R3 required total assistance with all ADLs. R3 was non ambulatory, she had no behaviors or falls. The Care Plan documented the following: Staff were to encourage R3 to use call light for assistance, provide a safe environment with adequate low glare light, a working and reachable call light and personal items within reach dated 06/18/21. Staff were instructed R3 was a high fall risk due to my lack of safety awareness, dated 03/22/22. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Staff were instructed to look in on R3 when passing room to make sure all needs were met as a green leaf symbol was placed outside R3's room date initiated 11/18/22. Staff were to provide reminders to R3 to wear appropriate footwear when ambulating and use walker, date initiated 05/16/23. Staff were instructed to offer toileting or check brief every couple of hours and provide incontinent care as needed date initiated 07/09/24. Staff were instructed to assist R3 to toilet before meals date initiated 07/09/24. Staff were instructed to provide R3 with a hi/lo bed and keep bed in lowest position whole R3 was in bed date initiated 07/30/24. The 06/09/24 at 10:15 PM Progress Note revealed staff found R3 on the bathroom floor, seated upright with legs out in front of her with her walker. The note documented R3 was confused and did not know what happened and was incontinent at that time. The 06/09/24 Fall Scene Investigation Report included an immediate intervention to re-educated R3 to use the call light (she won't remember more than likely) and to watch R3 closely as she has no alarm. The 07/09/24 at 12:31 PM Progress Note revealed staff found R3 seated on floor near her doorway in her room. Staff noted that R3's floor was partially wet from recently being mopped and a caution wet floor sign was appropriately placed. The 07/09/24 Fall Scene Investigation Report included an immediate intervention to check frequently on R3 and staff instructed to provide toileting before each meal. Additionally, the report documented R3 was last seen in bed at 11:40 AM with eyes closed and staff attempted to assist her up for lunch. Also noted R3's medications had been held that morning due to unable to wake R3 up to administer medications. The 07/30/24 at 05:38 AM Progress Note revealed R3 called out for help and staff found R3 on the floor, with her walker in front of her. Staff noted a large hematoma (collection of blood trapped in the tissues of the skin or in an organ, resulting from trauma) on the right side of R3's face. R3 was transferred to the hospital. The 07/30/24 Fall Scene Investigation Report revealed that R3 was last seen in bed with her wheelchair and walker next to bed by an unidentified Certified Nurse Assistant (CNA) at 05:00 AM. During an interview on 01/22/25 at 09:35 AM, R3 could not recall if she had any falls. Observed a folded fall mat in R3's room propped up against a wall. During an observation on 01/27/25 at 04:03 AM, R3 was in bed placed in lowest position with a fall mat placed next to left side of bed, and R3's walker in reach on the fall mat. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/27/25 at 04:06 AM, CNA H reported that R3's walker was placed next to her bed per the care plan, she reported that R3 had not ambulated. CNA H verified that the fall mat on R3's floor was not on the care plan and CNA H reported she placed it on the floor as it was in R3's room. During an interview on 01/27/25 at 04:23 AM, Licensed Nurse (LN) K reported the staff would discuss an immediate intervention and write that down on the report. However, she reported that the care plan intervention in the EHR would be completed by administrative nurse staff, not by the charge nurses. During an interview on 01/27/25 at 01:55 PM, CNA F reported she would look on the EHR on a resident kardex to verify what cares, and devices a resident is required to be provided with. During an interview 01/27/25 at 03:31 PM, Administrative Nurse B reported she expected the care plan interventions to be documented on the EHR in a timely manner and confirmed that did not always occur. She expected the charge nurses to update the care plan in the EHR. Administrative Nurse B confirmed that R3 did not have a fall mat intervention on her current care plan. During an interview on 01/27/25 at 04:07 PM, Administrative Staff A reported that a care plan should be updated in a timely manner. Administrative Staff A revealed 30 days to update a care plan after an occurrence was unacceptable. The facility's undated Care Plans, Comprehensive Person-Centered documented a comprehensive person-centered care plan with measurable objectives and timetables would be developed and implemented for each resident and included revisions and updates if a desired outcome was not met The facility failed to revise R3's care plan for 30 days after a fall. This deficient practice had the potential to lead to uncommunicated needs which could result in additional falls with the potential for injury or actual harm. 46960 - Review of the Electronic Health Record (EHR) for Resident (R)15 included diagnoses of generalized dependence on wheelchair, dementia (a progressive mental disorder characterized by failing memory, confusion) and Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness). The Annual Minimum Data Set (MDS) dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 12 which indicated moderately impaired cognition. The assessment documented that R15 utilized a walker and/or wheelchair for locomotion and documented one fall with injury since the previous assessment. R15 required partial/moderate assistance for toileting and personal hygiene, supervision/touching assistance for upper body dressing, setup/cleanup assistance for oral hygiene and was independent with eating. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The ADL Functional / Rehabilitation Potential Care Area Assessment (CAA) dated 05/13/24, documented R15 had limited range of motion to both lower extremities and required partial assistance for transfers and supervision for ambulation (walking). The Falls CAA dated 05/13/24 documented R15 had balance problems with walking and had decreased muscular coordination and used assistive devices. The Quarterly MDS dated [DATE], documented a BIMS score of 15, which indicated intact cognition. The assessment documented that R15 utilized a walker and/or wheelchair for locomotion and documented two or more non-injury falls and one fall with minor injury since the previous assessment. R15 required setup/cleanup assistance with bathing but was otherwise independent with cares. The 01/09/20 Care Plan, documented R15 was at risk for falls related to Parkinson's disease and poor safety awareness and listed the following interventions: On 07/27/20, staff would offer gentle reminders for R15 to use the call light for assistance and safety related to transfers, revised 03/27/21. On 08/24/23, staff would reeducate R15 related to call light use for assistance with cares. On 10/30/23, staff would encourage R15 to ask for additional assistance in the mornings related to morning stiffness before medications started working. On 11/30/23, staff would encourage R15 to dress in a seated position. On 12/01/23, staff would remind R15 to utilize his walker if he was observed attempting to walk without it. On 04/13/24, staff educated R15 related to poor decision making, initiated on 10/07/24. On 05/08/24, staff educated R15 related to poor decision making related to pushing another resident in their wheelchair while simultaneously attempting to ambulate with a walker, initiated on 10/07/24. On 08/10/24, staff educated R15 to use his scooter for locomotion while outside, initiated on 10/07/24. On 08/10/24, staff to provide stand-by assistance for all transfers, initiated on 10/07/24. Review of the five Fall Risk assessments from 02/08/24 through 01/08/24, revealed R15 was at risk for falls. Review of the Progress Notes dated 06/01/24 at 06:36 AM documented R15 reported to staff that he had fallen and only his right knee struck the ground. The facility failed to provide a fall investigation report for this fall that documented root cause analysis, immediate intervention to mitigate the risk of falls for the rest of the shift or a permanent care plan intervention. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Fall Report on 09/12/24 documented a fall without injury. The report lacked an appropriate root cause analysis and immediate intervention to mitigate the risk of falls for the rest of the shift. The Progress Notes on 09/12/24 at 02:17 PM documented that R15 self-reported a fall during the night. The progress note documented that R15 reported he was walking with his walker in his room and his feet became tangled and he fell . The Fall Report dated 01/08/25 documented a fall without injury and lacked an appropriate root cause analysis or immediate intervention to mitigate the risk of falls for the rest of the shift. The Progress Notes dated 01/08/25 at 03:36 PM documented R15 had an unwitnessed fall with minor injury and was found by staff at 02:15 PM in his room. The Care Plan lacked an intervention related to the fall on 01/08/25. Observation on 01/22/25 at 10:41 AM, R15 was seated in the recliner in his room. Observation on 01/23/25 at 01:02 PM, R15 was seated in his motorized wheelchair in his room. Observation on 01/27/25 at 06:00 AM, R15 self-propelled his motorized wheelchair down the hallway into the dining area and retrieved a cup of coffee, then returned to his room. During an interview on 01/27/25 at 07:41 AM, Certified Medication Aide (CMA) Q revealed when a resident fell staff would ensure the resident was safe, then alert other staff that assistance was required, and would notify the nurse. Upon the arrival of the nurse, the staff would follow the instructions of the nurse. After the fall was over, the nurse would hold an impromptu meeting with the staff to discuss the risks and determine the cause of the fall and implement a new intervention. The staff would also fill out a report and give it to the nurse. CMA Q stated that if a resident self-reported a fall, then the same process would be followed. CMA Q further revealed that each resident had a care plan that directed the staff to provide individualized care to each resident. During an interview on 01/27/25 at 09:41 AM, Certified Nurse Aide (CNA) R revealed that in the event of a fall, staff would stay with the resident to ensure their safety and alert other staff for help using the two-way radio or call light system, then follow the instructions of the nurse after they arrived and assessed the resident. After the fall, the nurse would collect statements from the staff and have a small meeting to discuss why the fall happened and would collectively develop a new intervention for the resident. CNA R further revealed that each resident had a care plan which provided instructions for individualized care for each resident. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/27/25 at 04:23 AM, Licensed Nurse (LN) K reported that if a fall occurred, she would fill out a fall packet that had printed instructions on the front of the envelope. LN K reported she would assess the resident, notify family, physician, Administrative Staff A, and Administrative Nurse B of the event. LN K reported that she would complete the paperwork for neurological checks (a series of tests and questions that assess the function of the brain, spinal cord, and nerve), prior to occurrence form, and witness statements. She reported that she would complete required documentation in EHR for resident which included a risk management report. LN K reported the staff would discuss an immediate intervention and write that down on the report. However, she reported that the care plan intervention in the EHR is completed by administrative nurse staff, not by the charge nurses. During an interview on 01//27/23 at 09:50 AM Administrative Nurse C defined a fall as a change in plane (when a person unexpectedly changed from standing to sitting or lying positions or any combination thereof). Administrative Nurse C revealed if a resident fell (witnessed or unwitnessed), the staff would remain with the resident to ensure safety and alert additional staff for assistance which included the nurse. The nurse would assess the resident for injuries and initiate any care that was required and make the necessary notifications, additionally, the nurse would request paper reports from all of the staff to determine what happened before the fall and obtain witness statements if necessary. The nurse would hold a meeting with the staff to determine why the fall occurred and develop an immediate intervention to mitigate the risk of falls for the shift and included a care plan intervention. During an interview 01/27/25 at 03:31 PM, Administrative Nurse B reported she expected the care plan interventions to be documented on the EHR in a timely manner and confirmed that did not always occur and expected the charge nurses to update the care plan in the EHR. During an interview on 01/27/25 at 03:40 PM, Administrative Staff A defined a fall as a change in plane. Administrative Staff A confirmed the information regarding the fall on 06/01/24 constituted a fall and should have resulted in a fall investigation and confirmed that it did not exist. Administrative Staff A confirmed the above information related to fall investigation reports being incomplete and missing appropriate root cause analyses, immediate interventions and permanent care plan interventions and stated her expectation was for fall investigation reports to be accurate and contain appropriate root cause analyses, immediate interventions and permanent care plan interventions to mitigate the risk of future falls. The facility's undated Care Plans, Comprehensive Person-Centered documented a comprehensive person-centered care plan with measurable objectives and timetables would be developed and implemented for each resident and included revisions and updates if a desired outcome was not met The facility failed to review and revise R15's person-centered care plan related to accident hazards and falls when the facility failed to conduct appropriate fall investigations on 06/01/24, develop interventions to mitigate the risk of falls or develop care plan interventions to prevent additional falls on 09/12/24 and 01/08/25. These deficient practices had the potential to lead to uncommunicated needs which could result in additional falls with the potential for injury or actual harm.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50659 The facility reported a census of 32 residents with 12 residents in the sample and four residents reviewed for accidents. Based on observation, interview, and record review, the facility failed to provide an environment that remained free from accident hazards for four residents. The facility failed to identify, implement, and reevaluate fall prevention interventions to prevent falls for two residents. Resident (R) 15 had multiple falls with a lack of appropriate fall interventions. Additionally, the facility failed to implement new interventions to prevent R19 after she had an elopement (when a cognitively impaired resident leaves the facility without the knowledge or supervision of staff) from facility. The facility failed to put an effective smoking plan in place for R9. These deficient practices could potentially result in an injury. Findings included: - The Electronic Health Records (EHR) documented R9 had the following diagnoses depression, repeated falls, and hypotension (low blood pressure). The 11/11/24 Admission Minimum Data Set (MDS) documented a brief interview for mental status (BIMS) of five, which indicated severe cognitive impairment. Total severity score of zero which indicated no depression. R9 had behaviors noted. R5 required supervision assistance with activities of daily living (ADLs) of ambulation 150 feet and he was independent with the remainder of his ADLs. R9 had falls prior to admission and received an anti-depressant (class of medications used to treat mood disorders) and anti-coagulant (class of medication to thin blood to prevent clotting). The 11/15/24 Functional Abilities Care Area Assessment (CAA) documented: R9 was at risk for ADL declines and falls. Goal is for resident to maintain his independence without declines. The 11/15/24 Cognitive Loss/Dementia CAA documented R9 was at risk for ADL declines and falls due to cognitive impairment. Goal is to maintain his cognitive functioning without complications or decline. The 12/09/24 Quarterly MDS documented a BIMS score of 10, which indicated moderately impaired cognition. R9 was independent with ADLs, except required supervision with bathing. No falls noted. R9 received anti-depressant, and anti-coagulant medication. The Care Plan dated 01/22/25 lacked any documentation of R9's smoking. The EHR lacked any smoking evaluation/assessment that was reviewed on 01/22/25. The Physician Orders 01/22/25 lacked any orders regarding smoking. The Admission Data Collection dated 11/05/24 at 04:27 PM, documented R9 was a current smoker. However, it lacked any further documentation of R9 being a smoker. The 11/06/24 at 06:39 PM Progress Note documented R9's family member brought him in cigarettes. (continued on next page)

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	175207	A. Building B. Wing	01/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunporch of Dodge City	501 W Beeson Road Dodge City, KS 67801

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 12/11/24 at 06:37 PM Progress Note revealed R9 would go outside for smoke breaks after his meals. During an interview on 01/22/25 at 09:55 AM, R9 reported that he was a smoker, and he was just going outside to smoke. R9 had a lighter and one cigarette in his front pocket of his jacket. He ambulated independently down hallway 300, punched to code into the exit panel and ambulated over to the designated smoking area. During an interview on 01/22/25 at 10:03 AM, Maintenance Director O reported that he was not sure if R9 could go outside to smoke independently. He reported the R9 had a staff member with him yesterday when he observed him smoking outside. During an interview on 01/23/25 at 08:20 AM, Certified Nurse Aide (CNA) R reported that R9 required staff supervision when he would want to smoke. CNA R reported that R would need to go locked cart and ask the charge nurse if he could have a cigarette. CNA R reported that if R9 had a lighter and cigarette in his pocket and went outside to smoke independently that would not be acceptable. CNA R reported that staff should look at the care plan to know the required care needed for smokers. During an observation on 01/23/25 at 08:26 AM thru 08:46 AM, R9 was assisted outside by CNA R to assist R9 with a cigarette break. During an observation on 01/23/25 at 12:50 PM, R9 exited independently outside hallway 300 exit door and ambulated to the designated smoking area. R9 pulled a cigarette and lighter out of his front pocket and lit the cigarette independently. R9 re-entered the 300 hallway door at 12:57 PM. During an interview on 01/23/25 at 01:31 PM, Licensed Nurse (LN) G reported that would give R9 his lighter and cigarette when he would request them. LN G reported the charge