STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175239	A. Building B. Wing	08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Diversicare of Council Grove	400 Sunset Drive Council Grove, KS 66846

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34056 The facility reported a census of 43 residents with 14 residents sampled, including two residents reviewed for dignity. Based on observation, interview, and record review, the facility failed to show respect and dignity to two Residents (R)19, by failing to cover the resident's bare lap, which left the silicone portion of an indwelling urinary catheter (a catheter that is inserted into the bladder and left in place for many days or weeks) visible to others while in the dining room and R41 for failure to utilize a dignity cover for the collection leg bag of the resident's indwelling urinary catheter while in the dining room and common's area. Findings included: - Review of Resident (R)41's electronic medical record (EMR) revealed a diagnosis of obstructive and reflux uropathy (when urine flow is blocked (partially or completely) through the ureter (the duct by which urine passes from the kidney to the bladder), bladder, or urethra (the duct by which urine is conveyed out of the body from the bladder) due to an obstruction and when urine flows backward from the bladder into the kidneys). The Admission Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of six, indicating severe cognitive impairment. He had an indwelling catheter (a catheter that is inserted into the bladder and left in place for many days or weeks) and required substantial to maximal staff assistance with toileting. The Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA), dated 03/27/24, documented the resident had a urinary catheter due to urinary retention and obstruction. The Quarterly MDS, dated [DATE], documented the resident had a BIMS score of six, indicating severe cognitive impairment. He had an indwelling catheter and required substantial to maximal staff assistance with toileting. The indwelling urinary catheter care plan, revised 06/27/24, lacked staff instruction regarding the use of a dignity cover for the resident's leg collection bag. Review of the resident's EMR revealed the following physician's order: (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Indwelling urinary catheter 16 French (fr--the measurement of the external diameter of the catheter tube), 10 centimeters (cc--the length of the urinary tubing), to dependent drainage, ordered 05/07/24. On 08/27/24 at 07:47 AM, the resident sat in the dining room awaiting breakfast. His urinary catheter leg bag was attached at the right ankle and lacked a dignity cover, making the collection bag containing urine, visible to all in the dining room. On 08/27/24 at 10:45 AM, the resident sat in the common's area watching TV. His urinary catheter leg bag was attached at the right ankle and lacked a dignity cover, making the collection bag containing urine, visible to all in the common's area. On 08/27/24 at 10:53 AM, the resident sat in the dining room awaiting lunch. His urinary catheter leg bag was attached at the right ankle and lacked a dignity cover, making the collection bag containing urine, visible to all in the dining room. On 08/27/24 at 10:55 AM, the resident stated he would prefer others not be able to see his catheter bag. On 08/27/24 at 01:13 PM, Certified Nurse Aide (CNA) N stated the staff attach the leg bag to the resident's ankle. CNA N stated they did not have a dignity bag to place over the leg bag. On 08/27/24 at 01:13 PM, CNA M stated the facility did not have bags to place the catheter leg bags in to hide them. They only had covers for the normal sized catheter bags. On 08/28/24 at 08:03 AM, Administrative Nurse D stated it was the expectation for staff to use a cover of some type for all catheter bags. The facility policy for Rights of Nursing Facility Residents, dated May 2012, included: Every resident has the right to be treated with dignity, respect, and consideration. The facility failed to utilize a dignity cover for this dependent resident's catheter bag, making the bag, containing urine, visible to others in the dining room and common areas of the facility. 28560 - Review of Resident (R) 19's medical record revealed diagnoses that included cerebral vascular accident (CVA - stroke sudden death of brain cells due to lack of oxygen), osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain), chronic obstructive pulmonary disease (COPD a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), and neurogenic bladder (dysfunction of the urinary bladder caused by a lesion of the nervous system). The Significant Change Minimum Data Set (MDS), dated [DATE], assessed the resident with a Brief Interview for Mental Status (BIMS) score of four, which indicated severe cognitive impairment. The resident required substantial to maximal assistance for transfers and utilized a wheelchair for mobility. The resident had an indwelling urinary catheter. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Urinary Incontinence and Indwelling Catheter (CAA), dated 01/29/24, was not developed. The Falls CAA dated 01/29/24, assessed the resident as unsteady on her feet and did not remember to call. The resident had multiple diagnoses that affected her balance and had a recent decline in her ability to transfer, ambulate, and make her elf understood. The resident had urinary catheter placed for urinary retention. The Quarterly MDS dated [DATE] revealed the resident had a BIMS score of three, which indicated severe cognitive impairment. The resident required supervision/touching assistance for transfers and utilized a wheelchair for mobility. The resident had one non-injury fall during the look back period. The resident had an indwelling urinary catheter. The Care Plan reviewed 08/21/24, instructed staff to provide catheter care with soap and water every shift. A Physician's Order dated 07/24/24, instructed staff to maintain a number 18 French (a size of tubing that is inserted directly into the bladder) urinary catheter to dependent drainage. Observation, on 08/26/24 at 11:39 AM, revealed the resident seated in her wheelchair in the dining room with approximately six inches of the urine collection tubing lay directly on floor. Observation, on 08/27/24 at 08:00 AM, revealed the resident seated in the common dining area without a lap robe to cover her exposed thighs. The actual urinary catheter was visible and hanging down between the resident's open legs. Approximately eight inches of the urine collection tubing lay directly on the floor. Observation, on 08/27/24 at 08:17 AM, revealed the Certified Nurse Aide (CNA) P transported the resident in her wheelchair to her room. Approximately eight inches of the catheter tubing lay directly on the floor during the transport. Upon transfer into the bed the catheter moved under the resident's right thigh and lacked an anchoring device. CNA P stated the resident should have an anchoring device, but she usually took them off. Search for an anchoring device in the bed or on the floor failed to find the device. Interview, on 08/28/24 at 08:08 AM, with Administrative Nurse D, revealed she would expect staff to provide an anchoring device, but the resident did frequently remove the device herself and would need to explore options for catheter anchoring to keep the device secure and protected. Administrative Nurse D stated she would expect to be diligent in ensuring the resident unknowingly exposed herself and catheter in public places. The facility policy for Rights of Nursing Facility Residents, dated May 2012, included: Every resident has the right to be treated with dignity, respect, and consideration. The facility failed to ensure staff maintained the R19's dignity when she unknowingly exposed herself and the urinary catheter in common living areas.