STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175221	A. Building B. Wing	01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Advena Living at Fountainview	601 N Rose Hill Road Rose Hill, KS 67133

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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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41302 The facility reported a census of 47 residents with 14 residents sampled. Based on observations, interviews, and record review, the facility failed to ensure that one Resident (R) 6 had a current and valid Preadmission Screening and Annual Resident Review (PASARR). Findings included: - Review of the Electronic Health Record (EHR) for R6 included diagnoses of schizoaffective disorder bipolar type (mental illness is a combination of symptoms of schizophrenia and symptoms of a mood disorder, anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), and depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). The Annual Minimum Data Set (MDS) dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The assessment documented R6 had the diagnoses of anxiety, depression, and schizophrenia. Received antipsychotic, antianxiety, hypnotic, anticoagulant, antibiotic, diuretic, and opioid, with indications noted. The 01/09/20 Care Plan reviewed 09/24/24, documented R6 took medications and instructed staff to administer and monitor for and/or report possible side effects (unintended effects caused by medication use). Review of the Certificate of Care assessment dated [DATE], documented the assessment was good for one year. Observation on 01/23/25 at 10:20 AM revealed R6 seated in her wheelchair in her room. During an interview 01/23/25 at 03:23 PM, Administrative Nurse D confirmed R6 had a Care Assessment completed in 2020 and that was the only one completed. Administrative Nurse D stated that the regional director had informed them that this was the only assessment needed, unless a resident was to discharge to the community for greater than six months. The facility's Preadmission Screening and Annual Resident Review (PASARR) revised October 2024, documented the purpose of this policy was to ensure that individuals with mental illness and intellectual disabilities receive that care and serviced that they need in the most appropriate setting. The PASARR will be evaluated annually and upon any significant change for those individuals identified. (continued on next page)

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

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility failed to ensure that one Resident (R) 6 had a current and valid Preadmission Screening and Annual Resident Review (PASARR).

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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. 41302 The facility had a census of 47 residents and the sample included 14 residents. Based on observation, record review, and interview, the facility failed to ensure a safe environment free from accident hazards for Resident (R) 25 who had a medication located in her room that was not secured. This failure placed the affected residents at risk for preventable accidents and related injuries. Findings included: - During the onsite survey, the surveyors identified a concern regarding the unsecured medications observed in one resident's room during interview. During an observation on 01/21/25 at 11:31 AM, R25 had a 16-ounce, spray wound cleaning medication on her over the bed table. The medication had a warning label Keep out of reach of children. During an observation on 01/22/25 at 11:07 AM, R25 had a 16-ounce, spray wound cleaning medication on her dresser. The medication had a warning label Keep out of reach of children. During an interview on 01/22/25 at 11:07 AM, R25's roommate R6 reported she was unsure why the spray bottle was there and that the staff must have forgotten it. During an interview on 01/23/25 at 08:10 AM, Certified Nurse Aide (CNA) N reported that residents should not have medications for wound care in their rooms. During an interview on 01/27/25 at 11:43 AM, License Nurse (LN) I reported she would not think that any wound care medication would be left at the bedside unsecured. During an interview on 01/27/25 at 12:53 PM, Administrative Nurse E reported that the wound cleanser should not be left unattended in any resident room. The facility's Control of Hazardous Chemicals policy dated October 2024 documented the facility was committed to eliminating ad controlling hazards that could cause injury of illness to our elders. The facility will meet the requirements of safety standards where there are specific rules about hazards or potential hazards in our facility. All substances with warning labels, including but not exclusive to Keep out of reach of children, will be locked and inaccessible at all times. The facility failed to ensure a safe environment free from accident hazards for R25. This placed the resident at risk for injury and preventable accidents.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36881 The facility reported a census of 47 residents, which included one resident sampled for respiratory care. Based on observation, interview, and record review, the facility failed to provide appropriate respiratory care in maintaining respiratory equipment to prevent the spread of infection, for one Resident (R) 35. The facility failed to ensure safe storage of oxygen nasal cannula and oxygen tubing when not in use to prevent cross contamination and the spread of infection. Finding included: - Review of Resident (R)35's Physician Orders, dated 01/14/25, revealed diagnoses which included acute respiratory failure with hypoxia (inadequate supply of oxygen). The Admission Minimum Data Set, (MDS) dated [DATE], documented the Brief Interview for Mental Status (BIMS) of 15, indicating intact cognition. R35 received oxygen. The Care Plan, (CP), dated 01/21/25, directed staff to know the resident received oxygen via nasal cannula. The CP lacked direction regarding the maintenance and upkeep of the resident's oxygen supplies such as the storage of oxygen cannulas and tubing when not in use. The Physician Orders, revealed an order dated 12/20/24, which documented the resident required oxygen at one to two liters via nasal cannula, continuously. An observation on 01/21/25 at 12:43 PM, revealed the resident lying in the bed in his room. The resident's nasal cannula and oxygen tubing laid directly on the floor, next to his bed and without a storage bag present. During an interview on 01/21/25 at 12:48 PM, Certified Nurse Aide O, verified the above findings and stated oxygen tubing and nasal cannulas should be stored in a container when not in use to prevent cross contamination and the spread of infection. During an interveiw 01/22/25 at 01:18 PM, Administrative Nurse E stated oxygen tubing and nasal cannulas should be stored in a container when not in use to prevent cross contamination and the spread of infection. The facility policy Policies and Practices-Infection Control, dated 10/2024, lacked address of storage of nasal cannulas and oxygen tubing to prevent cross contamination and the spread of infection. The facility failed to provide appropriate respiratory care for R35, related to storage of oxygen nasal cannula when not in use to prevent cross contamination and the spread of infection.

