STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175233	A. Building B. Wing	04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Galena Nursing & Rehab Center	1220 E 8th Street Galena, KS 66739

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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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted 51334 The facility identified a census of 39 residents. The sample included 15 residents with one sampled for dialysis (a procedure where impurities or wastes were removed from the blood). Based on observation, interview, and record review, the facility failed to address necessary dialysis assessments, care, and services on Resident (R) 143's baseline care plan. This deficient practice had the risk of adverse outcomes and dialysis complications for R143 due to uncommunicated care needs. Findings: - R143's Electronic Medical Record (EMR) documented a diagnosis of end-stage renal disease (ESRD-a terminal disease of the kidneys) and dependence on dialysis. The Admission Minimum Data Set (MDS), was in progress. R143's Baseline Care Plan, dated 04/04/25, was reviewed on 04/14/25 at 03:48 PM. It documented R143 was a full code (desired resuscitative measures) and on skilled services with therapy. R143'sBaseline Care Plan lacked documentation that R143 received dialysis or any direction for dialysis care and services. R143's EMR under the Orders tab lacked evidence of orders related to dialysis care and services. R143's EMR revealed the following: An admission Progress Note on 04/04/25 at 07:50 PM documented R143 received dialysis on Monday, Wednesday, and Friday and his representative transported him. On 04/15/25 at 08:44 AM, R143 finished eating then staff assisted him to lie down in bed. R143 reported he went to dialysis on Monday, Wednesday, and Friday but he sometimes went on Tuesday if he had too much fluid. R143 reported the facility nurses did not do anything prior to him leaving including not obtaining his vital signs, pre-dialysis weight, or dialysis site assessment. He reported that sometimes he left before breakfast. So dialysis gives him a protein bar while he is there. On 04/15/25 at 12:41 PM, Certified Nurse Aide (CNA) N stated R143 was on a fluid restriction that just started because he went to dialysis. She was not aware of anything else related to dialysis treatment. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/15/25 at 01:35 PM, Licensed Nurse (LN) G stated that the facility missed R143's orders for assessment and monitoring for dialysis on admission. LN G stated the nurses did not do any pre or post-assessment for dialysis. LN G stated R143's representative took him to dialysis, so the facility missed his dialysis assessments. LN G verified the facility had not put anything on R143's Baseline Care Plan related to dialysis and said it should have been on admission. On 04/15/25 at 01:50 PM, Administrative Nurse D verified staff had not put any dialysis instructions on R143's Baseline Care Plan that was completed on admission and further said it should have included dialysis. Administrative Nurse D stated they expected the nurse to listen to R143's bruit (blowing or swishing sound heard when blood flows through a shunt) and feel the thrill (a fine vibration felt that reflects the blood flow by a dialysis resident's shunt) of his dialysis shunt, complete a pre and post dialysis assessment, weigh R143 daily, and provide communication between the dialysis center and the facility. Administrative Nurse D stated staff should receive education that no blood pressure should be done on that arm with the dialysis shunt. The facility policy for Baseline Care Plans, undated, included: The facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meets professional standards of quality of care.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34056 The facility reported a census of 39 residents, with 15 residents included in the sample. Based on observation, record review, and interview, the facility failed to complete a comprehensive care plan for one of the residents sampled, Resident (R)16, to include staff instruction for the use of foot pedals while propelling the resident in his wheelchair. Findings included: - Review of R16's electronic medical record (EMR) revealed the following diagnoses: chorea (movement disorder) and Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure). The Annual Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of nine, indicating moderately impaired cognition. He had no impairment in functional range of motion (ROM) and was independent with his wheelchair for locomotion. The Functional Ability Care Area Assessment (CAA), dated 01/20/25, documented the resident would not have a further activity of daily living (ADL) decline. The Quarterly MDS, dated [DATE], documented the resident had a BIMS score of nine. He had no impairment in functional ROM and was independent with his wheelchair for locomotion. R16's Care Plan, revised 02/10/25, instructed staff the resident had jerking movements due to a diagnosis of chorea and was independent with his walker. R16's EMR, from 03/19/25 through 04/14/25, revealed the resident was mostly independent with his walker, and at times he was dependent on staff for mobility while in his wheelchair. On 04/14/25 at 08:57 AM, Social Services Staff X propelled the resident in his wheelchair from the dining room to his room following breakfast. The resident had shoes on and his feet were crossed at the ankle and tucked back underneath the seat of his wheelchair with the toe of his left foot skimming the floor. The wheelchair lacked foot pedals at that time. On 04/14/25 at 08:57 AM, Social Services Staff X stated the resident did not have foot pedals because he usually propelled himself in the wheelchair. On 04/15/25 at 12:05 PM, Certified Medication Aide (CMA) R stated the resident would propel himself in the wheelchair most of the time but did at times require staff assistance. CMA R said staff were to utilize the foot pedals on R16's wheelchair while propelling the resident. On 04/15/25 at 02:41 PM, Administrative Nurse D stated it was the expectation for the nurses to update the care plan when needed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy for Comprehensive Care Plans, undated, included: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52154 The facility reported a census of 39 residents with 15 residents sampled, including 6 residents reviewed for activities of daily living (ADLS). Based on observation, interview, and record review, the facility failed to provide necessary ADL cares for four sampled resident, Resident (R)16 was not shaven, R6 had dirty clothes, R29 did not get showered, and R17 received no feeding assistance. This deficient practice placed the affected residents at risk for impaired quality of life, weight loss and poor hygiene. Findings included: - The Physician Order Sheet (POS) for R16, documented the resident had a diagnosis of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), and chorea (movement disorder). The Annual Minimum Data Set (MDS) for R16, dated 01/20/25, documented a Brief Interview for Mental Status (BIMS) of nine indicating moderate cognitive impairment. He required substantial to maximum assistance for bathing. The Functional Abilities Care Area