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36881 The facility reported a census 43 residents with 14 residents sampled, which included Resident (R)18 reviewed for reasonable accommodation. Based on observation, interview, and record review, the facility failed to ensure reasonable accommodation of R18's needs when the facility failed to follow up on recommendations for a different wheelchair, which would meet the resident's physical needs and preference to maintain his independence. Findings included: - Review of Resident (R)18's Physician Orders, dated 08/18/24, included diagnoses muscular dystrophy (MD - group of inherited disorders that involve muscle weakness and loss of muscle tissue, and worsen over time), contracture (abnormal permanent fixation of a joint or muscle) of the right and left ankles, immobility syndrome (paraplegic-paralysis characterized by motor or sensory loss in the lower limbs and trunk) and anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear). The Modified Annual Minimum Data Set (MDS), dated [DATE] documentation included a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact. He required staff assistance for activities of daily living (ADLs). The resident had functional limitation with range of motion of his upper and lower extremities and had no behaviors. He reported it was very important to have his family or a close friend involved in discussion about his care. R18 lacked any noted skin conditions or treatments. The Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA), dated 10/19/23 revealed the resident was dependent with most activities of daily living (ADLs) due to his MD. The resident was independently mobile once he is in his motorized wheelchair. The Care Plan dated 08/01/24, directed the staff to know the resident had an activities of daily living (ADL) deficit, he was non weight bearing, and used electric wheelchair for locomotion. Review of the Occupational Therapy (OT) Evaluation & Plan of Treatment dated 03/03/23 (17 months prior) documentation included the resident and clinician were to participate in a seating and positioning assessment to determine the resident's wheelchair needs to maximize his upright posture and decrease the risk of further skin breakdown/contracture's as the resident's disease process continued. His current electric wheelchair was donated to him years ago. The note stated the resident's knees were increasingly flexed and he had poor positioning of ankles/feet, which lead to worsening the risk of contracture's to the resident's lower extremities. The Weekly Nurses Note, dated 07/21/24 at 08:57 AM, included R18 had muscular dystrophy which was slowly advancing. The resident worried about his diagnosis and any subtle changes in his body or routine were very upsetting to him. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Physician Progress Note, in the electronic medical record (EMR), dated 08/21/24 at 03:51 PM, included the resident's muscular dystrophy, which was slowly progressing was causing weakness and disabilities. The note lacked documentation noting the resident's representative/1st emergency contact or responsible party were contacted regarding an evaluation or assessment for a new electric wheelchair or follow-up related to his changing condition. Review of R18's Electronic Medical Record dated 03/23/23 through 08/23/24 (17 months,) lacked documentation or follow-up regarding the assessment recommendation for R 18's specific wheelchair to meet his needs for seating and positioning related to maintain his functioning identified by therapy on 03/03/23, as noted above. On 08/27/24 at 09:54 AM, revealed the resident in the shower room and Certified Nurse Aide (CNA) R answered the call light and entered the shower room to assist the resident with dressing after his shower. CNA R confirmed the resident was dependent on the staff for transfers to the wheelchair and then operated his electric wheelchair independently. Observation on 08/27/24 at 10:03 AM the resident exited the shower room as he sat in his electric wheelchair maneuvering it independently. The resident controlled the wheelchair with his right hand maneuvered through the doorway without difficulty. R18 reported his wheelchair was on its last leg due to the wheels going flat and the last maintenance man and his brother had to patch and pumped the wheels up. He stated his brothers were talking with the nursing home administrator (NHA) about possibility of getting another wheelchair, but he did not know what the status was with his wheelchair. On 08/27/24 at 12:26 PM, R18's designated representative reported he made multiple attempts to contact the facility administrator and left messages with the staff of the facility regarding the resident obtaining a electric wheelchair to meet R18's needs. The representative expressed his displeasure with the facility's lack of communication, which included the failure to return phone calls and/or response to messages regarding the resident's need for a different wheelchair to prevent further decline and maintain his functioning. He stated he called and left messages with the facility as recent as 06/07/24 and 07/11/24. The administrator had not called him back at the time of the interview. R18's representative stated it should not be so difficult to get a timely response from the facility so he would have information on how to meet his family member's needs. On 08/28/24 at 09:45 AM, Administrative Staff A stated a year or so ago therapy staff recommended the resident receive an evaluation for a new electric wheelchair. The provider assessed the resident and made recommendations. The recommendations were forwarded to the facility's corporate office for determination on how to proceed. On inquiry Administrative Staff A confirmed the resident's medical record lacked documentation of the assessment, recommendations, and/or corporate determination/directive how to proceed with meeting the identified need related to the resident's assessment and resulting recommendation. Additionally, Administrative Staff A verified the resident's electronic medical record lacked documentation of follow-up regarding the recommendations with the resident's representative, and he did not recall talking with the resident's representative regarding the providers recommendation or corporate decision regarding the provision of the needed device. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/28/24 at 11:12 AM, R18 reported the therapist recommended a new wheelchair that would fit him better than the current one. He reported the current electric wheelchair was on its last leg and he did not know the status regarding obtaining a wheelchair that met his identified need for positioning R18 reported he thought the facility administrator was discussing the wheelchair with his chosen representative. He stated his representative informed him that he had trouble getting in touch with the administrator, although he had tried multiple times. R18 confirmed he expected the facility to communicate with his chosen representative regarding health care decisions because he forgot things sometimes. On 08/28/24 at 11:50 AM, Therapy Consultant HH stated she tried to get R18 a new wheelchair in March of 2023. She reported she felt a new wheelchair fitted to the resident would be beneficial to maximize the resident's upright posture and decrease the risk of skin breakdown and contracture's as the resident's disease progressed. The company that assessed the resident was specialized in seating and positioning. Consultant HH reported the resident exhibited tightening of his bilateral leg muscles related to his diagnosis. She felt the current electric wheelchair would contribute to further decline and it was her opinion that a power tilt chair would benefit the resident and enhance his independence. The company assessed the resident and recommended the resident to have a power tilt wheelchair. The recommendation was then submitted to the administrator who informed her the recommendation was forwarded to the facility's corporate office. Consultant HH stated she was not aware of the follow up or final determination regarding the resident getting the recommended electric wheelchair. The facility lacked a policy to address reasonable accommodation of identified needs for a resident. The facility failed to ensure reasonable accommodation of R18's needs when the facility failed to follow up on recommendations for a different wheelchair, which would meet the resident's physical needs and preference to maintain his independence.