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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. 36881 The facility reported a census of 47 residents. Based on observation, interview, and record review, the facility failed to conduct annual performance reviews for five of five direct care staff reviewed, to ensure the residents received adequate cares. Findings included: - The facility failed to complete annual performance reviews for the five certified Medication Aide and/or Certified Nurse Aides (CMA/CNA) sampled that were employed by the facility for 12 months or greater as follows: 1. CNA M, hired 6/7/23 2. CNA N hired 4/3/23 3. CNA P hired 1/11/23 4. CNA Q hired 7/21/22 5. CMA S hired 2/22/23 On 1/23/25 at 12:48 PM, Administrative Staff A, confirmed the above findings. She stated she had been employed as administrator of the facility for approximately six weeks and could not explain why the sampled staff lacked annual performance evaluations. Administrative Staff A reported she had reviewed the personnel files and checked with human resources and could not locate performance evaluations for the direct care staff noted above. She agreed staff should have annual evaluations which identify their weaknesses and have an action plan to include training to address those identified areas. The facility lacked a policy to address annual performance evaluations for the direct care staff. The facility failed to conduct annual performance reviews for five direct care staff, to ensure the residents received adequate cares.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41302 The facility identified a census of 47 residents. The sample included 13 residents. Based on observation, record review, and interviews, the facility failed to provide adequate pharmaceutical services to ensure Resident (R) 25 had their prescribed medications available in a timely manner for administration. This deficient practice placed both R25 and R38 at risk of delayed treatment, which could have adverse consequences. Findings included: - R25's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), hyperlipidemia (condition of elevated blood lipid levels), and anemia (inadequate number of healthy red blood cells to carry adequate oxygen to body tissues). The Annual Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 0, which indicated severely impaired cognition. R25's Care Plan dated 06/27/24 documented nursing staff would administer medication as ordered, monitor for side effects, and notify the physician as needed. R25's EMR under the Orders tab documented the following physician orders: Atorvastatin (HMG-CoA reductase inhibitors -statins) tablet 20 milligrams (mg), give one tablet by mouth at bedtime for high cholesterol dated 03//21/24. Review of R25's Medication Administration Record (MAR) for January 2025 revealed R25's high cholesterol medication Atorvastatin which was ordered on 03/2/24 was documented as a 9 (not administered) from 01/08/25 through 01/17/25. On 01/21/25 at 01:22 PM, R25 sat in her wheelchair out in the common area. On 01/23/25 at 08:10 AM, Certified Nurse Aide (CMA) R revealed she would inform the nurse if a resident did not have an ordered medication for administration. She stated that she could call the pharmacy if the nurse instructed her to, but that the nurse had to enter it in the electronic medical record. CMA R stated that she made a list daily and went over it with the nurse, she also gave a copy of the list to the ADON. On 01/23/25 at 08:41 AM, Licensed Nurse (LN) G revealed that if a CMA came to her with a missing medication, she would look in the medication room and in the overflow drawer, if she did not find it, she would contact the pharmacy to ensure it had been ordered and would be delivered. On 01/27/25 at 12:53 PM, Administrative Nurse E stated she kept an eye on the missing medications and could not explain why this resident did not have this medication in the middle of the order as the medication was on the pharmacy refill list. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Pharmacy Services Overview policy dated October 2024 documented the facility would accurately and safely provide or obtain pharmaceutical services, including provision of routine and emergency medications and biologicals, and the services of a licensed consultant pharmacist. Pharmacy services are available to residents 24 hours a day, seven days a week. The facility failed to provide adequate pharmaceutical services to ensure R25 received her prescribed medication. This deficient practice placed R25 at risk of delayed treatment which could have adverse consequences. - R38's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin) type II, polyneuropathy (neuropathy- weakness, numbness and pain from nerve damage, usually in the hands and feet), and anemia (inadequate number of healthy red blood cells to carry adequate oxygen to body tissues). The Admission Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 14, which indicated intact cognition. R38's Care Plan dated 08/15/24 documented nursing staff would administer medication as ordered, monitor for side effects, and notify the physician as needed. R38's EMR under the Orders tab revealed the following physician orders: Farxiga (medication used to treat DM) tablet 5 milligrams (mg), give one tablet by mouth daily for DM dated 12/21/24. Gabapentin (medication used to treat nerve pain) tablet 600 mg, give one tablet every six hours for neuropathy dated 11/20/24. Review of R38's Medication