STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175254	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Diversicare of Sedgwick	712 N Monroe Avenue, Box 49 Sedgwick, KS 67135

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. The facility reported a census of 42 residents. The sample included 15 residents, which included three residents selected for closed record review. Based on interviews and record review the facility failed to provide the necessary care and service needed to manage symptoms when staff failed to promptly identify and react to a change in condition for Resident (R) 29, who had diabetes mellitus. On 05/04/25 R29 refused all his morning medication including his diabetic medications; R29's blood glucose was 388 milligrams (mg) per deciliter (dL) at 05:45 AM that morning. Staff did not notify R29's physician of the medication refusal or the abnormally high blood glucose level. On the evening of 05/04/25, R29 refused all his medications again and had a blood glucose of 513 mg/dL at 09:00 PM but staff did not notify the provider of the dangerously high blood glucose or the medication refusals. On the morning of 05/05/25, staff entered an order for a one-time dose of Humalog (fast-acting insulin) at 06:13 AM but the insulin was not administered as R29 was unresponsive and sent by ambulance to the hospital at 07:40 AM. The facility's failure to identify and respond to changes in R29's medical condition and immediately involve the physician placed R29 in immediate jeopardy. Findings included: - R29's Electronic Medical Record (EMR) documented diagnoses of congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), anorexia (lack or loss of appetite), type 2 diabetes mellitus with diabetic neuropathy (DM-a long-term complication of type 2 diabetes where nerve damage occurs, primarily due to chronically elevated blood sugar levels), and acute osteomyelitis of left ankle and foot (an infection of the bone that develops fast). The Significant Change Minimum Data Set (MDS) dated 03/24/25 documented a Brief Interview for Mental Status (BIMS) score of 13, which indicated intact cognition. The assessment documented R29 required supervision or touching assistance activities of daily living (ADL) such as oral and personal hygiene, and partial to moderate assistance with bathing. The MDS noted R29 received insulin injections for all seven days in the observation period. R29's Care Plan dated 12/14/23 and revised on 11/18/24 documented R29 had an alteration in blood glucose due to being insulin-dependent with a diagnosis of diabetes mellitus. Interventions included the administration of medications and insulin as ordered. The plan directed staff to observe R29 for high blood sugar symptoms and report to the nursing/physician any changes in vision, decreased mental function, poorly healing wounds, dizziness, dehydration, vomiting, cardiac symptoms, or renal dysfunction. (continued on next page)