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36881 The facility reported a census 43 residents with 14 residents sampled, which included one Resident (R)18 reviewed for notification of change in condition. Based on observation, interview, and record review, the facility failed to notify the resident's chosen representative when the resident required a new form of treatment, related to the resident's newly diagnosed scabies infestation. Findings included: - Review of Resident (R) 18's Physician Orders, dated 08/18/24, included diagnoses muscular dystrophy (MD-group of inherited disorders that involve muscle weakness and loss of muscle tissue, and worsen over time), contracture (abnormal permanent fixation of a joint or muscle) of the right and left ankles, immobility syndrome (paraplegic) and anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear) disorder, and scabies infestation (contagious infestation of the skin by burrowing mites). The Modified Annual Minimum Data Set (MDS), dated [DATE] included a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact. He required staff assistance for activities of daily living (ADL), had functional limitation with range of motion of his upper and lower extremities, and used a wheelchair for mobility. He reported it was very important to have his family or a close friend involved in discussions about his care. The MDS lacked any noted skin conditions for R18's treatments. The Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA), dated 10/19/23, revealed the resident was dependent for most ADLs due to his muscular dystrophy. He was cognitively intact with a BIMS of 15 and independently mobile once in his motorized wheelchair. The Care Plan dated 08/01/24, lacked any interventions related to the resident's change of condition and/or treatment for a scabies infestation. R18's Physician Orders, dated 08/18/24, included an order for Permethrin External Cream 5 % (Permethrin-lotion used to treat scabies infestation). Staff were to apply to the resident's skin from neck down topically one time a day for rash for seven days at night and shower it off in the morning. Review of the Progress Notes dated 08/21/24, lacked documentation of the resident's representative/1st emergency contact, or responsible party were notified of the resident's change in condition and/or new order for treatment of scabies. The Weekly Nurses Note, dated 08/24/2024 at 10:17 AM, documentation included the resident was treated for a scabies type rash. Observation on 08/27/24 at 09:54 AM, revealed the resident in the shower room and Certified Nurse Aide (CNA) R answered the call light and entered the shower room to assist the resident with dressing after shower. CNA R confirmed the resident had a rash and received lotion for treatment of scabies infestations. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/27/24 10:03 AM, the resident exited the shower room as he sat in his electric wheelchair maneuvering it independently. The resident controlled it with his right hand and maneuvered through the doorway without difficulty. The resident reported no discomfort or itching. On 08/27/24 at 03:31 PM, Administrative Nurse D stated the resident's representative should be notified change of condition and/or medication /treatment. She reported when the physician diagnosed the resident with the scabies infestation and ordered the treatment, she expected the staff to notify the resident's chosen representative. Upon review of R18's electronic medical record she confirmed the resident's representative had not been notified of the change of condition and treatment plan. Additionally, the resident's care plan had not been updated to direct the staffs care of R18. On 08/28/24 at 11:12 AM, R 18 reported it was his understanding that the facility would let his chosen representative know about changes in his condition and/or changes in his treatment or medication. He confirmed his documented representative was his chosen representative and would want him aware of his health status at all times. R18 stated sometimes he forgot information and what was said. The facility Policy Notification of Change in Patient/Resident Health Status dated 06/2027 documentation included to ensure all interested parties are informed of the patient's/resident's change in health status so that a treatment plan can be developed which is in the best interest of the patient/resident. The center will notify the patient's representative when an acute illness occurs. The facility failed to notify the resident's chosen representative when there was a need to commence a new form of treatment, related to the resident's newly diagnosed scabies infestation.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 28560 The facility reported a census of 43 residents with 14 residents selected for review. Based on observation, interview, and record review, the facility failed to review and revise the care plans for four or the sampled residents, Resident (R) 18 and R8 for scabies (a contagious skin infection caused by mites) infections, R41 for use of urine collection leg bag device, and R19 for self-removal of anchoring device, and alternative catheter stabilizing devices. Findings included: - Review of R8's medical record, revealed a diagnosis of dementia (progressive mental disorder characterized by failing memory, confusion), and vision loss. The Significant Change Minimum Data Set (MDS), dated [DATE], assessed the resident with severely impaired cognition. The resident was dependent on staff for activities of daily living (ADLs). The Cognitive Loss/Dementia Care Area Assessment (CAA) revealed the resident required extensive/total assistance with all ADLs. The Care Plan reviewed 06/07/24, instructed staff the resident had altered skin integrity due to psoriasis (a chronic skin disease that causes thick scaley inflamed skin), staff were to provide treatments as ordered, and conduct weekly skin assessments. The care plan lacked an update for suspicion of scabies (a contagious skin infection caused by mites) infection. A Nurse Note dated 06/04/24, documented the staff noticed the resident scratching and digging at her stomach and chest, and noted pruritic (itching) bumps. A Physician's Order dated 06/06/24, instructed staff to apply Permethrin (a medicated cream used to treat mites) 5% cream to the resident's body at bedtime, one time, and then shower the resident and change all linens in the morning for scabies. A Nurse Note dated 08/03/24, documented the staff noticed a clustered itchy rash to the resident's trunk. A Physician's Order dated 08/03/24, instructed staff to apply Permethrin 5% cream R18's body at bedtime, and then shower resident and change all linens in the morning for scabies at bedtime for seven days for recurrent scabies. Interview, on 08/28/24 at 01:00 PM, with Administrative Nurse D, revealed the resident had suspected scabies infection, and had two rounds of Permethrin treatment. Administrative Nurse D stated the incidents were not added to the care plan. The facility policy Care Plans effective June 2027, instructed to revise the care plan as needed according to the resident status. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility failed to review and revise the resident's care plan to include the R8's initial and recurrent infection with scabies. - Review of Resident (R) 19's medical record revealed diagnoses that included cerebral vascular accident (CVA stroke sudden death of brain cells due to lack of oxygen), osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain), chronic obstructive pulmonary disease (COPD a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), neurogenic bladder (dysfunction of the urinary bladder caused by a lesion of the nervous system). The Significant Change Minimum Data Set (MDS), dated [DATE], assessed the resident with a Brief Interview for Mental Status (BIMS) score of four, which indicated severe cognitive impairment. The resident required substantial to maximal assistance for transfers and utilized a wheelchair for mobility. The resident had an indwelling urinary catheter. The Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA), dated 01/29/24, was not developed. The Falls CAA dated 01/29/24, assessed the resident as unsteady on her feet and noted she did not remember to call for assistance. The resident had multiple diagnoses that affected her balance and had a recent decline in her ability to transfer, ambulate, and make herself understood. The resident had a urinary catheter placed for urinary retention. The Quarterly MDS dated [DATE] revealed the resident had a BIMS score of three, which indicated severe cognitive impairment. The resident required supervision/touching assistance for transfers and utilized a wheelchair for mobility. The resident had one non-injury fall during the look back period. The resident had an indwelling urinary catheter. The Care Plan reviewed 08/21/24, instructed staff to provide catheter care with soap and water every shift. A Physician's Order dated 07/24/24, instructed staff to maintain a number 18 French (a size of tubing that is inserted directly into the bladder) urinary catheter to dependent drainage. Observation, on 08/26/24 at 11:39 AM, revealed the resident seated in her wheelchair in the dining room. Approximately six inches of the urine collection tubing lay directly on floor. Observation, on 08/27/24 at 08:00 AM, revealed the resident seated in the common dining area. The resident lacked a lap robe to cover her exposed thighs. The actual urinary catheter was visible and hanging down between the resident's open legs. Approximately eight inches of the urine collection tubing lay directly on the floor. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation, on 08/27/24 at 08:17 AM, revealed the Certified Nurse Aide (CNA) P transported the resident in her wheelchair to her room. Approximately eight inches of the catheter tubing lay directly on the floor during the transport. Upon transfer into the bed the catheter became placed under the resident's right thigh and lacked an anchoring device. CNA P stated the resident should have an anchoring device, but she usually took them off. Search for an anchoring device in the bed or on the floor failed to find the device. Interview, on 08/28/24 at 08:08 AM, with Administrative Nurse D, revealed she would expect staff to provide an anchoring device, but the resident did frequently remove the device herself and would need to explore options for catheter anchoring and include measures on the care plan. The facility policy Care Plans effective June 2027, instructed to revise the care plan as needed according to the resident status. The facility failed to review and revise the care plan to include R19's care plan to include alternatives for the urinary catheter device and R19's behavior of removing the anchoring device to ensure the catheter remained sanitary and in proper position. 34056 - Review of Resident (R)41's Electronic Medical Record (EMR) revealed a diagnosis of obstructive and reflux uropathy (when urine flow is blocked [partially or completely] through the ureter [the duct by which urine passes from the kidney to the bladder], bladder, or urethra [the duct by which urine is conveyed out of the body from the bladder] due to an obstruction and when urine flows backward from the bladder into the kidneys). The Admission Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of six, indicating severe cognitive impairment. He had an indwelling catheter (a catheter that is inserted into the bladder and left in place for many days or weeks) and required substantial to maximal staff assistance with toileting. The Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA), dated 03/27/24, documented the resident had a urinary catheter due to urinary retention and obstruction. The Quarterly MDS, dated [DATE], documented the resident had a BIMS score of six, indicating severe cognitive impairment. He had an indwelling catheter and required substantial to maximal staff assistance with toileting. The indwelling urinary catheter Care Plan, revised 06/27/24, lacked staff instruction regarding the use of a leg bag for the resident's catheter and lacked staff instruction regarding the need for a dignity cover for the leg bag. Review of the resident's EMR revealed the following physician's order: Indwelling urinary catheter 16 French (fr--the measurement of the external diameter of the catheter tube), 10 centimeters (cm--the length of the urinary tubing), to dependent drainage, ordered 05/07/24. (continued on next page)

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Diversicare of Council Grove	400 Sunset Drive Council Grove, KS 66846

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/27/24 at 07:47 AM, the resident sat in the dining room awaiting breakfast. His urinary catheter leg bag was attached at the right ankle and lacked a dignity cover, making the collection bag containing urine, visible to all in the dining room. On 08/27/24 at 10:45 AM, the resident sat in the common's area watching TV. His urinary catheter leg bag was attached at the right ankle and lacked a dignity cover, making the collection bag containing urine, visible to all in the common's area. On 08/27/24 at 10:53 AM, the resident sat in the dining room awaiting lunch. His urinary catheter leg bag was attached at the right ankle and lacked a dignity cover, making the collection bag containing urine, visible to all in the dining room. On 08/27/24 at 10:55 AM, the resident stated he would prefer others not be able to see his catheter bag. On 08/27/24 at 01:13 PM, Certified Nurse Aide (CNA) N stated the staff attach the leg bag to the resident's ankle. CNA N stated they did not have a dignity bag to place over the leg bag. On 08/27/24 at 01:13 PM, CNA M stated the facility did not have bags to place the catheter leg bags in, to hide them. They only had covers for the normal sized catheter bags. On 08/28/24 at 08:03 AM, Administrative Nurse D stated the leg bag and dignity bag should be included on the resident's care plan. The facility policy for Care Plans, revised June 2017, included: Care plans will be developed for all residents based upon the Resident Assessment Instrument (RAI) guidelines. Care plans are developed by the interdisciplinary team (IDT) and revised as needed according