Administration Record (MAR) for December 2024 documented R38's Gabapentin which was ordered on 11/20/24 was documented as a 9 (not administered) from 12/11/24 through 12/13/24. DM medication Farxiga which was ordered on 12/21/24 was documented as a 9 (not administered) from 12/21/24 through 12/31/24. January 2025 MAR documented R38's DM medication Farxiga which was ordered on 12/21/24 was documented as a 9 (not administered) from 01/01/25 through 01/27/25. On 01/22/25 at 03:01 PM, R38 sat in her wheelchair in the hallway outside of her room. On 01/23/25 at 08:10 AM, Certified Nurse Aide (CMA) R stated she would inform the nurse if a resident did not have an ordered medication for administration. She stated that she could call the pharmacy if the nurse instructed her to, but that the nurse had to enter it in the electronic medical record and fax it to the pharmacy. CMA R stated that she made a list daily and went over it with the nurse, she also gave a copy of the list to the ADON. On 01/23/25 at 08:41 AM, Licensed Nurse (LN) G stated that if a CMA came to her with a missing medication, she would look in the medication room and in the overflow drawer, if she did not find it, she would contact the pharmacy to ensure it had been ordered and would be delivered. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 22/20/24 at 03:30 PM, Administrative Nurse E stated she kept an eye on the missing medications and could not explain why this resident did not have the gabapentin medication in the middle of the order as the medication was on the pharmacy refill list. Administrative Nurse E revealed the Farxiga was being waited on due to the insurance company was refusing to cover the medication. The facility's Pharmacy Services Overview policy dated October 2024 documented the facility would accurately and safely provide or obtain pharmaceutical services, including provision of routine and emergency medications and biologicals, and the services of a licensed consultant pharmacist. Pharmacy services are available to residents 24 hours a day, seven days a week. The facility failed to provide adequate pharmaceutical services to ensure R38 received her prescribed medication. This deficient practice placed R25 at risk of delayed treatment which could have adverse consequences.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41302 The facility identified a census of 47 residents. The facility identified residents on Enhanced Barrier Precautions (EBP-infection control interventions designed to reduce transmission of resistant organisms that employ targeted gown and glove use during high contact care). Based on record review, observations, and interviews, the facility failed to ensure the gait belts were sanitized after each resident's use and further failed to ensure staff followed the protocols when a nurse provided a tube feeding for a resident. These deficient practices placed the residents at risk for infectious diseases. Findings included: - R37's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of dysphagia, gastric ulcer, digestive system surgical aftercare, and gastritis. The Significant Change Minimum Data Set (MDS) dated [DATE] the staff assessment for mental status documented R37 had long and short-term memory problems and severely impaired cognition. R37 had loss of liquids/solids from mouth, held food in mouth/cheek, coughed or choked when swallowing, and had complaints of difficulty or pain with swallowing. Received 51% or more of calories and 501cc fluid or more per day through tube feeding. R37's Care Plan dated 10/01/24 documented nursing staff would administer tube feedings and R37 took nothing by mouth. R37's EMR under the Orders tab revealed the following physician orders: Jevity 1.5 bolus 240ml feeding four times daily. Flush with 75ml water before and after feeding for a total of 150ml water flush. On 01/23/25 at 09:49 AM, R37 laid in her bed, covered with a blanket, resting without signs of distress noted. On 01/23/25 at 09:49 AM, Licensed Nurse (LN) G was observed giving R37 her tube feeding without wearing the proper personal protective equipment, she had only gloves in place. On 01/23/25 at 09:49 AM, LN G stated she knew about the enhanced barrier precautions, confirmed she did not, and stated she should have. On 01/27/25 at 12:53 PM, Administrative Nurse E stated she would expect all staff to know and abide by the enhanced barrier precautions protocol. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's undated Enhanced Barrier Precautions (EBP) policy documented that the facility followed recommendations and guidance from the Centers for Disease Control in order to keep all residents safe from Healthcare Acquired Infections (HAI). On the recommendation and approval of the facility Infection Preventionist in collaboration with the facility's Medical Director, Enhanced Barrier Precautions (EBP) are implemented as one intervention this facility uses to reduce transmission of resistant organisms that employs targeted Personal Protective Equipment (PPE) use during high contact resident care activities. Standard Precautions continue to apply to the care of all residents, regardless of suspected or confirmed infection or colonization status. The required PPE includes but is not limited to gloves and gowns prior to high-contact care activity. Change PPE before caring for another resident. The facility failed to ensure staff followed EBP protocol with tube feedings. This deficient practice placed the residents at risk for infection.