Assessment, dated 01/20/25, triggered secondary to R16 required assistance in ADLs and had functional impairment in activity. The Quarterly MDS, for R16, dated 10/22/24, documented a BIMS of nine. The MDS recorded bathing and showering was not applicable. R16's Care Plan for ADLs, dated 02/10/25, instructed staff to provide hygiene setup assistance. A look-back review of R16's electronic medical record (EMR) from 03/19/25 through 04/14/25 revealed the resident received showers on the following dates: 03/19/25, 03/26/25, 03/29/25, 04/13/25. No other bathing opportunities were documented for the resident. It further documented that the resident was independent to requiring staff supervision for personal hygiene. Observation on 04/15/25 at 07:23 AM, R16 propelled himself in wheelchair from his room to the dining room for breakfast. R16 was unshaven. During an interview on 04/15/25 at 09:31 AM, Certified Nurse Aide (CNA) M reported that the residents had a shower schedule. CNA M stated that there was a list of showers placed shower room listing who were due showers. She further reported that residents were shaven on shower day and then documented in the EMR. CNA M reported that R16 has not refused cares and that he has not always been shaven on shower days but should have been. During an interview on 04/15/25 at 12:05 PM, Certified Medication Aide (CMA) R stated that residents are showered twice weekly and that is when they are shaven. CMA R reported that the bath aide has been providing showers to the residents, but she has had to work the floor quite a bit due to call ins, so residents have not always been getting two showers per week. CMA R confirmed R16 needed to be shaven. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/15/25 at 02:05 PM, Licensed Nurse (LN) G reported that residents should be bathed/showered twice weekly, but this has not been happening due to not having enough staff. LN G stated that the shower aide has been pulled off of doing showers and has had to work the floor. She further stated that showers are documented in the EMR by the CNAs. LN G stated that she noticed the resident was needing to be shaved at breakfast and asked one of the CNAs to shave him. During an interview on 04/15/25 at 02:41 PM, Administrative Nurse D reported that residents had a choice as to how many showers they get, it's usually been at least two showers per week. Administrative Nurse D stated that the bath aide has been pulled to help on the floor, but it has usually been just to help out in the morning. She further stated that residents are generally shaven on the bath days based off the care plan preferences. The facility policy for Activities of Daily Living (ADLs), undated, included: A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good grooming and personal hygiene. - The Physician Order Sheet (POS) for R6, documented the resident had a diagnosis of delusional disorder (a mental illness characterized by persistent, fixed false beliefs [delusions] that are not based in reality) and dementia (a general term for the loss of memory and other thinking abilities that interfere with daily life). The Annual Minimum Data Set (MDS) for R6, dated 12/30/24, documented a Brief Interview for Mental Status (BIMS) of two indicating severe cognitive impairment. She was dependent on staff for dressing the upper portion of her body and rolling left and right in bed. The Cognition Care Area Assessment, dated 01/20/25, triggered related to the diagnosis of dementia and short-term memory loss, impaired communication, presence of delusions, and fluctuating episodes of inattention and disorganized thinking. She was recently admitted to hospice services related to Alzheimer's dementia that is progressive. The Quarterly MDS, for R6, dated 09/29/24, documented a BIMS of one indicating severe cognitive impairment. She was dependent on staff for dressing the upper portion of her body and rolling left and right in bed. R6's Care Plan ADL, dated 02/25/25, documented R6's ADL were impaired related to weakness and impaired balance, and she dependent on staff for locomotion in a Broda (specialty wheelchair with the ability to tilt and recline) chair, dependent on staff for transfers with a Hoyer lift and substantial to maximum assistance of staff for dressing. During an observation on 04/14/25 at 09:09 AM, R6 was sat at the dining table with Activity Director Z eating breakfast per self. R6's blue sweatshirt had a large wet area on the front. During an observation on 04/14/25 at 12:37 PM, Administrative Nurse E propelled R6 from the dining room where she had eaten lunch, and the front of her sweatshirt continued to be soiled with food and liquids. Administrative Nurse E parked the R6 in front of the nurse's desk in the soiled clothing before walking away. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 04/14/25 at 02:07 PM, R6 appeared to be resting in bed and continued to wear the soiled sweatshirt. During an observation on 04/14/25 at 03:17 PM, Certified Medication Aide (CMA) R, checked on R6 who was awake in her bed and did not offer to change the resident's soiled shirt. During an observation on 04/15/25 at 11:27 AM, R6 was sat at dining room table in a Broda chair awaiting lunch. She wore black pants with food debris on the thighs. During an interview on 04/15/25 at 09:41 AM, CMA R stated the resident was dependent on staff for all cares to include dressing. During an interview on 04/15/25 at 09:31 AM, Certified Nurse Aide (CNA) M stated [NAME] R6 was dependent for all cares and needed staff to dress her. CNA M further stated that R6's clothes should have been changed if they were dirty, it wouldn't have been right to take a R6 to the dining room in dirty clothes. During an interview on 04/14/25 at 12:37 PM, Administrative Nurse E stated that R6 would be left in her wheelchair by the nurse's station because she used to be a nurse there at the facility. During an interview on 04/15/25 at 02:41 PM, Administrative Nurse D stated she expected staff to change a resident's clothing if it were soiled. The facility policy for Activities of Daily Living (ADLs), undated, included: A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good grooming and personal hygiene. - The Physician Order Sheet (POS) for R29, documented the resident had a diagnosis of cerebral infarction accident (CVA-sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain). The Admission Minimum Data Set (MDS) for R29, dated 11/18/24, documented a Brief Interview for Mental Status (BIMS) of 13 indicating intact cognition. He required substantial to maximum assistance for personal hygiene. The Functional Abilities Care Area Assessment, dated 11/18/24, triggered related to R29 had actual ADL and self-care abilities declined related to weakness after an acute care stay related to congestive heart failure (CHF-decreased cardiac function). The Quarterly MDS, for R29, dated 02/18/25, documented a BIMS of six indicating moderate to severe cognitive impairment. R29 required substantial to maximum assistance to shower/bathe and setup/clean-up assistance for personal hygiene. R29's Care Plan ADL, dated 03/19/25, documented ADLs had declined related to weakness after an acute care stay related to CHF, R29 was independent with eating and required substantial assistance with bathing, personal hygiene and transfers. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R29's Electronic Health Record (EHR) look-back from 03/19/25 through 04/14/25 revealed R29 received a shower on the following dates: 03/19/25--Partial/mod assist, *03/26/25--Res unavailable, *03/29/25--Res refused, *04/05/25--Not attempted, 04/09/25--Sub/max assist, *04/12/25--Not attempted. Review of the R29's EHR from 03/19/25 through 04/14/25 revealed he required setup or cleanup assist to substantial to maximal assist of staff for personal hygiene, including shaving. During an observation on 04/15/25 at 07:25 AM, R29 was sat at the dining table unshaven, and his hair appeared greasy and dirty. During an interview on 04/15/25 at 09:31, Certified Nurse Aide (CNA) M stated that R29 had declined recently and he's now incontinent where he wasn't before. She reported that his dementia has gotten worse, but he hasn't refused cares. During an interview on 04/15/25 at 02:41 PM, Administrative Nurse D reported that residents had a choice as to how many showers they get, it's usually been at least two showers per week. Administrative Nurse D stated that the bath aide has been pulled to help on the floor, but it has usually been just to help out in the morning. She further stated that residents are generally shaven on the bath days based off the care plan preferences. The facility policy for Activities of Daily Living (ADLs), undated, included: A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good grooming and personal hygiene. - The Physician Order Sheet (POS) for R17, documented the resident had a diagnosis of cerebral infarction accident (CVA-sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain). The Annual Minimum Data Set (MDS) for R17, dated 04/22/24, documented a Brief Interview for Mental Status (BIMS) of nine indicating moderate cognitive impairment. He was listed as independent with eating. The Nutritional Status Care Area Assessment, dated 04/22/24, triggered related to R17 was at risk for alteration in nutritional status related to a diagnosis of Diabetes Mellitus with insulin use, altered dental status (see dental CAA), and elevated Body Mass Index (MDI). The Quarterly MDS, for R17, dated 01/23/25, documented a BIMS of nine. R17 required substantial to maximum assist with eating. R17's Care Plan for ADL, dated 02/04/25, documented R17 required substantial to maximal assist with eating. During an observation on 04/15/25 at 08:01 AM, R17 ate part of his food without assistance and then stared at his uneaten eggs. No staff assisted R17 at this time. During an observation on 04/15/25 at 08:05 AM, R17 fell asleep at the dining table and, a staff member walked by him. No staff assisted R17 at this time. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 04/15/25 at 08:13 AM, R17 continued to sit at the dining table and had not taken a drink and continued staring at his food as several staff walked by. No staff assisted R17 at this time. During an observation on 04/15/25 at 08:17 AM, Licensed Nurse (LN) G assisted R17 with his eggs and he ate them right away with staff assistance. During an observation on 04/15/25 at 11:38 AM, staff provided R17 with his lunch and cut it up. Staff provided a clothing protector and walked away. At 11:40 AM, R17 was looking around and not eating. During an observation on 04/15/25 at 11:57 AM, staff sat down beside R17 and assisted him with eating and there were no problems. During an interview on 04/15/25 at 08:26 AM, Certified Medication Aide (CMA) R stated that R17 sometimes needs help, lately he's needed more assistance. During an interview on 04/16/25 at 08:56 AM, Administrative Nurse D stated that the facility no longer had a restorative nurse, but the CNAs should have assisted R17 with the restorative program and with eating. She stated she would investigate it. During an interview on 04/16/25 at 03:24 PM, Administrative Nurse D stated that she educated the staff that R17 was supposed to get assistance with meals, The facility policy for Activities of Daily Living (ADLs), undated, included: A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good grooming and personal hygiene. 34056 The facility reported a census of 39 residents with 15 residents sampled, including six residents reviewed for activities of daily living (ADLS). Based on observation, interview, and record review, the facility failed to provide the necessary ADL cares for four sampled residents, Resident (R)16 was not shaven, R6 had dirty clothes, R29 did not get showered, and R17 received no feeding assistance. This deficient practice placed the affected residents at risk for impaired quality of life, weight loss and poor hygiene. Findings included: - The Physician Order Sheet (POS) for R16 documented the resident had a diagnosis of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), and chorea (movement disorder). The Annual Minimum Data Set (MDS) for R16, dated 01/20/25, documented a Brief Interview for Mental Status (BIMS) of nine indicating moderate cognitive impairment. He required substantial to maximum assistance for bathing. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Functional Abilities Care Area Assessment, dated 01/20/25, triggered secondary to R16 required assistance required in ADLs and had functional impairment in activity. The Quarterly MDS, for R16, dated 10/22/24, documented a BIMS of nine. The MDS recorded bathing and showering was not applicable. R16's Care Plan for ADLs dated 02/10/25, instructed staff to provide hygiene setup assistance. A look-back review of R16's electronic medical record (EMR) from 03/19/25 through 04/14/25 revealed the resident received showers on the following dates: 03/19/25, 03/26/25, 03/29/25, 04/13/25. No other bathing opportunities were documented for the resident. It further documented that the resident was independent to requiring staff supervision for personal hygiene. Observation on 04/15/25 at 07:23 AM, R16 propelled himself in wheelchair from his room to the dining room for breakfast. R16 was unshaven. During an interview on 04/15/25 at 09:31 AM, Certified Nurse Aide (CNA) M reported that the residents had a shower schedule. CNA M stated that there was a list of showers placed shower room listing who were due showers. She further reported that residents were shaven on shower day and then documented in the EMR. CNA M reported that R16 has not refused cares and that he has not always been shaven on shower days but should have been. During an interview on 04/15/25 at 12:05 PM, Certified Medication Aide (CMA) R stated that residents are showered twice weekly and that is when they are shaven. CMA R reported that the bath aide has been providing showers to the residents, but she has had to work the floor quite a bit due to call-ins, so residents have not always been getting two showers per week. CMA R confirmed R16 needed to be shaven. During an interview on 04/15/25 at 02:05 PM, Licensed Nurse (LN) G reported that residents should be bathed/showered twice weekly, but this has not been happening due to not having enough staff. LN G stated that the shower aide has been pulled off of doing showers and has had to work the floor. She further stated that showers are documented in the EMR by the CNAs. LN G stated that she noticed the resident was needing to be shaved at breakfast and asked one of the CNAs