to resident status or change. The facility failed to review and revise this dependent resident's care plan to include the leg bag for his urinary catheter and the need for a dignity bag. 36881 - Review of Resident (R) 18's Physician Orders, dated 08/18/24, included diagnoses muscular dystrophy (MD-group of inherited disorders that involve muscle weakness and loss of muscle tissue, and worsen over time), contracture (abnormal permanent fixation of a joint or muscle) of the right and left ankles, immobility syndrome (paraplegic) and anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear) disorder, and scabies infestation (contagious infestation of the skin by burrowing mites). The Modified Annual Minimum Data Set (MDS), dated [DATE] documentation included a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact. He required staff assistance for activities of daily living (ADL). The resident had functional limitation with range of motion of his upper and lower extremities and used a wheelchair for a mobility device. He reported it was very important to have his family or a close friend involved in discussions about his care. R18 lacked any noted skin conditions or treatments. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA), dated 10/19/23 revealed the resident was dependent for most ADLs due to his Muscular Dystrophy. He was cognitively intact with a BIMS of 15 and independently mobile once in his motorized wheelchair. The Care Plan dated 08/01/24, failed to address the resident's change of condition and treatment for a scabies infestation. R18's Physician Orders, dated 08/18/24, documentation included an order for Permethrin External Cream 5 % (Permethrin-lotion used to treat scabies infestation). Staff were to apply the cream to from neck down, topically, one time a day for rash for seven days at night and shower it off in the morning. Review of Progress Notes dated 08/21/24 lacked documentation of the resident's representative/1st emergency contact, or responsible party were notified of the resident's change in condition and/or new order for treatment. The Weekly Nurses Note, dated 08/24/24 at 10:17 AM documentation included the resident was treated for a scabies type rash. Observation on 08/27/24 at 09:54 AM, revealed the resident in the shower room and Certified Nurse Aide (CNA) R answered the call light and entered the shower room to assist the resident with dressing after shower. CNA R confirmed the resident had a rash and received lotion for treatment of scabies infestations. On 08/27/24 at 10:03 AM the resident exited the shower room. He sat in his electric wheelchair maneuvering it independently. The resident controlled it with his right hand and maneuvered through the doorway without difficulty. The resident reported no discomfort or itching. On 08/27/24 at 03:31 PM, Administrative Nurse D stated the resident's care plan should have been updated to provide guidance to the staff related to the treatment of R18's scabies infestation when ordered by the physician. She confirmed the resident's care plan had not been updated to direct the staff's care of R18. The facility Policy Notification of Change in Patient/Resident Health Status dated 06/2027 documentation included a treatment plan should be developed to ensure patient's/resident's change in health status to address an acute change in condition/treatment (intervention). The facility failed to review and revise R18's care plan to reflect a new acute diagnosis of scabies infestation and its prescribed treatment for the resident.

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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 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** 28560 The facility reported a census of 43 residents with 14 residents selected for review, which included three residents reviewed for accidents. Based on observation, interview and record review, the facility failed to ensure staff provided safe transfers for one, Resident (R)19, of the three residents reviewed. Findings included: - Review of Resident (R)19's medical record revealed diagnoses that included cerebral vascular accident (CVA stroke sudden death of brain cells due to lack of oxygen), osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain), chronic obstructive pulmonary disease (COPD a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), neurogenic bladder (dysfunction of the urinary bladder caused by a lesion of the nervous system). The Significant Change Minimum Data Set (MDS), dated [DATE], assessed the resident with a Brief Interview for Mental Status (BIMS) score of four, which indicated severe cognitive impairment. The resident required substantial to maximal assistance for transfers and utilized a wheelchair for mobility. The resident had two or more non-injury falls during the look back period. The Falls Care Area Assessment (CAA), dated 01/29/24, assessed the resident as unsteady on her feet and did not remember to call. The resident had multiple diagnoses that affected her balance and had a recent decline in her ability to transfer, ambulate, and make her elf understood. The resident had urinary catheter placed for urinary retention. The Quarterly MDS dated [DATE] revealed the resident had a BIMS score of three, which indicated severe cognitive impairment. The resident required supervision/touching assistance for transfers and utilized a wheelchair for mobility. The resident had one non-injury fall during the look back period. The Care Plan reviewed 08/21/24, instructed staff the resident was at risk for falls with a decreased perception of safety and to place a bedside table near the resident for personal items. The resident had antiroll back brakes on her wheelchair. Staff were instructed to place call light and personal items within easy reach. Staff were instructed to provide partial to moderate assistance with toilet hygiene and all transfers per revision on 07/03/24. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation, on 08/27/24 at 08:17 AM, revealed the Certified Nurse Aide P transported the resident in her wheelchair to her room. CNA P aligned the wheelchair perpendicular to the bed and instructed the resident to grab the side rail and transfer herself into the bed. The resident leaned forward and grabbed the wheelchair, and the chair moved due to the resident weight still in a seated position in the chair but reaching for the siderail. CNA P then locked the brakes on the wheelchair. The resident attempted to stand several times but had difficulty to bring herself to a standing position. CNA P stated the resident usually transferred herself and did not require staff assistance. CNA P then obtained a gait belt to assist the resident to stand. The resident then stood with staff assistance and pivoted into the bed. The resident's water cup was on the floor beside the head of the bed out of her reach. CNA P stated the cup should be placed on the footstool so the resident could reach it from the low position of her bed to prevent her from overreaching and to keep the cup sanitary. Interview, on 08/28/24 at 08:08 AM, with Administrative Nurse D, revealed she would expect staff to use a gait belt to transfer residents and lock the brakes on the wheelchair when transferring a resident as per standard of practice. The facility policy Falls Prevention dated April 2024 instructed staff to identify interventions to prevent falls. The facility failed to ensure staff provided safe transfer techniques for this resident at risk for falls with weakness and balance deficits.