nurse only had a key for the locked lighters and cigarettes. LN G reported that it should be on R9's care plan and there should be a smoking evaluation for safety needs be completed. LN G reported she was unsure how often a smoking safety evaluation should be completed. LN G reported that she had not looked on EHR to verify that R9 could independently smoke, she reported she was trained that he could. LN G reviewed the EHR and reported that R9 did have a smoking evaluation assessment completed, and his care plan had documented that R9 could smoke independently. LN G then reported that the evaluation and care plan was implemented today on 01/23/25. During an interview on 01/23/25 at 01:59 PM, Administrative Nurse M reported that she had just completed R9's smoking evaluation and documented the smoking focus on R9's care plan just today. Administrative Nurse M reported she had noticed it had not been completed. Administrative Nurse M revealed that the smoking evaluation for safety and his care plan should have been completed when he admitted on [DATE]. Administrative Nurse M reported the R9 is independent with all his ADLs, and he should be able to smoke by himself. Administrative Nurse M reported when she completed the evaluation this morning, she charted no cognitive deficit that she had not looked at R9's BIMS and verified that in 11/2024 R9 had a BIMS score of five which indicated severely impaired cognition and in 12/24 R9 had a BIMS score of 10 which indicated moderately impaired cognition. Administrative Nurse M reported that the staff know the residents when asked how the staff would know R9's smoking privileges before the care plan was initiated today. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/27/25 at 03:31 PM Administrative Nurse B reported it was a concern that R9 did not have a smoking evaluation for safety, or his care plan initiated for smoking until 01/23/25 and expected staff to complete the assessments and care plan in the EHR when a resident was admitted . The facility's Smoking -Resident policy dated 10/2023 documented this facility has established and maintains safe resident smoking practices. Resident smoking status is evaluated upon admission. If a smoker, the evaluation includes ability to smoke safely with or without supervision (per a completed Safe Smoking Evaluation). Any smoking-related privileges, restrictions, and concerns are noted on the care plan, and all personnel caring for the resident shall be alerted to these issues. Residents who have independent smoking privileges are permitted to keep cigarettes, electronic-cigarettes, pipes, tobacco, and other smoking items in their possession. Only disposable safety lighters are permitted. The facility failed to evaluate a cognitively impaired R9 smoking evaluation for safety and failed to care plan R9's smoking privileges when admitted 78 days ago. This deficient practices could potentially result in an injury. 46960 - Review of the Electronic Health Record (EHR) for Resident (R)15 included diagnoses of generalized dependence on wheelchair, dementia (a progressive mental disorder characterized by failing memory, confusion) and Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness). The Annual Minimum Data Set (MDS) dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 12 which indicated moderately impaired cognition. The assessment documented that R15 utilized a walker and/or wheelchair for locomotion and documented one fall with injury since the previous assessment. R15 required partial/moderate assistance for toileting and personal hygiene, supervision/touching assistance for upper body dressing, setup/cleanup assistance for oral hygiene and was independent with eating. The ADL Functional / Rehabilitation Potential Care Area Assessment (CAA) dated 05/13/24, documented R15 had limited range of motion to both lower extremities and required partial assistance for transfers and supervision for ambulation (walking). The Falls CAA dated 05/13/24 documented R15 had balance problems with walking and had decreased muscular coordination and used assistive devices. The Quarterly MDS dated [DATE], documented a BIMS score of 15, which indicated intact cognition. The assessment documented that R15 utilized a walker and/or wheelchair for locomotion and documented two or more non-injury falls and one fall with minor injury since the previous assessment. R15 required setup/cleanup assistance with bathing but was otherwise independent with cares. The 01/09/20 Care Plan reviewed 01/23/25, documented R15 was at risk for falls related to Parkinson's disease and poor safety awareness and listed the following interventions: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/27/20, staff would offer gentle reminders for R15 to use the call light for assistance and safety related to transfers, revised 03/27/21. On 08/24/23, staff would reeducate R15 related to call light use for assistance with cares. On 10/30/23, staff would encourage R15 to ask for additional assistance in the mornings related to morning stiffness before medications started working. On 11/30/23, staff would encourage R15 to dress in a seated position. On 12/01/23, staff would remind R15 to utilize his walker if he was observed attempting to walk without it. On 04/13/24, staff educated R15 related to poor decision making, initiated on 10/07/24. On 05/08/24, staff educated R15 related to poor decision making related to pushing another resident in their wheelchair while simultaneously attempting to ambulate with a walker, initiated on 10/07/24. On 08/10/24, staff educated R15 to use his scooter for locomotion while outside, initiated on 10/07/24. On 08/10/24, staff to provide stand-by assistance for all transfers, initiated on 10/07/24. Review of the five Fall Risk assessments from 02/08/24 through 01/08/24, revealed R15 was at risk for falls. Review of the Progress Notes dated 06/01/24 at 06:36 AM documented R15 reported to staff that he had fallen and only his right knee struck the ground. The facility failed to provide a fall investigation report for this fall that documented root cause analysis, immediate intervention to mitigate the risk of falls for the rest of the shift or a permanent care plan intervention. Review of the Fall Report on 09/12/24 documented a fall without injury. The report lacked an appropriate root cause analysis and immediate intervention to mitigate the risk of falls for the rest of the shift. The Progress Notes on 09/12/24 at 02:17 PM documented that R15 self-reported a fall during the night. The progress note documented that R15 reported he was walking with his walker in his room and his feet became tangled and he fell . The Care Plan on 09/12/24 documented staff reminded R15 to utilize the call light for assistance during the overnight hours, initiated on 10/07/24. The Fall Report dated 01/08/25 documented a fall without injury and lacked an appropriate root cause analysis or immediate intervention to mitigate the risk of falls for the rest of the shift. The Progress Notes dated 01/08/25 at 03:36 PM documented R15 had an unwitnessed fall with minor injury and was found by staff at 02:15 PM in his room. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Care Plan lacked an intervention related to the fall on 01/08/25. Observation on 01/22/25 at 10:41 AM, R15 was seated in the recliner in his room. Observation on 01/23/25 at 01:02 PM, R15 was seated in his motorized wheelchair in his room. Observation on 01/27/25 at 06:00 AM, R15 self-propelled his motorized wheelchair down the hallway into the dining area and retrieved a cup of coffee, then returned to his room. Observation on 01/27/25 at 09:37 AM, R15 was rested in the recliner in his room. During an interview on 01/27/25 at 07:41 AM, Certified Medication Aide (CMA) Q stated when a resident fell staff would ensure the resident was safe, then alert other staff that assistance was required, and would notify the nurse. Upon the arrival of the nurse, then staff would follow the instructions of the nurse. After the fall was over, the nurse would hold an impromptu meeting with the staff to discuss the risks and determine the cause of the fall and implement a new intervention. The staff would also fill out a report and give it to the nurse. CMA Q stated that if a resident self-reported a fall, then the same process would be followed. During an interview on 01/27/25 at 09:41 AM, Certified Nurse Aide (CNA) R revealed that in the event of a fall, staff would stay with the resident to ensure their safety and alert other staff for help using the two-way radio or call light system, then follow the instructions of the nurse after they arrived and assessed the resident. After the fall, the nurse would collect statements from the staff and have a small meeting to discuss why the fall happened and would collectively develop a new intervention for the resident. During an interview on 01/27/25 at 04:23 AM, Licensed Nurse (LN) K reported that if a fall occurred, she would fill out a fall packet that had printed instructions on the front of the envelope. LN K reported she would assess the resident, notify family, physician, Administrative Staff A, and Administrative Nurse B of the event. LN K reported that she would complete the paperwork for neurological checks (a series of tests and questions that assess the function of the brain, spinal cord, and nerve), prior to occurrence form, and witness statements. She reported that she would complete required documentation in EHR for resident which included a risk management report. LN K reported the staff would discuss an immediate intervention and write that down on the report. However, she reported that the care plan intervention in the EHR is completed by administrative nurse staff, not by the charge nurses. During an interview on 01//27/23 at 09:50 AM Administrative Nurse C defined a fall as a change in plane (when a person unexpectedly changed from standing to sitting or lying positions or any combination thereof). Administrative Nurse C revealed if a resident fell (witnessed or unwitnessed), the staff would remain with the resident to ensure safety and alert additional staff for assistance which included the nurse. The nurse would assess the resident for injuries and initiate any care that was required and make the necessary notifications, additionally, the nurse would request paper reports from all of the staff to determine what happened before the fall and obtain witness statements if necessary. The nurse would hold a meeting with the staff to determine why the fall occurred and develop an immediate intervention to mitigate the risk of falls for the shift and included a care plan intervention. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview 01/27/25 at 03:31 PM, Administrative Nurse B reported she expected the care plan interventions to be documented on the EHR in a timely manner and confirmed that did not always occur and expected the charge nurses to update the care plan in the EHR. During an interview on 01/27/25 at 03:40 PM, Administrative Staff A defined a fall as a change in plane. Administrative Staff A confirmed the information regarding the fall on 06/01/24 constituted a fall and should have resulted in a fall investigation and confirmed that it did not exist. Administrative Staff A confirmed the above information related to fall investigation reports being incomplete and missing appropriate root cause analyses, immediate interventions and permanent care plan interventions and stated her expectation was for fall investigation reports to be accurate and contain appropriate root cause analyses, immediate interventions and permanent care plan interventions to mitigate the risk of future falls. The facility's Falls - Clinical Protocol policy, dated 03/2018, documented for an individual who has fallen, the staff and practitioner will begin to try to identify possible causes within 24 hours of the fall. The staff and practitioner will review each resident's risk factors for falling and document in the medical record. The facility failed to provide an environment free of accident hazards when the facility failed to conduct appropriate fall investigations on 06/01/24, develop interventions to mitigate the risk of falls or develop care plan interventions to prevent additional falls on 09/12/24 and 01/08/25. These deficient practices had the potential to lead to additional falls with the potential for injury or actual harm.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 50659 The facility reported a census of 32 residents with 12 residents sampled, including two residents reviewed for respiratory care. Based on observations, record reviews, and interviews, the facility failed to properly clean the nebulizer (a device for administering inhaled medications) after each medication was administered for Resident (R)3 and R134 in accordance with the standards of care This deficient practice had the potential to spread possible lung infections to the residents. During an observation on 01/22/25 at 09:34 AM, Licensed Nurse (LN) G removed the nebulizer equipment off f R3 after breathing treatment was completed. LN G placed the nebulizer equipment into a bag. LN G washed her hands, and she reported she would not rinse the nebulizer equipment after she had administered a breathing treatment as the nebulizer equipment was cleaned once a day on the night shift. During an observation on 01/22/25 at 02:35 PM, R134's nebulizer was intact with a clear liquid residue noted in chamber, that was placed in a bag. During an interview on 01/27/25 at 04:23 AM, LN K reported that the nebulizer equipment is cleaned and rinsed once a day on the night shift. LN K reported that she did not rinse the nebulizer after each medication was administered. During an observation on 01/27/25 at 06:48 AM, R3's nebulizer equipment was intact and hanging on the side of nebulizer machine with a clear liquid substance noted in chamber. During an interview on 01/27/25 at 02:20 PM, Administrative Nurse C Infection Control Nurse reported she expected nurses to rinse out the nebulizer after each medication was administered and let equipment air dry on a paper towel. Administrative Nurse C reported that the night shift was expected to clean and rinse all resident's nebulizer equipment with the three to one water/vinegar mixture. The facility's policy Departmental (Respiratory Therapy) - Prevention of Infection dated 11/2011, documented the purpose of this procedure is to guide prevention of infection associated with respiratory therapy tasks and equipment. Infection control considerations related to medication nebulizers/continuous aerosol after completion of therapy remove the nebulizer container, rinse the container with fresh tap water, and dry on a clean paper towel or gauze sponge. The facility failed to provide respiratory care consistent with professional standards of care for R3 and R134, regarding the cleaning of the nebulizer equipment after each use when medication was administered. This deficient practice had the potential to spread possible lung infections to residents.

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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. 46960 The facility reported a census of 32 residents. Based on interview and record review, the facility failed to complete an annual performance review at least once every 12 months for two Certified Nurse Aides (CNAs) reviewed, to ensure adequate appropriate cares and services provided to the residents of the facility. The facility identified 12 CNAs employed over 12 the month period. Findings included: - Review of employee files on 01/27/25 at 05:08 PM revealed a lack of performance evaluations or skills check-off for two Certified Nurse Aides (CNAs), CNA S and CNA T. CNA S had a date of hire of 09/09/23 and CNA T had a date of hire of 03/11/23. On 01/27/24 at 05:20 PM, Administrative Staff A revealed all CNA staff were required to complete a skills check-off in lieu of a performance evaluation annually. If the CNA was unable to perform the required tasks satisfactorily, then remediation was performed until the CNA could perform the required tasks. Administrative Staff A further reported CNA S and CNA T were absent during the most recent skills check-off and were supposed to have made up the check off with Administrative Nurse B and confirmed that it had not happened yet. The facility did not provide a policy related to annual performance evaluations or skills check-off evaluations for CNA staff as requested on 01/27/25. The facility failed to complete an annual performance review at least once every 12 months for two CNAs reviewed, to ensure adequate appropriate cares and services provided to the residents of the facility. This deficient practice had the potential to negatively affect the physical and psychosocial well-being of all the residents in the facility.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46960 The facility reported a census of 32 residents with 12 residents sampled and five reviewed for unnecessary medications. Based on observations, interviews and record review, the facility failed to ensure the physician responded in a timely manner to monthly medication regimen reviews (MRR) for Resident (R)15, 19 and R25 related to psychotropic (any class of medications that alters mood or thought) medications and for R3 when the physician failed to provide appropriate rational when they declined a pharmacy recommended gradual dose reduction (GDR) for psychotropic medications. These deficient practices had the potential to lead to the residents receiving medications unnecessarily. Findings included: - Review of the Electronic Health Record (EHR) for Resident (R)15 included diagnoses of generalized dependence on wheelchair, dementia (a progressive mental disorder characterized by failing memory, confusion), Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness), hypertensive (high blood pressure) chronic kidney disease (CKD - a long-term condition where the kidneys gradually lose their ability to filter waste and excess fluids from the blood), diabetes mellitus type 2 (DM2 - when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), major depressive disorder (MDD - major mood disorder which causes persistent feelings of sadness) with psychotic (any major mental disorder characterized by a gross impairment in reality perception) symptoms and hypothyroidism (condition characterized by hyperactivity of the thyroid gland). The Annual Minimum Data Set (MDS) dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 12 which indicated moderately impaired cognition. The assessment documented R15 had a PHQ-9 (a scale used to determine the presence of depression) score of zero which indicated no depression and had no behavioral symptoms related to psychosis. R15 utilized a walker and/or wheelchair for locomotion and documented one fall with injury since the previous assessment. R15 required partial/moderate assistance for toileting and personal hygiene, supervision/touching assistance for upper body dressing, setup/cleanup assistance for oral hygiene and was independent with eating. Additionally, the assessment documented R15 received antipsychotic (a class of medications used to treat major mental conditions which cause a break from reality) medications and antidepressant (class of medications used to treat mood disorders) medications. The Cognitive Loss / Dementia Care Area Assessment (CAA), dated 05/13/24 documented R15 had moderate cognitive impairment. The ADL Functional / Rehabilitation Potential (CAA) dated 05/13/24, documented R15 had limited range of motion to both lower extremities and required partial assistance for transfers and supervision for ambulation (walking). The Falls CAA dated 05/13/24 documented R15 had balance problems with walking and had decreased muscular coordination and used assistive devices. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Psychotropic Drug Use CAA dated 05/13/24 documented R15 took Seroquel (quetiapine - an antipsychotic medication) and Paxil (paroxetine - an antidepressant) and had no recent gradual dose reduction (GDR) attempt. The Quarterly MDS dated [DATE], documented a BIMS score of 15, which indicated intact cognition. The assessment documented R15 had a PHQ-9 score of zero, which indicated no depression and utilized a walker and/or wheelchair for locomotion and documented two or more non-injury falls and one fall with minor injury since the previous assessment. R15 required setup/cleanup assistance with bathing but was otherwise independent with cares. Additionally, the assessment documented R15 received antipsychotic and antidepressant medications. The Care Plan , documented R15 took antipsychotic and antidepressant medications and instructed staff to monitor for possible side effects (unintended effects caused by medication use) and notify the charge nurse, initiated on 01/17/22 Review of the Physician Orders revealed the following: Seroquel (quetiapine fumarate - an antipsychotic medication), 25milligram (mg) tablet, give 0.5 tablet by mouth (PO) two times daily (BID) for behaviors related to MDD with psychotic symptoms and give one tablet PO in the evening (HS) related to MDD with psychotic symptoms, dated 07/27/22 at 08:00 PM. Paxil (paroxetine - an antidepressant medication), 20 mg, give one tablet po one time a day related to MDD with psychotic symptoms, dated 02/29/20 at 07:00 AM. Review of the pharmacy MRR reports revealed that on 12/16/24 the pharmacist recommended a GDR for Paxil (paroxetine) and Seroquel (quetiapine). The facility faxed the physician on 12/19/24 and 01/23/25 without a response from the physician. Observation on 01/22/25 at 10:41 AM, R15 was seated in the recliner in his room and appeared calm and relaxed. Observation on 01/27/25 at 06:00 AM, R15 self-propelled his motorized wheelchair down the hallway into the dining area and retrieved a cup of coffee, then returned to his room. R15 appeared calm and relaxed with a pleasant/cheerful demeanor During an interview 01/23/25 at 03:23 PM, Administrative Nurse B confirmed the above information related to the timeliness of the MRR and GDR request stated that her expectation is that the physician would respond within a week, and then a second request would be made. Additionally, Administrative Nurse B revealed that she does not expect a timely response from R15's physician. Administrative Nurse B stated that the facility does have a medical director that is not R15's physician and was unsure of what policy and/or procedures were in place to ensure timely follow-up from a physician who refuses to respond timely or appropriately to MRR or GDR requests. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility's undated Medication Regimen Reviews policy documented that a consultant pharmacist would conduct a MRR of each resident who received medication in the facility at least monthly and as needed, if indicated. If the physician does not provide a timely or adequate response to the report or if no action has been taken, the consultant pharmacist would contact the medical director or administrator. The facility's undated Designation of a Personal Physician policy documented that residents in the facility had the right to choose a personal attending physician and exercise that right based on the physician's ability and willingness to meet pertinent responsibilities which included the physician must follow the facility's established guidelines governing the responsibilities of the physician to the resident and to the facility. Additionally documented should the resident's attending physician fail or refuse to fulfill their responsibilities to the resident in a timely manner, the facility may contact the medical director for order fulfillment and/or to assume resident care. The facility did not provide a policy specific to a GDR process as requested on 01/27/25. The facility failed to ensure that R15's medication remained free of unnecessary medications when the facility failed to ensure that R15's physician responded in a timely manner to a GDR request from the consultant pharmacist. 50659 - The Electronic Health Records (EHR) documented R19 had the following diagnosis of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure). The 012/23/24 Annual Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of three, indicating severely impaired cognition. R19 had no behaviors or depression. R19 required Set up for showers and was independent with all other activities of daily living (ADLs). R19 had no falls, and she was administered anti-psychotic (class of medications used to treat major mental conditions which cause a break from reality) medication, and anti-depressant (class of medications used to treat mood disorders) medication. The 01/03/25 Cognitive Loss/Dementia Care Area Assessment (CAA) documented R19 had Alzheimer's and had severely impaired cognition. She was at risk for ADL declines, behaviors and communication deficiencies. Goal is to avoid declines or complications due to her cognitive impairment. The 10/01/24 Quarterly MDS documented a BIMS score of five, indicating severely impaired cognition. R19 no depression and had behaviors one to three days with wandering. R19 was independent in all ADLs, she received anti-psychotic, and anti-depressant medications. She wore a Wander Guard (bracelet that sets off an alarm when residents wearing one attempt to exit the building without an escort). The Care Plan documented the following: Staff instructed took antipsychotic and antidepressant medications and instructed staff to monitor for possible side effects (unintended effects caused by medication use) and notify the charge nurse, initiated on 08/17/21. (continued on next page)

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	175207	A. Building B. Wing	01/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunporch of Dodge City	501 W Beeson Road Dodge City, KS 67801

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the Physician Orders revealed the following: Remeron (Mirtazapine - an anti-depressant medication), 15 milligram (mg) tablet, give one tablet by mouth, one time a day for major depressive disorder (MDD - major mood disorder which causes persistent feelings of sadness) with severe psychotic (any major mental disorder characterized by a gross impairment in reality perception), date ordered 10/23/22. Citalopram Hydrobromide Oral Tablet (an anti-depressant medication), 20 mg tablet, give one tablet one time a day for MDD, with severe psychotic features, date ordered 02/26/23. Seroquel (quetiapine fumarate - an antipsychotic medication), 50 mg tablet, give one tablet by mouth, every evening for behavior, date ordered 04/04/24. Seroquel 50 mg tablet, give one tablet by mouth, in the morning for anti-psychotic related to dementia in other diseases without behavioral disturbances, psychotic disturbances, mood disturbances ad anxiety, date ordered 11/04/24. Review of the pharmacy medication regimen reviews (MRR) reports revealed that on 07/23/24 MRR R19 was currently on Citalopram 20 mg, Mirtazapine 15 mg and Quetiapine 25 mg in am and 50 mg at pm. The facility must attempt gradual dose reduction of psychotropic medications to find the lowest effective dose. The facility lacked a physician response for the MRR. During an observation on 01/22/25 at 10:00 AM, R19 had been wandering up and down the 300 hallway several times. R19 was well groomed, was wearing an outdoor vest, carried her black handbag and her walking cane under her arm. During an observation on 01/22/25 at 02:30 PM R19 wandered in hallway 300, she wore a burgundy coat and carried her black handbag. During an observation on 01/23/25 at 01:40 PM, R19 was seated in front lobby chair approximately 12 feet from the exit/entrance door. R19 watched the oxygen vendor man punch the code on the exit panel. During an interview 01/23/25 at 03:23 PM, Administrative Nurse B confirmed the above information related to the timeliness of the MRR and GDR request stated that her expectation is that the physician would respond within a week, and then a second request would be made. Additionally, Administrative Nurse B revealed that she does not expect a timely response from R15's physician. Administrative Nurse B stated that the facility does have a medical director that is not R15's physician and was unsure of what policy and/or procedures were in place to ensure timely follow-up from a physician who refuses to respond timely or appropriately to MRR or GDR requests. During an interview on 01/27/25 at 11:10 AM Administrative Nurse B reported she could not locate the MRR or R19 for 07/23/24. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility's undated Medication Regimen Reviews policy documented that a consultant pharmacist would conduct a MRR of each resident who received medication in the facility at least monthly and as needed, if indicated. If the physician does not provide a timely or adequate response to the report or if no action has been taken, the consultant pharmacist would contact the medical director or administrator. The facility's undated Designation of a Personal Physician policy documented that residents in the facility had the right to choose a personal attending physician and exercise that right based on the physician's ability and willingness to meet pertinent responsibilities which included the physician must follow the facility's established guidelines governing the responsibilities of the physician to the resident and to the facility. Additionally documented should the resident's attending physician fail or refuse to fulfill their responsibilities to the resident in a timely manner, the facility may contact the medical director for order fulfillment and/or to assume resident care. The facility did not provide a policy specific to a GDR process as requested on 01/27/24. The facility failed to ensure that R19's medication remained free of unnecessary medications when the facility failed to ensure that R19's physician responded in a timely manner to a GDR request from the consultant pharmacist. - The Electronic Health Records (EHR) documented Resident (R)3 had the following diagnoses that included dementia (progressive mental disorder characterized by failing memory, confusion), pain and anxiety. The 02/28/24 Annual Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of zero, which indicated severely impaired cognition. R3 had a total mood severity score of zero, which indicated no depression, and she had one wandering behavior noted. R3 required moderate assistance with activities of daily living (ADL) such as toileting hygiene, showering, personal hygiene, and dressing. R3 required supervision for ambulation and transfer and set-up for eating. R3 was occasionally incontinent of bladder, and she had no falls. R3 received antipsychotic (class of medications used to treat major mental conditions which cause a break from reality), antidepressants (class of medications used to treat mood disorders), and anti-anxiety (class of medications that calm and relax people) medications during the lookback period. The 03/11/24 Psychotropic Drug Use Care Area Assessment (CAA) R3 was administered Quetiapine (an anti-psychotic medication) for dementia with behavioral disturbance, Clonazepam (an anti-anxiety medication) for anxiety, and Mirtazapine (an anti-depressant medication) for depressive episodes. R3 was at risk for adverse consequences due to medication use, goal was to avoid adverse consequences of medication use and to have improvement in her behavior and depressive symptoms. The 11/12/24 Quarterly MDS lacked a BIMS and total mood severity score. R3 required total assistance with all ADLs. R3 was non ambulatory, she had no behaviors or falls. R3 received anti-psychotic, anti-depressant, and anti-anxiety medications during lookback period. The Care Plan documented the following: R3's medications would be reviewed by the pharmacist consultant monthly, and by a physician every 60 days, and by both as needed, date initiated 06/18/21. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Staff instructed to look at Black Box Warning (BBW- highest safety-related warning that medications can have assigned by the Food and Drug Administration) for all listed drugs could be located in the physician orders and the EHR on medication administration record, date initiated 06/18/21. Review of the Physician Orders revealed the following: Remeron (Mirtazapine - an anti-depressant medication), 7.5 milligram (mg) tablet, give one tablet by mouth, one time a day for depression, date ordered 10/18/22. Seroquel (quetiapine fumarate - an antipsychotic medication), 50 mg tablet, give one tablet by mouth, tow times a day dementia with unspecified severity, with other behavioral disturbances, date ordered 04/18/23. Clonazepam (an anti-anxiety medication), 0.5 mg tablet, give one tablet, by mouth, two times a day, for anxiety/restlessness, date ordered 06/23/24. Clonazepam 0.5 mg tablet, give one tablet, by mouth, every four hours as needed for anxiety, date ordered 06/24/25. Review of the pharmacy medication regimen reviews (MRR) reports revealed that on 09/24/24 MRR R3 had received, Clonazepam 0.5 mg twice a day, and Clonazepam 0.5 mg tab every four hours as needed. Mirtazapine 15 mg po at bedtime, and Seroquel 50 mg twice a day. The facility must attempt a gradual dose reduction (GDR stepwise tapering of a dose to determine if symptoms, conditions, or risks can be managed by a lower dose or if the dose or medication can be discontinued) of psychotropic medications to find the lowest effective dose. The facility lacked an appropriate physician response for the GDR with his only statement was disagree, dated 10/22/24. During an observation of 01/23/25 at 07:21 AM, R3 was seated in her wheelchair in the lobby with her eyes closed. During an observation of 01/27/25 at 06:48 AM, R3 received care from Certified Nurse Aide (CNA) F and Certified Medication Aide (CMA) P. R3 had no behaviors, followed requests and showed understanding to what staff were asking her to do. R3 kept her eyes closed most of the time During an interview 01/23/25 at 03:23 PM, Administrative Nurse B confirmed the above information related to the timeliness of the MRR and GDR request stated that her expectation is that the physician would respond within a week, and then a second request would be made and was unsure of what policy and/or procedures were in place to ensure timely follow-up from a physician who refuses to respond timely or appropriately to MRR or GDR requests. The facility's undated Medication Regimen Reviews policy documented that a consultant pharmacist would conduct a MRR of each resident who received medication in the facility at least monthly and as needed, if indicated. If the physician does not provide a timely or adequate response to the report or if no action has been taken, the consultant pharmacist would contact the medical director or administrator. The facility did not provide a policy specific to a GDR process as requested on 01/27/24. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility failed to ensure that R3s medication remained free of unnecessary medications when the facility failed to ensure that R3's physician responded in a timely manner to a GDR request from the consultant pharmacist. 51332 - The Electronic Health Records (EHR) documented Resident (R)25 had the following diagnoses that included Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness), Alzheimer's disease, (progressive mental disorder characterized by failing memory, confusion),anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), insomnia (inability to sleep), hypertension (elevated blood pressure) depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and dementia (progressive mental disorder characterized by failing memory, confusion). The 06/04/24 Annual Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of four, which indicated severely impaired cognition, and a PHQ-9 (an assessment scale to determine the presence of depression) totaled 0. R25 had no behaviors to indicate psychosis (any major mental disorder characterized by a gross impairment in reality perception). R25 received an antipsychotic (a class of medications used to treat major mental conditions which cause a break from reality), antianxiety (class of medications that calm and relax people), hypnotic (a class of medications used to induce sleep and treat insomnia) medication, opioid (class of drug used to treat moderate to severe pain) medication, antiplatelet (class medications that prevent platelets from clumping together and forming clots) medications and antidepressant (class of medications used to treat mood disorders) medications . The 06/14/24 Psychotropic Drug Use Care Area Assessment (CAA) documented R25 is on Restoril (temazepam- a sedative/hypnotic medication), Geodon (ziprasidone- an antipsychotic medication), Seroquel (quetiapine - an antipsychotic medication), Pristiq (desvenlafaxine- antidepressant medication) and Lorazepam (Ativan- an antianxiety medication.) The 11/12/24 Quarterly MDS documented Brief Interview for Mental Status BIMS score of 99 staff unable to complete and lacked a PHQ-9th. R25 had behaviors of yelling and hitting. R25 received an antipsychotic, antianxiety, hypnotic, opioid, antiplatelet and antidepressant. On 11/25/24 the Care Plan documented Medical Doctor responded to gradual dose recommendations (GDR) request noting this is a chronic long-term issue and no changes would be made unless R25 had a significant change. Initiated 07/07/23. The 11/25/24 Care Plan documented R25 utilized the following medications: Pristiq (desvenlafaxine ER), Seroquel (quetiapine), Geodon (ziprasidone), Plavix (clopidogrel - a blood thinner medication), Restoril (temazepam), Lorazepam (Ativan), and Ultram (Tramadol - an opioid medication). Initiated on 07/01/22, staff would monitor and report adverse reactions (unintended effects caused by medication use) to medication to nurse if R25 exhibited signs and symptoms: falls, weight loss, fatigue, agitation, depression, lethargy, unsteadiness, confusion, poor appetite, constipation, diarrhea, bruising, and red eyes. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The 11/25/24 Care Plan documented R25 utilized the following psychotropic medications (Geodon and Quetiapine) r/t dementia with psychotic disturbance. Initiated on 07/14/22, staff would monitor and report adverse reactions of psychotropic medications such as unsteady gait, tardive dyskinesia(abnormal condition characterized by involuntary repetitive movements of the muscles of the face, limbs and trunk), EPS (shuffling gait, rigid muscles, shaking), frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideations, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, muscle cramps nausea, vomiting and any behavior symptoms not usual to the person. On 01/23/25, review of the Physician Orders revealed the following: Restoril (Temazepam), oral capsule 30 milligram (mg), give one tablet, by mouth (PO), at bedtime (HS), every day, for sleep and restlessness, ordered 01/02/25, end date indefinite. Restoril (Temazepam), oral capsule 15 milligram (mg), give one tablet, by mouth (PO), at bedtime (HS), every day, for insomnia, ordered 09/24/24, end date indefinite. Revised 09/30/24, discontinued 01/02/25. Restoril (Temazepam), oral capsule 30 milligram (mg), give one tablet, by mouth (PO), as needed, at bedtime (HS) milligram, for sleep, ordered 09/03/24, end date indefinite. Review of the pharmacy monthly medication review (MRR) reports revealed that on 09/24/24 the pharmacist recommended a GDR for Geodon (ziprasidone- an antipsychotic medication). The facility faxed the physician on 10/14/24 and the physician disagreed without a date or a rationale which and was documented as noted by the facility on 10/22/24. On 10/22/24, Consultant Pharmacist recommended discontinuing the order for Restoril (Temazepam), scheduled for Once a day at bedtime (qHS) since there were two active orders with different dosages scheduled at this time. One order was for Restoril (Temazepam), 30mg qHS and the other was for Restoril (Temazepam) 15 mg qHS. Provider responded to discontinue the order for Restoril (Temazepam) 30 mg and keep the order of Restoril (Temazepam) 15 mg QHS on 10/22/24. Facility this on 11/4/24. On 12/16/24 Consultant Pharmacist recommended, reviewing and updating the missing side effects for Pristiq (desvenlafaxine) to residents chart. The facility was unable to provide documentation of a physician response. Observation on 01/22/25 at 09:05 AM R25 shirt appeared to have stains from uneaten food present. R25 had not been shaved and appeared unkept with hair unbrushed and face unwashed. Observation on 01/23/25 at 09:31 AM, R25 was administered his morning medications while seated on his couch and R25 appeared calm and relaxed with a pleasant/joking demeanor. R25 allowed staff to administer medications without difficulty and to aid with cares without difficulty. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview 01/23/25 at 03:23 PM, Administrative Nurse B confirmed the above information related to the timeliness of the MRR and GDR request stated that her expectation is that the physician would respond within a week, and then a second request would be made. Additionally, Administrative Nurse B revealed that she does not expect a timely response from R25's physician. Administrative Nurse B stated that the facility does have a medical director that is not R25's physician and was unsure of what policy and/or procedures were in place to ensure timely follow-up from a physician who refuses to respond timely or appropriately to MRR or GDR requests. The facility's undated Medication Regimen Reviews policy documented that a consultant pharmacist would conduct a MRR of each resident who received medication in the facility at least monthly and as needed, if indicated. If the physician does not provide a timely or adequate response to the report or if no action has been taken, the consultant pharmacist would contact the medical director or administrator. The facility's undated Designation of a Personal Physician policy documented that residents in the facility had the right to choose a personal attending physician and exercise that right based on the physician's ability and willingness to meet pertinent responsibilities which included the physician must follow the facility's established guidelines governing the responsibilities of the physician to the resident and to the facility. Additionally documented should the resident's attending physician fail or refuse to fulfill their responsibilities to the resident in a timely manner, the facility may contact the medical director for order fulfillment and/or to assume resident care. The facility did not provide a policy specific to a GDR process as requested on 01/27/25. The facility failed to ensure that R25's medication remained free of unnecessary medications when the facility failed to ensure that R25's physician responded in a timely manner to a GDR request from the consultant pharmacist.

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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. 46960 The facility census totaled 32 residents on three halls with a commons area where residents gathered for meals and activities. The facility had two medication carts and one nurse treatment cart that services the facility. Based on observation, interview, and record review, the facility failed to provide a safe environment by the failure to ensure a medication cart that contained prescription medications, narcotic medications in a locked box within the medication cart and over-the-counter (OTC - medications that do not require a prescription) and a nurse treatment cart that contained insulin (a medication used to treat diabetes [a disease when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin]), topical ointments and creams, remained locked when not in direct line of vision of the nurse, in an area where residents could access it. Findings included: - During an observation on 01/23/25 at 07:38 AM a medication cart was observed in the residents' hallway unlocked with keys hanging from the locking mechanism. A nurse treatment cart was next to the medication cart and was also unlocked and both were unattended. Three unknown staff members walked by the unlocked carts and did not secure the carts. During an interview on 01/23/25 at 07:42 AM, Licensed Nurse (LN) G identified the unlocked and unattended cart as the treatment cart and confirmed it contained insulins, topical ointments, medicated creams, wound care supplies. Additionally, LN G identified the medication cart that contained prescription medication, OTC medication and narcotics that were in a separate locked box within the cart. LN G verified the medication cart and treatment cart should be locked when not within line of site of staff member responsible for the carts. LN G identified the medication cart serviced approximately half of the residents, and the treatment cart serviced all of the residents in the facility. During an interview on 01/23/25 at 08:57 AM, Administrative Nurse B stated it was her expectation staff should lock all medication and treatment carts when not use or in line of sight of the staff responsible for the cart. During an observation on 01/27/25 at 05:00 AM, LN K left the nurse treatment cart unlocked and unattended in the nurse's office with the door open. The nurse's office was located in the hallway where two residents' hallways converge. During an interview on 01/27/25 at 05:11 AM, LN K identified the unlocked cart as the nurse treatment cart that contained insulins, topical ointments, medicated creams, wound care supplies and confirmed that the cart should be locked when not within an arm's reach without regard to where the cart is located. The facility identified 12 residents as confused and independently mobile. (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 undated Storage of Medications policy documented that the facility would store all medications in a safe, sure and orderly manner and all compartments (drawers, cabinets, carts, etc.) would be locked when not in use and not left unattended if open or otherwise potentially available to others. The facility failed to provide a safe environment for the residents by the failure to ensure a medication cart and nurse treatment cart remained locked when not in direct line of vision of the licensed nurse responsible for the carts.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 50659 The facility reported a census of 32 residents. Based on observation, interview, and record review, the facility failed to follow sanitary dietary standards related to the storage of food. This deficient practice placed the residents at risk related to food-borne illnesses. Findings included: - Observation of the kitchen and food storage areas on 01/22/25 at 08:19 AM, revealed the following areas of concern: Two bread bags were opened without a date. The freezers had items that were not labeled with an open date, which included: bread, rolls, spinach, french fries, onion rings, beef tips, and chicken tenders. Items in walk in cooler were not labeled with an open date, which included: a gallon of milk, a container of half and half, one container of grape jelly, a bottle of ketchup, a half of an onion, and a tray of blueberry muffins. During an interview on 01/22/25 at 08:40 AM, Dietary Manager U, confirmed the food items in the refrigerator and the undated, opened, bread was unacceptable. She reported she was unaware the items in the freezer were required to be labeled and dated when opened. The facility's policy Refrigerators and Freezers dated 12/2014 documented this facility will ensure safe food expiration guidelines. All food shall be appropiately dated to ensure proper rotation by expiration dates. The policy lacked when food is opened to label and date items in refrigerator and freezer. The facility did not provide a dry food storage policy. The facility failed to follow sanitary dietary standards related to the storage of food. This deficient practice placed the residents at risk related to food-borne illnesses.