to shave him. During an interview on 04/15/25 at 02:41 PM, Administrative Nurse D reported that residents had a choice as to how many showers they get, it's usually been at least two showers per week. Administrative Nurse D stated that the bath aide has been pulled to help on the floor, but it has usually been just to help out in the morning. She further stated that residents are generally shaven on the bath days based off the care plan preferences. The facility policy for Activities of Daily Living (ADLs), undated, included: A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good grooming and personal hygiene. - The Physician Order Sheet (POS) for R6, documented the resident had a diagnosis of delusional disorder (a mental illness characterized by persistent, fixed false beliefs [delusions] that are not based in reality) and dementia (a general term for the loss of memory and other thinking abilities that interfere with daily life). (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Annual Minimum Data Set (MDS) for R6, dated 12/30/24, documented a Brief Interview for Mental Status (BIMS) of two indicating severe cognitive impairment. She was dependent on staff for dressing the upper portion of her body and rolling left and right in bed. The Cognition Care Area Assessment, dated 01/20/25, triggered related to the diagnosis of dementia and short-term memory loss, impaired communication, presence of delusions, and fluctuating episodes of inattention and disorganized thinking. She was recently admitted to hospice services related to Alzheimer's dementia that is progressive. The Quarterly MDS, for R6, dated 09/29/24, documented a BIMS of one indicating severe cognitive impairment. She was dependent on staff for dressing the upper portion of her body and rolling left and right in bed. R6's Care Plan for ADL dated 02/25/25, documented R6's ADL were impaired related to weakness and impaired balance, and she was dependent on staff for locomotion in a Broda (specialty wheelchair with the ability to tilt and recline) chair, dependent on staff for transfers with a Hoyer lift and substantial to maximum assistance of staff for dressing. During an observation on 04/14/25 at 09:09 AM, R6 sat at the dining table with Activity Director Z eating breakfast per self. R6's blue sweatshirt had a large wet area on the front. During an observation on 04/14/25 at 12:37 PM, Administrative Nurse E propelled R6 from the dining room where she had eaten lunch, and the front of her sweatshirt continued to be soiled with food and liquids. Administrative Nurse E parked the R6 in front of the nurse's desk in the soiled clothing before walking away. During an observation on 04/14/25 at 02:07 PM, R6 appeared to be resting in bed and continued to wear the soiled sweatshirt. During an observation on 04/14/25 at 03:17 PM, Certified Medication Aide (CMA) R, checked on R6 who was awake in her bed and did not offer to change the resident's soiled shirt. During an observation on 04/15/25 at 11:27 AM, R6 sat at the dining room table in a Broda chair awaiting lunch. She wore black pants with food debris on the thighs. During an interview on 04/15/25 at 09:41 AM, CMA R stated the resident was dependent on staff for all cares to include dressing. During an interview on 04/15/25 at 09:31 AM, Certified Nurse Aide (CNA) M stated [NAME] R6 was dependent for all cares and needed staff to dress her. CNA M further stated that R6's clothes should have been changed if they were dirty, it wouldn't have been right to take a R6 to the dining room in dirty clothes. During an interview on 04/14/25 at 12:37 PM, Administrative Nurse E stated that R6 would be left in her wheelchair by the nurse's station because she used to be a nurse there at the facility. During an interview on 04/15/25 at 02:41 PM, Administrative Nurse D stated she expected staff to change a resident's clothing if it were soiled. (continued on next page)

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Galena Nursing & Rehab Center	1220 E 8th Street Galena, KS 66739

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility policy for Activities of Daily Living (ADLs), undated, included: A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good grooming and personal hygiene. - The Physician Order Sheet (POS) for R29 documented the resident had a diagnosis of cerebral infarction accident (CVA-sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain). The Admission Minimum Data Set (MDS) for R29, dated 11/18/24, documented a Brief Interview for Mental Status (BIMS) of 13 indicating intact cognition. He required substantial to maximum assistance for personal hygiene. The Functional Abilities Care Area Assessment, dated 11/18/24, triggered related to R29 had actual ADL and self-care abilities declined related to weakness after an acute care stay related to congestive heart failure (CHF- decreased cardiac function). The Quarterly MDS for R29, dated 02/18/25, documented a BIMS of six indicating moderate to severe cognitive impairment. R29 required substantial to maximum assistance to shower/bathe and setup/clean-up assistance for personal hygiene. R29's Care Plan for ADL dated 03/19/25 documented ADLs had declined related to weakness after an acute care stay related to CHF. R29 was independent with eating and required substantial assistance with bathing, personal hygiene and transfers. R29's Electronic Health Record (EHR)s look-back from 03/19/25 through 04/14/25 revealed R29 received a shower on the following dates: 03/19/25--Partial/mod assist, *03/26/25--Res unavailable, *03/29/25--Res refused, *04/05/25--Not attempted, 04/09/25--Sub/max assist, *04/12/25--Not attempted. Review of the R29's EHR from 03/19/25 through 04/14/25 revealed he required setup or cleanup assist to substantial to maximal assist of staff for personal hygiene, including shaving. During an observation on 04/15/25 at 07:25 AM, R29 sat at the dining table unshaven, and his hair appeared greasy and dirty. During an interview on 04/15/25 at 09:31, Certified Nurse Aide (can) M stated that R29 had declined recently and he's now incontinent where he wasn't before. She reported that his dementia has gotten worse, but he hasn't refused cares. During an interview on 04/15/25 at 02:41 PM, Administrative Nurse D reported that residents had a choice as to how many showers they get, it's usually been at least two showers per week. Administrative Nurse D stated that the bath aide has been pulled to help on the floor, but it has usually been just to help out in the morning. She further stated that residents are generally shaven on the bath days based off the care plan preferences. The facility policy for Activities of Daily Living (ADLs), undated, included: A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good grooming and personal hygiene. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- The Physician Order Sheet (POS) for R17, documented the resident had a diagnosis of cerebral infarction accident (CVA-sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain). The Annual Minimum Data Set (MDS) for R17, dated 04/22/24, documented a Brief Interview for Mental Status (BIMS) of nine indicating moderate cognitive impairment. He was listed as independent with eating. The Nutritional Status Care Area Assessment, dated 04/22/24, triggered related to R17 was at risk for alteration in nutritional status related to a diagnosis of Diabetes Mellitus with insulin use, altered dental status (see dental CAA), and elevated Body Mass Index (MDI). The Quarterly MDS, for R17, dated 01/23/25, documented a BIMS of nine. R17 required substantial to maximum assist with eating. R17's Care Plan for ADL dated 02/04/25, documented R17 required substantial to maximal assistance with eating. During an observation on 04/15/25 at 08:01 AM, R17 ate part of his food without assistance and then stared at his uneaten eggs. No staff assisted R17 at the time. During an observation on 04/15/25 at 08:05 AM, R17 fell asleep at the dining table and a staff member walked by him. No staff assisted R17 at the time. During an observation on 04/15/25 at 08:13 AM, R17 continued to sit at the dining table and had not taken a drink and continued staring at his food as several staff walked by. No staff assisted R17 at the time. During an observation on 04/15/25 at 08:17 AM, Licensed Nurse (LN) G assisted R17 with his eggs and he ate them right away with staff assistance. During an observation on 04/15/25 at 11:38 AM, staff provided R17 with his lunch and cut it up. Staff provided a clothing protector and walked away. At 11:40 AM, R17 was looking around and not eating. During an observation on 04/15/25 at 11:57 AM, staff sat down beside R17 and assisted him with eating and there were no problems. During an interview on 04/15/25 at 08:26 AM, Certified Medication Aide (CMA) R stated that R17 sometimes needs help, lately he's needed more assistance. The facility policy for Activities of Daily Living (ADLs), undated, included: A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good grooming and personal hygiene.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 51334 The facility identified a census of 39 residents, with 15 residents sampled, including two residents reviewed for quality of care. Based on record review, interview, and observation, the facility failed to ensure Resident (R) 5 had adequate care when the facility did not monitor R5's weights and notify the provider of weight fluctuations as ordered. This deficient practice placed the resident at risk for health complications. Findings included: - Review of the Electronic Medical Record (EMR) documented R5 had a pertinent diagnosis of congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid). The 11/03/24 Annual Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) of 13, indicating intact cognition. R5's Care Plan dated 11/06/24, documented that R5 required a daily weight. The plan directed staff to notify heart failure of weight gain of three pounds overnight or five pounds in three days, increased shortness of breath, or increased swelling. R5's EMR from 02/01/25 through 04/14/25, revealed R5 gained weight on the following dates without provider notification: On 02/13/25 R5 gained 3.8 pounds from the previous day. No notification to provider. On 02/20/25 R5 gained 3 pounds from the previous day. No notification to provider. On 02/26/25 R5 gained 3.2 pounds from the previous day. No notification to provider. On 03/12/25 R5 gained 3.6 pounds from the previous day. No notification to provider. On 03/19/25 R5 gained 5.4 pounds in the past 3 days. No notification to provider. On 04/07/25 R5 gained 3.2 pounds from the previous day. No notification to provider. During an observation on 04/15/25 at 04:17 PM, R5 had edema to both legs and wore compression socks. During an interview on 04/16/25 at 11:48 AM, Licensed Nurse (LN) G stated that she was aware of the order to notify the provider with weight gain. LN G stated that the nurse enters the weights and looks at the previous one at that time. She would notify the provider for any weight gain. During an interview on 04/16/25 at 12:04 PM, Administrative Nurse D stated she expected staff to follow orders and notify the provider when appropriate. No policy was provided.

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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** 34056 The facility reported a census of 39 residents with 15 residents sampled including four residents reviewed for accidents. Based on observation, record review and interview, the facility failed to ensure a safe environment free from accident hazards for Resident (R)16 when staff failed to have foot pedals in place when staff propelled the resident in the chair. This placed R16 at risk for avoidable accidents. Findings included: - Review of R16's electronic medical record (EMR) revealed the following diagnoses: chorea (movement disorder) and Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure). The Annual Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of nine, indicating moderately impaired cognition. He had no impairment in functional range of motion (ROM) and was independent with his wheelchair for locomotion. The Functional Ability Care Area Assessment (CAA), dated 01/20/25, documented the resident would have a further activity of daily living (ADL) decline. The Quarterly MDS, dated [DATE], documented the resident had a BIMS score of nine. He had no impairment in functional ROM and was independent with his wheelchair for locomotion. R16's Care Plan, revised 02/10/25, instructed staff the resident had jerking movements due to a diagnosis of chorea and was independent with his walker. R16's EMR, from 03/19/25 through 04/14/25, revealed the resident was mostly independent with his walker and at times he was dependent on staff for mobility while in his wheelchair. On 04/14/25 at 08:57 AM, Social Services Staff X propelled the resident in his wheelchair from the dining room to his room following breakfast. The resident wore shoes and his feet were crossed at the ankle and tucked back underneath the seat of his wheelchair with the toe of his left foot skimming the floor. The wheelchair lacked foot pedals at that time. On 04/14/25 at 08:57 AM, Social Services Staff X stated the resident did not have foot pedals, because he usually propelled himself in the wheelchair. On 04/15/25 at 12:05 PM, Certified Medication Aide (CMA) R stated the resident would propel himself in the wheelchair most of the time but did at times require staff assistance. CMA R said staff were to utilize the foot pedals on R16's wheelchair while propelling the resident. On 04/15/25 at 02:41 PM, Administrative Nurse D stated she expected staff to utilize foot pedals while propelling R16 in his wheelchair. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility did not provide a policy regarding safe transport of residents while in their wheelchairs.