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28560 The facility reported a censes of 43 residents with 14 residents selected for review and three residents reviewed for bowel and bladder. Based on observation, interview, and record review, the facility failed to analyze one Resident (R) 95's three-day voiding diary to determine type of incontinence and pattern of incontinence to mitigate fall occurrences and provide sanitary urinary catheter (a tube that drains urine from the bladder) care for one resident (R19) to prevent urinary tract infections of the three residents reviewed. Findings included: - Review of Resident (R) 19's medical record revealed diagnoses that included cerebral vascular accident (CVA stroke sudden death of brain cells due to lack of oxygen), osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain), chronic obstructive pulmonary disease (COPD a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), neurogenic bladder (dysfunction of the urinary bladder caused by a lesion of the nervous system). The Significant Change Minimum Data Set (MDS), dated [DATE], assessed the resident with a Brief Interview for Mental Status (BIMS) score of four, which indicated severe cognitive impairment. The resident required substantial to maximal assistance for transfers and utilized a wheelchair for mobility. The resident had an indwelling urinary catheter. The Urinary Incontinence and Indwelling Catheter (CAA), dated 01/29/24, was not developed. The (Falls CAA dated 01/29/24, assessed the resident as unsteady on her feet and did not remember to call. The resident had multiple diagnoses that affected her balance and had a recent decline in her ability to transfer, ambulate, and make her elf understood. The resident had urinary catheter placed for urinary retention. The Quarterly MDS dated [DATE] revealed the resident had a BIMS score of three, which indicated severe cognitive impairment. The resident required supervision/touching assistance for transfers and utilized a wheelchair for mobility. The resident had one non-injury fall during the look back period. The resident had an indwelling urinary catheter. The Care Plan reviewed 08/21/24, instructed staff to provide catheter care with soap and water every shift. A Physician's Order dated 07/24/24, instructed staff to maintain a number 18 French (a size of tubing that is inserted directly into the bladder) urinary catheter to dependent drainage. Observation, on 08/26/24 at 11:39 AM, revealed the resident seated in her wheelchair in the dining room. Approximately six inches of the urine collection tubing lay directly on floor. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation, on 08/27/24 at 08:00 AM, revealed the resident seated in the common dining area. The resident lacked a lap robe to cover her exposed thighs. The actual urinary catheter was visible and hanging down between the resident's open legs. Approximately eight inches of the urine collection tubing lay directly on the floor. Observation, on 08/27/24 at 08:17 AM, revealed the Certified Nurse Aide (CNA) P transported the resident in her wheelchair to her room. Approximately eight inches of the catheter tubing lay directly on the floor during the transport. Upon transfer into the bed the catheter became placed under the resident's right thigh and lacked an anchoring device. CNA P stated the resident should have an anchoring device, but she usually took them off. Search for an anchoring device in the bed or on the floor failed to find the device. Interview, on 08/28/24 at 08:08 AM, with Administrative Nurse D, revealed she would expect staff to provide an anchoring device, but the resident did frequently remove the device herself and would need to explore options for catheter anchoring. Administrative Nurse D stated she would expect to be diligent in ensuring the tubing did not directly lay on the floor. Administrative Nurse D stated the facility used a skills checklist as a policy for catheter care but failed to provide it. The facility failed to ensure staff provided sanitary catheter care for this resident with a history of urinary tract infections. - Review of Resident (R) 95's medical record revealed diagnoses that included stress incontinence (sudden loss of urine due to increased abdominal pressure), nocturia (urination during the night), transient ischemic attack (TIA an episode of cerebrovascular (blood flow to the brain) insufficiency), diabetes (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin) and osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain). The Admission Minimum Data Set (MDS) dated [DATE]. Assessed the resident with a Brief Interview for Mental Status (BIMS) score of 00 which indicated severe cognitive impairment and frequently incontinent of urine with no toileting plan in place. The resident required supervision/touch assist with toileting and had no impairment in upper or lower extremities. The Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA), dated 07/22/24, assessed the resident required assistance with toileting needs and had incontinent episodes and the Care Plan will initiate and review interventions to improve and maintain current toileting skills and continent status to decrease falls, and risk of pressure ulcers, and urinary tract infections. The Interim Payment MDS dated [DATE], assessed the resident with a BIMS score of 14, which indicated normal cognitive function. The Care Plan reviewed 07/22/24, instructed staff the resident had an alteration in elimination of bowel and bladder and had functional incontinence. The care plan instructed staff to remind the resident to call for assistance, encourage fluids and exercise, observe and report changes in the ability to toilet/continence status, and observe for urinary tract infection signs and symptoms. The care plan lacked a personalized toileting plan. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Elimination assessment dated [DATE] indicated the resident awakened for toileting and utilized briefs and pads and was continent of urine. The 3 Day Voiding Trial dated 07/15-07/17/24, documented 17 episodes of a wet condition (indicated incontinence). The Interpretation of Data was not completed to determine R95's voiding pattern. A Nurse Note dated 08/25/24 at 02:15 PM, documented staff found the resident sitting on the floor by her bed. The resident told staff she needed to toilet. Observation, on 08/27/24 at 08:49 AM, revealed the resident seated in her wheelchair in the common dining room feeding herself breakfast. The resident propelled herself with her feet in the wheelchair and wheeled herself into the community bathroom. Interview, on 08/27/24 at 09:17 AM, with Certified Nurse Aide (CNA) P revealed the resident could tell staff when she needed to toilet but did not know if there was a toileting plan in place. CNA P stated the resident could take herself to the bathroom but should request staff assistance and assisted the resident in the common bathroom. Interview, on 08/27/24 at 09:30 AM, with Certified Medication Aide (CMA) R, revealed the resident had good and bad days, and should request staff assistance at times, but did not know if there was a toileting plan for the resident as she thought the resident took herself to the bathroom most of the time. Interview, on 08/28/24 at 08:30 AM, with Administrative Nurse D, confirmed the three-day voiding diary lacked interpretation of data and the resident had fallen on 08/25/24 when trying to get to the bathroom. Administrative Nurse D stated the intervention for the fall included toileting the resident before she lays down for a nap. The facility policy Fall Prevention dated April 2024 instructed staff to evaluate a toileting schedule. The facility failed to interpret the 3-Day Voiding Trial data to determine R95's toileting patterns to develop a personalized care plan.