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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. 50659 The facility reported a census of 32 residents. The sample included 12 residents. Based on observation, interview, and record review, the facility failed to maintain an effective infection control program related to the lack of hand hygiene when incontinent care was provided to R3 and improper removal of personal protective equipment (PPE- gowns, face shields and/or eyeglasses/goggles, and gloves) after care provided to R3. The facility staff failed to wear proper PPE when emptying a catheter (a flexible tube inserted through a narrow opening into a body cavity, particularly the bladder, for removing fluid) drainage bag and when changing the leg bag (a small bag that collects urine from a Foley catheter and is worn on the leg during the day) to the gravity drainage bag. The facility failed to provide respiratory care consistent with professional standards of care for R3 and R134, regarding the cleaning of the nebulizer (device which changes liquid medication into a mist easily inhaled into the lungs) equipment after each use when medication was administered. This deficient practice had the potential to spread possible infections to the residents in the facility. Findings included: During an observation on 01/22/25 at 09:34 AM, Licensed Nurse (LN) G removed the nebulizer equipment off from R3 after breathing treatment was completed. LN G placed the nebulizer equipment into a bag. LN G washed her hands, and she reported she would not rinse the nebulizer equipment after she administered a breathing treatment as the nebulizer equipment was cleaned once a day on the night shift. During an observation on 01/22/25 at 02:35 PM, R134's nebulizer was intact with a clear liquid residue noted in chamber, that was placed in a bag. During an interview on 01/27/25 at 04:23 AM, LN K reported that the nebulizer equipment is cleaned and rinsed once a day on the night shift. LN K reported that she did not rinse the nebulizer after each medication was administered. During an observation on 01/27/25 at 06:48 AM, R3's nebulizer equipment was intact and hanging on the side of nebulizer machine with a clear liquid substance noted in chamber. During an observation on 01/27/25 at 06:48 AM, Certified Nurse Aide (CNA)F and Certified Medication Aide (CMA) P applied PPE, prior to entering R3's room to provide care neither CNA F or CMA P performed hand hygiene before applying gloves. Incontinent care was provided to R3, neither CNA F or CMA P performed hand hygiene after they removed their gloves and applied new gloves to finish care. During care provided CNA F and CMA G placed soiled pajamas and bed pad onto the floor. After all care was administered CMA P reached behind her gown with her gloved hand and broke the ties on the gown and removed the gown and gloves at the same time. However, she did not roll the gown away from her she removed it quickly and just stuffed the gown and gloves into the garbage can. During an interview on 01/27/25 at 07:15 AM, CNA F reported that she should have performed hand hygiene prior to applying PPE and after she removed her gloves prior to applying new gloves. CNA F reported that soiled linen should not be placed on the floor that she should have placed a barrier over a garbage can then placed soiled linen on that. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175207	A. Building B. Wing	01/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunporch of Dodge City	501 W Beeson Road Dodge City, KS 67801

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 01/27/25 at 07:25 AM, CMA P reported that she washed her hands prior to applying her PPE. However, she did report that she had touched objects after she performed hand hygiene and should have washed her hands again. CMA P reported that she did not wash her hands after she removed her gloves and applied new gloves and reported she should have. CMA P also reported that soiled linen should not have been placed on the floor. During an observation on 01/27/25 at 07:20 AM, R6's catheter bag observed resting on floor with drain port locked but hanging free. CMA Q performed emptying of foley catheter drainage bag and removal of foley drainage bag and application of leg drainage bag for R6. CMA Q did not apply eyewear protection as part of her PPE during the care provided. During an interview on 01/27/25 at 07:39 AM, CMA Q stated they would not have done anything different. During an interview on 01/27/25 at 09:50 AM, Administrative Nurse C reported if a foley bag is found on the floor it should be cleaned with isopropyl alcohol and reassembled and washed out with three to one water vinegar mixture for 20 - 30 minutes, then hung to dry. Administrative Nurse C reported that staff should wear eye protection for splash hazard when emptying a foley bag. During an interview on 01/27/25 at 02:20 PM, Administrative Nurse C Infection Control Nurse reported she expected nurses to rinse out the nebulizer after each medication was administered and let equipment air dry on a paper towel. Administrative Nurse C reported that the night shift was expected to clean and rinse all resident's nebulizer equipment with the three to one water/vinegar mixture. Administrative Nurse C reported she expected all staff to perform hand hygiene after gloves were removed. The facility's policy Handwashing/Hand Hygiene dated 10/2023 documented this facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections. All personnel are trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections. Hand hygiene is indicated immediately after glove removal. The facility failed to maintain an effective infection control program related to the lack of proper hand hygiene when incontinent care was provided to R3 and improper removal of PPE after cares were performed. The facility staff failed to wear proper PPE when emptying a catheter, a drainage bag and when changing the leg bag to the gravity drainage bag. The facility failed to provide respiratory care consistent with professional standards of care for R3 and R134, regarding the cleaning of the nebulizer equipment after each use when medication was administered. This deficient practice had the potential to spread possible infections to the residents in the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175207	A. Building B. Wing	01/27/2025

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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. 51332 The facility reported a census of 32 residents. The sample included 12 residents, with five reviewed for immunizations. The facility failed to provide proper documentation of vaccination or declination of vaccines for COVID-19 (vaccines designed to prevent COVID-19 [highly contagious respiratory virus]) for, Resident (R) R11. Also failed to provide documentation of pneumococcal (vaccines designed to prevent pneumonia [inflammation of the lungs which can be debilitating or lethal in the elderly]) for R84. Findings included: - Review of the Electronic Health Record (EHR) for Resident (R) 11 lacked documentation that the COVID vaccine was offered or had been declined. Review of the Electronic Health Record (EHR) for Resident (R) 84 lacked documentation of any pneumococcal vaccine or COVID vaccine being given or declination of the vaccine(s). On 01/28/24 at 10:41 AM, Administrative Nurse C confirmed the requested proof of vaccines or declinations could not be found. Administrative Nurse B stated the Covid vaccine was not offered to R11 as he was not in the facility when the vaccines where being given. Administrative Nurse B stated she is not able to produce documentation of R84 vaccines currently. The facility did not provide a policy specific to a Pneumococcal or Covid Vaccine process as requested on 01/27/24. The facility failed to provide proof of vaccination or declination of vaccines for the COVID vaccine and pneumococcal vaccines for R11 and R84. This deficient practice had the potential to lead to an outbreak of respiratory infections with the residents in the facility.