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51334 The facility identified a census of 39 residents with 15 sampled. Based on observation, interview, and record review, the facility failed to provide care and services to maintain acceptable parameters of nutritional status by failing to properly follow the plan of care for Resident (R) 17. Also, the facility failed to properly assess nutritional status for R143. This deficient practice had the potential to negatively affect the residents physical well-being and nutritional status. Findings: - R17's Electronic Medical Record (EMR) revealed the following diagnoses: cerebrovascular accident (CVA-stroke- sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), and loss of cognition. The 04/22/24 Annual Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) of nine, indicating moderately impaired cognition. The MDS recorded R17's current weight was 174 and he had no weight loss. He consumed a regular textured diet with no eating or swallowing concerns. The 04/22/24 Cognitive Loss / Dementia (CAA) documented R17 had impaired mobility related to a stroke and required staff assistance with activities of daily life (ADL) performance and mobility. The 04/22/24 Nutrition CAA documented R17 was at risk for alteration in nutritional status. R17 was weighed at least monthly, and the weights reviewed. R17 will be reviewed in risk meetings per policy. The 01/23/25 Quarterly MDS documented a BIMS score of nine. He weighed 167 lbs. and had no significant weight loss. He ate a mechanically altered diet with no difficulty. The MDS documented R17 was independent with eating, but the staff documented he required substantial to maximal assistance with eating. R17's Care Plan documented R17 had impaired mobility related to a stroke and required staff assistance with care initiated on 06/15/22. An intervention on 10/30/24 documented R17 required substantial to maximal assistance with eating. An intervention dated 07/22/24 noted R17 required a soft diet with [NAME] portions; staff were directed to assist him with meals, and provide a lid with a straw in drinks. The plan directed R17 received mighty shakes (nutritional health shake). R17's EMR noted on 02/04/25, the resident weighed 165.2 pounds (lbs.) On 04/08/25, the resident weighed 152.2 lbs. which was a -7.87 % Loss. On 03/10/25, the resident weighed 161.9 lbs. On 04/08/25, the resident weighed 152.2 pounds which was a -5.99 % Loss. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Nutrition Risk Evaluation (NRE) - SNF - V 2 registered dietitian (RD) annual review dated 04/11/25 documented R17 was on a regular, soft diet. He received double portions as needed and mighty shakes two times a day. The RD noted a 13-pound weight loss in 60 days and recommended the addition of fortified foods with meals. The Progress Notes section of R17's EMR lacked documentation of weight loss. During an observation on 04/15/25 at 08:01 AM, R17 sat at the dining room table. He had already been assisted with his biscuits and gravy. He sat with the fork in his hand and stared at his uneaten eggs. During an observation on 04/15/25 at 08:05 AM, R17 rested with his head hanging down. Several staff walked by him, did not say a word, and just kept walking, R17 woke back up, stared down at his plate with his eggs, fork in hand not moving his hand. During an observation on 04/15/25 at 08:08 AM, Certified Medication Aide (CMA) S sat a health shake on the table beside R17. During an observation on 04/15/25 at 08:17 AM Licensed Nurse (LN) G asked R17 if he was done, and if he was going to eat the eggs. She sat down beside R17 and assisted him with the rest of his breakfast. R17 still had not taken a drink of the health shake and LN G did not offer it to him. During an observation on 04/15/25 08:22 AM R17 ate 100% with assistance from staff. LN G directed him to finish drinking his health shake and left. R17 picked up his health shake slowly then lowered it down. He did not take a drink. CMA R sat beside him and encouraged him to drink it, but did not assist him. R17 did not drink it. Staff then assisted R17 to the television room. During an observation on 04/15/25 at 11:38 AM, staff delivered R17's food and cut it up. She provided R17 a clothing protector and walked away. R17 sat at the table and looked around. He did not eat any food until 11:57AM when staff sat down to assist him. During an observation on 04/15/25 at 12:06 PM, with staff assistance, R17 had eaten all of the chicken pot pie. He ate part of the lima beans, but said he did not like them. The nurse left and R17 was able to slowly take one more bite of his dessert. During an observation on 04/16/25 at 03:32 PM, Social Services X assisted R17 in his wheelchair to be weighed. She placed his wheelchair on the scale and weighed him at 201.6 pounds. She noted the weight of the wheelchair on the side was 44.6 pounds. Social Service X stated the subtracted amount was three pounds more than she got this morning. During an interview on 04/15/25 at 08:26 AM, CMA R stated that R17's ability to feed himself varies, but lately, he has needed more assistance. During an interview on 04/16/25 at 08:56 AM, Administrative Nurse D reported that the facility had no restorative aide. The nurse aides do the program. Administrative Nurse D said the CNAs should assist R17 if he needed it. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/16/25 at 03:24 PM, Administrative Nurse D reported that R17 has been getting double portions and a health shake two times a day, Administrative Nurse D went to the kitchen with this surveyor and confirmed that R17 had not been getting double portions because the instruction did not flow over to the kitchen. Administrative Nurse D said she will put him on fortified foods, give double portions, and provide assistance. The facility policy for Weight Monitoring, undated, included: The facility will ensure that all residents maintain acceptable parameters of nutritional status unless the resident's clinical condition demonstrates that this is not possible, or the resident's preferences indicate otherwise. Findings: - R143's Electronic Medical Record (EMR) documented a diagnosis of end-stage renal disease (ESRD-a terminal disease of the kidneys) and dependence on dialysis. The Admission Minimum Data Set (MDS), was in progress. R143's Baseline Care Plan, dated 04/04/25, was reviewed on 04/14/25 at 03:48 PM. It documented R143 was a full code (desired resuscitative measures) and on skilled services with therapy. R143 was to have a regular diet. R143's Baseline Care Plan lacked documentation that R143 received dialysis or any direction for dialysis care and services. R143's EMR under the Orders tab documented R143 was on a regular diet dated 04/04/25. The Discharge Instructions from the hospital dated 04/04/25 R143 was to be on a diabetic, heart healthy diet and gave instructions for this diet. R143's EMR under the Orders tab documented R143 had an order for daily weight before breakfast dated 04/11/25. Review of the EMAR showed that on 04/11/25 and 04/14/25 a weight was not obtained. Review of the EMAR showed R143 had a discontinued order for weekly weights on Mondays dated 04/04/25. This was not obtained on 04/08/25. Review of the EMR from 04/04/25 to 04/14/25 documented weights obtained on 04/04/25, 04/12/25, and 04/13 /25. R143's Nutrition Risk Evaluation (NRE) - SNF - V 2 dated 04/07/25 lacked documentation that he was on dialysis or any altered diet. R143's EMR revealed the following: A Progress Note on 04/06/25 at 01:27 AM documented R143 was on heart healthy diabetic diet. A Progress Note on 04/07/25 at 02:45 AM documented R143 was on heart healthy diabetic diet. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/15/25 at 08:44 AM, R143 finished eating then staff assisted him to lay down in bed. R143 reported he went to dialysis on Monday, Wednesday, and Friday but he sometimes went on Tuesday if he had too much fluid. R143 reported the facility nurses did not do anything prior to him leaving including not obtaining his vital signs or pre-dialysis weight, or dialysis site assessment. He reported that sometimes he left before breakfast. So, dialysis gives him a protein bar while he is there. On 04/15/25 at 12:41 PM, Certified Nurse Aide (CNA) N stated R143 was on a fluid restriction that just started because he went to dialysis. She was not aware of anything else related to dialysis treatment. On 04/15/25 at 01:35 PM, Licensed Nurse (LN) G stated that the facility missed R143's orders for assessment and monitoring for dialysis on admission including diet orders. LN G verified the facility had not put anything on R143's Baseline Care Plan related to dialysis and said it should have been on admission. On 04/15/25 at 01:50 PM, Administrative Nurse D verified staff had not put any dialysis instructions on R143's Baseline Care Plan that was completed on admission and further said it should have included dialysis. Administrative Nurse D stated they expected a diabetic resident on dialysis should have diet orders that address ESRD including a fluid restriction and phosphorous binders. Administrative Nurse D also reported the Registered Dietician should have addressed dialysis in her assessment. The facility policy for Hemodialysis, undated, included: The facility will coordinate and collaborate with the dialysis facility to assure that the resident's needs related to dialysis treatments are met. The facility policy for Weight Monitoring, undated, included: The facility will ensure that all residents maintain acceptable parameters of nutritional status unless the resident's clinical condition demonstrates that this is not possible, or the resident's preferences indicate otherwise. New admits were to be weighed weekly unless daily weights were clinically indicated.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 51334 The facility identified a census of 39 residents. The sample included 15 residents with one sampled for dialysis (a procedure where impurities or wastes were removed from the blood) review. Based on observation, interview, and record review, the facility failed to provide the necessary dialysis assessment, care, and services for Resident (R) 143. This deficient practice had the risk for adverse outcomes and dialysis complications for R143. Findings: - R143's Electronic Medical Record (EMR) documented a diagnosis of end-stage renal disease (ESRD-a terminal disease of the kidneys) and dependence on dialysis. The Admission Minimum Data Set (MDS), was in progress. R143's Baseline Care Plan, dated 04/04/25, was reviewed on 04/14/25 at 03:48 PM. It documented R143 was a full code and on skilled services with therapy. The Baseline Care Plan lacked documentation that R143 received Dialysis services or any direction for dialysis care and services. R143's EMR under the Orders tab lacked evidence of orders related to dialysis care and services. R143's EMR revealed the following: An admission Progress Note on 04/04/25 at 07:50 PM documented R143 received dialysis on Monday, Wednesday, and Friday and his representative transported him. A Progress Note on 04/05/25 and 04/06/25 documented R143 received dialysis three times a week and his representative transported him. The fistula was intact. A Progress Note on 04/07/25 lacked documentation that R143 went to dialysis, returned from dialysis, or assessment related to dialysis. A Progress Note on 04/09/25 lacked documentation that R143 went to dialysis, returned from dialysis, or assessment related to dialysis. A Progress Note on 04/11/25 lacked documentation that R143 went to dialysis or assessment related to dialysis. A Progress Note on 04/11/25 at 05:21 PM documented R143 returned from dialysis with his representative at approximately 04:00 PM. R143 had no complaints at that time and staff documented his vital signs. The Progress Note lacked evidence of a fistula assessment. The facility was unable to provide any completed dialysis communication forms before and after dialysis. (continued on next page)

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	175233	A. Building B. Wing	04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Galena Nursing & Rehab Center	1220 E 8th Street Galena, KS 66739

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/15/25 at 08:44 AM, R143 finished eating then staff assisted him to lay down in bed. R143 reported he went to dialysis on Monday, Wednesday, and Friday but he sometimes went on Tuesday if he had too much fluid. R143 reported the facility nurses did not do anything prior to him leaving including not obtaining his vital signs or pre-dialysis weight, or dialysis site assessment. He reported that sometimes he left before breakfast. So dialysis gives him a protein bar while he is there. On 04/15/25 at 12:41 PM, Certified Nurse Aide (CNA) N stated R143 was on a fluid restriction that just started because he went to dialysis. On 04/15/25 at 01:35 PM, Licensed Nurse (LN) G stated that the facility missed R143's orders for assessment and monitoring for dialysis on admission. LN G stated the nurses did not do any pre or post assessment for dialysis. LN G stated R143's representative took him to dialysis, so the facility missed his dialysis assessments. On 04/15/25 at 01:50 PM, Administrative Nurse D stated the facility did not put R143's dialysis orders in on admission. Administrative Nurse D stated they expected the nurse to listen to R143's bruit (blowing or swishing sound heard when blood flows through a shunt) and feel the thrill (a fine vibration felt that reflects the blood flow by a dialysis resident's shunt) of his dialysis shunt, complete a pre and post dialysis assessment, weigh R143 daily, and provide communication between the dialysis center and the facility. Administrative Nurse D stated staff should receive education that no blood pressure should be done on that arm with the dialysis shunt. Administrative Nurse D stated the facility planned to get a new dialysis form and proper orders and education were being completed. The facility's Hemodialysis policy, undated, directed the facility coordinated and collaborated with the dialysis to assure that the resident's needs related to dialysis treatments were met.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. 51334 The facility identified a census of 39 residents. The sample included 15 residents with five reviewed for unnecessary medications. Based on observation, record review, and interviews, the facility failed to ensure blood pressure monitoring was conducted related to the use of midodrine (a medication used to increase blood pressure) for Resident (R)143. This placed R143 at risk of complications related to abnormal blood pressure. Findings included: - Review of R143's electronic medical record (EMR) revealed a diagnosis of hypotension (low blood pressure). The 04/10/25 Admission Minimum Data Set (MDS) was in progress. The 04/1/425 Baseline Care Plan dated 04/04/25 documented that midodrine (a medication used to increase blood pressure) had a Black Box Warning on it. It also gave instructions for staff to take a blood pressure before giving the medication and have the resident sitting upright when they do. It directed staff not to give the medication while the resident was laying down, or within four hours of bedtime. Review of R143's EMR revealed the following physician's order: Midodrine 10 