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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. 28560 The facility reported a census of 43 residents, 14 residents selected for review, which included one resident reviewed for respiratory care. Based on observation, interview, and record review the facility failed to ensure staff provided sanitary care to respiratory equipment and administration of aerosolized (vapor) medication for one Resident (R) 39. Findings included: - Review of Resident (R)39's medical record revealed diagnoses that included chronic obstructive pulmonary disease (COPD a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing) and congestive heart failure (CHF a condition with low heart output and the body becomes congested with fluid). The Admission Minimum Data Set (MDS). Dated 02/05/24, assessed the resident with a Brief Interview for Mental Status (BIMS) score of seven, with indicated severe cognitive impairment. The Cognitive Loss Care Area Assessment (CAA) dated 02/05/24, assessed the resident had COPD and CHF The resident had a low oxygen level without her continuous flow oxygen and understood the importance of keeping the oxygen on. The Care Plan reviewed instructed staff to administer oxygen as per the physician's order and assist with oxygen tubing when she ambulated. A Physician's Order, dated 01/29/24, instructed staff to provide oxygen to the resident by nasal cannula at 2 liters (L) per minute continuously for COPD. A Physician's Order, dated 04/24/24, instructed staff to administer ipratropium-albuterol (medications used to dilate the airway and lungs to make breathing easier and allow more efficient oxygen exchange) inhalation solution 0.5-2.5 milligrams (mg)/3 milliliters (ml) one vial orally via nebulizer (a devise that turns liquid medication into vapor) four times a day for COPD. Observation, on 08/26/24 at 02:56 PM, revealed the resident seated in her room. The oxygen tubing cannula lay directly on the floor. Certified Medication Aide (CMA) Q Q washed her hands but did not don gloves. The oxygen tubing cannula lay directly on the floor. CMA Q obtained a wet paper towel and began to wipe the cannula and tubing off. Upon questioning for effectiveness of sanitization, CMA Q stated she would replace the cannula and tubing. CMA Q washed her hands but did not don gloves. CMA Q connected the components of the nebulizer, then placed the vial of ipratropium-albuterol into the aerosol chamber and handed it to the resident. After completion of the treatment, CMA Q without performing hand hygiene or donning gloves, rinsed the components with water from the bathroom sink wiped them with a paper towel, and was about to return them to the storage container, but dropped them on the floor. CMA Q then proceeded to re-rinse the components with water from the bathroom sink. When questioned on the effectiveness of sanitation, CMA Q stated she should replace the nebulizer components. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview, on 08/28/24 at 08:08 AM, with Administrative Nurse D, revealed she would expect staff to obtain new oxygen cannula, tubing, and nebulizer components if they fell on the floor per the standard of practice, and staff should perform hand hygiene and gloving when providing the nebulizer treatments and when cleaning the equipment. The facility policy Oxygen Guideline updated 08/10/24, instructed staff to provide oxygen in accordance with acceptable standard of practice. The facility policy Nebulizer Guidelines updated 08/01/24, instructed staff to follow guidance by the Center for Disease Control Guidelines for Preventing Healthcare-Associated Pneumonia The facility failed to ensure staff provided respiratory care in a sanitary manner to this resident with a compromised respiratory system to prevent the spread of airborne infections.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 34056 The facility reported a census of 43 residents. Based on observation, record review, and interview, the facility failed to display accurate, publicly accessible, and identifiable staffing information, on a daily basis, for the 43 residents who resided in the facility. Findings included: - Review of the facility's Daily Staffing Sheets, for the past 90 days, revealed the actual hours worked had not been completed on the daily staffing sheets. On 08/28/24 at 09:37 AM, Administrative Nurse D stated the facility did not include the actual hours worked on the daily staffing sheets. The staffing sheets were completed for the day and hung up each morning without any changes made. The facility lacked a policy for the completion of daily staffing sheets. The facility failed to properly complete the daily staffing sheets for the residents of the facility.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34056 The facility reported a census of 43 residents with 14 residents sampled, including five residents reviewed for unnecessary medications. Based on interview and record review, the facility failed to ensure two Residents (R) 12 and R 27 remained free from unnecessary medications related to failure to administer as needed (PRN) medications for bowel movements (BM). Findings included: - Review of Resident (R) 12's electronic medical record (EMR) revealed a diagnosis of constipation (the inability to pass stool). The Annual Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. She required extensive assistance of two staff for transfers and toileting. She was always continent of bowel and had no constipation during the assessment period. The Activities of Daily Living (ADL) Functional/Rehabilitation Potential Care Area Assessment (CAA), dated 08/28/23, documented the resident required staff assistance with transferring and toileting. The Urinary Incontinence and Indwelling Catheter CAA, dated 08/28/23, documented the resident would notify staff for assistance with toileting. The Quarterly MDS, dated [DATE], documented the resident had a BIMS of 14, indicating intact cognition. She was dependent on staff for toileting transfers and was frequently incontinent of bowel. The Alteration in Elimination of Bowel Care Plan, revised 08/22/24, instructed staff the resident had constipation and staff were to administer bowel medication, as needed (PRN). Review of the resident's EMR, from 07/28/24 through 08/25/24, revealed the resident did not have a bowel movement (BM) from 08/21/24 through 08/25/24, a total of five days. Review of the resident's Medication Administration Record (MAR) for August, revealed the resident did not have any PRN medications available for administration regarding constipation. On 08/26/24 at 09:52 AM, the resident stated she had constipation from time to time, but rarely received medication to help her move her bowels. On 08/27/24 at 02:32 PM, Certified Nurse Aide (CNA) O stated staff documented BMs on the computer. On 08/27/24 at 12:24 PM, Licensed Nurse (LN) G stated the computer would send an alert for all residents who had not had a BM in three days. Not all residents received the same thing for constipation. It depended on who the resident was. If a resident needed something for constipation LN G stated she would give them prune juice. LN G was unsure if there was a specific bowel protocol at the facility. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175239	A. Building B. Wing	08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Diversicare of Council Grove	400 Sunset Drive Council Grove, KS 66846

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/27/24 at 02:27 PM, LN G stated the day shift nurse would run a list of all residents who needed a PRN medication for constipation. Nursing will give the residents PRN medications depending on what orders they had. LN G stated the resident did not have any orders for constipation so the physician would need to be notified and an order obtained. On 08/28/24 at 07:33 AM, Administrative Nurse D stated the nurses were responsible for pulling a report from the computer of any resident who had not had a BM in three days or more. The nurse would then need to notify the physician if the resident did not have PRN orders for bowels. The facility did not have standing orders for a bowel protocol. The facility lacked a policy regarding bowel movements. The facility failed to utilize PRN medications for this dependent resident with constipation. - Review of Resident (R)27's electronic medical record (EMR) revealed a diagnosis of constipation (the inability to pass stool). The Annual Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. He required substantial to maximal staff assistance for toileting transfers. He was occasionally incontinent of bowel. Constipation was not assessed. The Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA), dated 08/08/24, documented the resident required staff assistance with toileting. The Quarterly MDS, dated [DATE], documented the resident had a BIMS score of 15, indicating intact cognition. He required substantial to maximal staff assistance with toileting transfers and was always continent of bowel. The Care Plan for alteration in elimination of bowel, revised 08/08/24, instructed staff the resident had a diagnosis of constipation. Staff were to administer bowel medications, as ordered. Review of the resident's EMR, from 07/29/24 through 08/02/24, revealed the resident did not have a bowel movement (BM) from 07/31/24 through 08/04/24, a total of four days. Review of the resident's EMR revealed the following physician's orders: Milk of Magnesia (MOM-a laxative used to help the bowels move), 30 milliliters (ml), by mouth (po), every (Q) 24 hours, as needed (PRN), for constipation, ordered 12/16/20. MiraLAX powder (a laxative), 17 grams (gm), po, Q 24 hours, PRN, for constipation, ordered 08/30/23. Senekot (a stool softener to assist in the passing of stool with constipation), 8.6-50 mg, po, twice daily (BID), for constipation, ordered 09/21/22. (continued on next page)

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	175239	A. Building B. Wing	08/28/2024

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/26/24 at 09:48 AM, the resident stated that he would often have constipation and would ask the nurse for a PRN medication. The resident stated the nurses would sometimes give him something for the constipation and other times would not. On 08/27/24 at 02:32 PM, Certified Nurse Aide (CNA) O stated staff documented BMs on the computer. On 08/27/24 at 12:24 PM, Licensed Nurse (LN) G stated the computer would send an alert for all residents who had not had a BM in three days. Not all residents received the same thing for constipation. It depends on who the resident was. If a resident needed something for constipation LN G stated she would give them prune juice. LN G was unsure if there was a specific bowel protocol at the facility. On 08/27/24 at 02:27 PM, LN G stated the day shift nurse would run a list of all residents who needed a PRN medication for constipation. Nursing would give the residents PRN medications depending on what orders they had. On 08/28/24 at 07:33 AM, Administrative Nurse D stated the nurses were responsible for pulling a report from the computer of any resident who had not had a BM in three days or more. The nurse would then need to notify the physician if the resident did not have PRN orders for bowels. The facility did not have standing orders for a bowel protocol. The facility lacked a policy regarding bowel movements. The facility failed to utilize PRN medications for this dependent resident with constipation.

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 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 34056 The facility reported a census of 43 residents. Based on observation, interview, and record review the facility failed to electronically submit to Centers for Medicare and Medicaid Services (CMS) with complete and accurate direct staffing information, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS on the Payroll Base Journal (PBJ), related to licensed nursing staffing information, when the facility failed to accurately report weekend staffing for Quarter 3 of 2023 (April 1-June 3), Quarter 4 of 2023 (July 1-September 30), Quarter 1 of 2024 (October 1-December 31) and Quarter 2 of 2024 (January 1-March 31). Findings Included: - Review of the Payroll Base Journal (PBJ) Staffing Data Report for fiscal year (FY), Quarter 3 2023 (April 1-June 3), Quarter 4 (July 1-September 30), Quarter 1 2024 (October 1-December 31) and Quarter 2 (January 1-March 31), revealed excessively low weekend staffing. Review of the facility's daily staffing sheets revealed the facility's weekend staffing to be the same as the staffing on weekdays. On 08/28/24 at 09:37 AM, Administrative Staff A stated that Administrative Nurse D worked most weekends. Since Administrative Nurse D was a salaried employee, her hours were not shown on the facility timesheet hours. Administrative Staff A stated the facility would send their hours to their corporate office and the corporate office was responsible for turning the time into Centers for Medicare and Medicaid Services (CMS). The facility lacked a policy regarding the completion of the PBJ. The facility failed to accurately report weekend staffing on the PBJ for four quarters.