milligrams (mg), by mouth, every eight hours as needed for a diagnosis of hypotension. Staff were to monitor the resident's blood pressure (BP) and give the medication if his systolic blood pressure (SBP- the top number, the force your heart exerts on the walls of your arteries each time it beats) was less than 100 millimeters of Mercury (mm/Hg) ordered 04/04/25. Review of the resident's BPs in her EMR, from 04/04/25 through 04/14/25, revealed the following: On 04/06/25 at 09:09 AM, R143 had a SBP of 97, no midodrine was given, and the doctor was not notified. On 04/14/25 at 04:48 PM, R145 had a SBP of 98, no midodrine was given, the doctor was not notified. During an observation on 04/15/25 at 08:44 AM, R143 finished eating and was assisted to lay down in bed. During an interview on 04/16/25 at 11:48 AM, Licensed Nurse (LN) G stated that she was now aware of the order to give the midodrine. LN G said the Certified Medication Aides (CMA) should notify the nurse if there was a blood pressure that is out of range. LN G stated they will look into a better way to put the order into the EMR so it does not get missed. She said she would notify the provider for any blood pressures that were out of range. During an interview on 04/16/25 at 12:04 PM, Administrative Nurse D stated she expected staff to follow orders and notify the provider when appropriate. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No policy was provided.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 52154 The facility reported a census of 39 residents. The sample included 15 residents. Based on interviews, record reviews, and observation, the facility staff failed to implement Enhanced Barrier Precautions (EBP a set of infection control measures that use gowns and gloves to reduce the spread of multidrug-resistant organisms [MDROs] in nursing homes) for Resident (R) 5 who had a foley catheter (a flexible tube inserted through a narrow opening into a body cavity, particularly the bladder, for removing fluid) and for R37 who received a tube feeding (administration of nutritionally balanced liquefied foods or nutrients through a tube) and wound care. Additionally, R7, who had an ostomy (a surgical procedure that creates an opening in the abdomen to allow waste or urine to pass out of the body) lacked EBP in place. This deficient practice had the potential to spread possible infections to the residents in the facility. Findings included: - During an observation on 04/14/25 at 08:30 AM, no EBP signage or precautions were noted outside any of the residents' doors in any of the hallways during an initial tour of the facility. During an observation on 04/14/25 08:42 AM, R37 sat in her room in her wheelchair. She had open wounds to her arm, buttock, and back. There was no EBP personal protective equipment (PPE) available and no signage present. During an observation on 04/14/25 01:13 PM, R7 had an ostomy in place, no EBP PPE was placed at or around the resident's room to be used when providing cares. During an observation on 04/15/25 at 10:15 AM, R7 had no EBP PPE or signage outside or around his room. During an observation on 04/14/25 at 02:47 PM, R5 had a foley catheter with a drainage bag and there were no EBP PPE, or signage placed. During an interview on 04/14/25 at 08:42 AM, R37 reported that staff did not use gowns when taking care of her. She further stated she received tube feedings. During an interview on 04/14/25 at 02:47 PM, R5 reported that he had a catheter leg bag on, he further stated that staff did not wear gowns or anything when they provided cares. During an interview on 04/14/25 at 10:11 AM, Certified Medication Aide (CMA) R reported that EBP were used when a resident had a foley catheter or if there were wounds. CMA R stated that the EBP PPE would be set-up outside the resident's room and a sign would be placed on the resident's door. During an interview on 04/14/25 at 10:15 AM, Licensed Nurse (LN) G reported that EBP would be utilized when a resident had an infection or a foley catheter. During an interview on 04/15/25 at 01:27 PM, CMA R stated they had not been doing EBP, but they had been trained that day and EBP had now been placed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/15/25 at 01:30 PM, LN G stated that they had not been using EBP due to the Director of Nursing being new, and they had just forgotten to use them. The facility's undated policy Enhanced Barrier Precautions documented that all staff received training upon hire and at least annually and they are expected to comply with all designated precautions. The policy documented the following conditions require EBP; wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) and/or indwelling medical devices (urinary catheters, feeding tubes) even if the resident is not known to be infected or colonized with a multidrug-resistant bacteria organism (MDRO). Make gowns and gloves available immediately near or outside the resident's room.

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34056 The facility reported a census of 39 residents with 15 residents sampled. Based on observation, interview, and record review, the facility failed to inspect Resident (R)6's bed frame and mattress, as part of a regular maintenance program to identify areas of possible entrapment. This placed the resident at risk for injuries. Findings included: - Review of R6's electronic medical record (EMR) revealed a diagnosis of dementia (progressive mental disorder characterized by failing memory and confusion). The Annual Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of two, indicating severe cognitive impairment. She was dependent on staff for rolling left and right while in bed and had no limitation in range of motion (ROM). The Functional Ability Care Area Assessment (CAA), dated 12/30/24, did not trigger. The Quarterly MDS, dated [DATE], documented the resident had a BIMS score of one, indicating severe cognitive impairment. She had limitations in ROM to her bilateral lower extremities (BLE) and was dependent on staff for rolling left and right while in bed. R6's Care Plan for hospice, revised 02/25/25, instructed staff that hospice would supply the resident's bed and mattress. On 04/14/25 at 02:07 PM, the resident rested in bed with her eyes closed. Observation of the resident's bed revealed a gap of approximately six inches from the top of the resident's mattress to the head of her bed (HOB). On 04/15/25 at 09:41 AM, Certified Nurse Aide (CNA) M and Certified Medication Aide (CMA) R transferred the resident from her wheelchair to her bed with the use of a full-body lift. Observation of the resident's bed revealed a gap of approximately six inches from the top of the resident's mattress to the HOB, remained. On 04/15/25 at 09;41 AM, CMA R stated the resident's mattress has been shorter than her bed frame for a long time. On 04/16/25 at 11:45 AM, Maintenance Staff U stated he had not checked the resident's bed to ensure it was in good working condition as it was not a facility bed. On 04/15/25 at 02:41 PM, Administrative Nurse D stated she expected the resident's mattress to fit the resident's bed frame. The facility policy for Accommodation of Needs, undated, included: The facility will make reasonable accommodations to individualize the resident's physical environment including their bedroom.