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

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

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R29's Care Plan dated 08/01/24 documented R29 was at risk for decreased mood related to a history of depression, use of medication for management, and refusal to eat. Interventions included the administration of medications as ordered and informing the physician if symptoms were not improving. R29's Care Plan dated 01/21/25 documented R29 was at risk for impaired cardiovascular status related to congestive heart failure, coronary artery disease (heart disease), and peripheral vascular disease. Interventions included giving medications as ordered by the physician, observing and reporting any signs of chest pain, edema (swelling), shortness of breath, abnormal pedal (foot) pulses, restlessness, and fatigue; staff were to observe for any changes in condition. R29's Care Plan dated 04/07/25 documented R29 had the potential for alteration in hydration related to diabetes mellitus with an active infection. Staff were directed to notify the physician of signs or symptoms of excess fluid. The plan directed staff to observe R29 for mental status changes and changes in mood or behavior. R29's EMR under the Orders tab listed an order for a fasting and evening blood glucose level two times daily for DM, dated 08/26/24. The order lacked instructions regarding notification parameters. R29's May 2025 Medication Administration Record/ Treatment Administration Record (MAR/TAR) revealed on 05/04/25 documented a 2 indicating R29 refused all his morning (AM) scheduled medication including aspirin, liquid protein supplement, metoprolol tartrate (a medication used to treat high blood pressure and cardiac issues), Reglan (medication used to treat digestive issues), amoxicillin (antibiotic), thiamine HCl (supplement), cholecalciferol (supplement), clopidogrel bisulfate (used to prevent blood clots), ferrous sulfate (iron supplement), folic acid (supplement), Megace (appetite stimulant), mirtazapine (medication used to treat depression), pantoprazole sodium (medication used to treat digestive disorders), rosuvastatin (medication used to lower cholesterol), and Sertraline HCl (medication used to treat depression). The MAR/TAR also listed R29 refused his empagliflozin (medication used to treat diabetes mellitus) and Tradjenta (injectable medication to treat high blood glucose). R29's EMR and MAR/TAR lacked evidence the staff notified R29's physician regarding the medication refusals. R29's May 2025 MAR/TAR recorded the 05:30 AM fasting blood glucose was 388 mg/dL (normal fasting glucose is between 80-120 mg/dL). R29's EMR lacked evidence the staff notified the physician regarding the abnormally high fasting blood glucose level. R29's May 2025 MAR/TAR documented a 2 to indicate the resident refused his evening (HS) medications which included mirtazapine (medication used to treat depression), melatonin (supplement used to promote sleep), tamsulosin HCl (medication used to treat prostate disorders), amoxicillin, liquid protein supplement, metoprolol tartrate, and Reglan (scheduled at 05:00 PM). R29's EMR and MAR/TAR lacked evidence the staff notified R29's physician regarding the evening medication refusals. R29's May 2025 MAR/TAR recorded R29's 08:00 PM blood glucose was 513 mg/dL. R29's EMR lacked evidence the staff notified the physician regarding the abnormally high blood glucose level. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R29's May 2025 MAR/TAR recorded no as-needed medication was administered on 05/04/25. R29's May 2025 MAR/TAR recorded an order dated 05/05/25 at 06:13 AM for Humalog, inject 10 units one time only, for elevated blood sugar; recheck blood sugar 30 minutes after administration. The order was documented at 4 indicating the medication was not administered because the resident was hospitalized . R29's EMR lacked any notes under the Notes tab for 05/03/25 and 05/04/25. R29's EMR recorded a Progress Note dated 05/05/25 at 06:18 AM which documented the above Humalog order. R29's EMR recovered a late entry note dated 05/05/25 at 03:17 PM which noted the resident was sent to the hospital at 07:40 AM due to the resident was unresponsive. A review of the facility's TEAM Health Standing Orders or Skilled and Long-Term Care Units dated 08/29/23 directed staff to notify the physician of blood glucose over 350 mg/dL unless otherwise specified. A review of the facility's investigation provided by the facility revealed LN G worked with R29 on 05/03/25 and 05/04/25 revealed the facility verified LN G did not perform her duties on 05/04/25 in regard to medication and charting issues. During an interview on 05/13/25 at 01:30 PM, Licensed Nurse (LN) I reported that the facility provider should be notified if a resident's blood glucose is 350 mg/dL or higher or 60 mg/dL and below. During an interview on 05/13/25 at 01:46 PM, Administrative Nurse C verified there were no progress notes in the EMR for R29 on 05/04/25. During an interview on 05/13/25 at 02:55 PM, LN I reported he charted by exception and did not chart anything on 05/04/25 due to R29 being lucid and responding appropriately. LN I reported he had previously contacted the provider and informed her that he believed R29 was giving up and reported the provider agreed. During an interview on 05/13/25 at 03:12 PM, Administrative Nurse C reported the facility charted by exception unless the resident was a new admit or had a change in status. During an interview on 05/14/25 at 08:59 AM, LN F stated the facility had standing orders to notify the provider if a resident had a blood glucose of 350 mg/dL or above or 60 mg/dL and below. LN F also reported that she had been instructed during orientation to notify the provider if a resident had refused medication during a shift. During an interview on 05/14/25 at 09:10 AM, Administrative Nurse C reported that facility protocol was to notify the provider if a resident had refused medications. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Notification of Patient/Resident Change Policy, dated 11/01/16, indicated that the facility would notify the resident's provider and notify the resident's legal representative or interested family member whenever there is an acute illness or a significant change in the resident's physical, mental, or psychosocial status or whenever a there was a need to significantly alter treatment. On 05/14/25 at 01:00 PM, Administrative Staff A received a copy of the Immediate Jeopardy [IJ] Template and was informed of the IJ for R29. On 05/14/25 at 05:00 PM, the facility submitted an acceptable removal plan which included the following corrective actions: 1. R29 was assessed on 05/05/25 at 06:45 AM. Staff contacted Emergency Medical Services for assessment and transport to the hospital. 2. Staff notified R29's physician and representative on 05/05/25 at 07:05 AM. 3. The facility initiated an investigation of the event on 05/05/25. LN G was placed on administrative leave pending the results of the investigation; LN G was terminated on 05/08/25. 4. An audit of all residents with a diagnosis of diabetes mellitus was completed to evaluate for change of condition and physician notifications were made as appropriate on 05/14/25 5. The Director of Nursing (DON) and Designee provided re-education to all licensed nursing staff on 05/14/25 and/or prior to working on immediate physician notification for blood glucose levels exceeding 350 mg/dL or per resident-ordered parameters and documentation protocols for refusals and physician notifications. 6. A full clinical review of all diabetic residents was conducted by DON on 05/14/25. No other residents were identified to be at immediate risk due to medication refusal or lack of provider notification. 7. The facility conducted a Quality Assurance and Performance Improvement (QAPI) meeting addressing the incident on 05/14/25 with the attendance of the Administrator, DNS, and Medical Director by phone. Removal of the immediacy was verified by the onsite survey team on 05/15/25. The deficient practice remained at a scope and severity of G to represent the actual harm to R29.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. The facility identified a census of 42 residents. The sample included 15 residents with one reviewed for activities of daily living (ADL). Based on observation, record review, and interviews, the facility failed to ensure Resident (R) 21, a resident in a persistent vegetative state (state of wakefulness accompanied by a complete lack of cognitive function) received adequate restorative care, including the application of splints, to minimize further decline. This deficient practice placed R21 at risk for increased pain and contractures (abnormal fixation of joints or muscles). Findings included: - A review of R21's Electronic Medical Record (EMR) revealed a diagnosis of a persistent vegetative state. The 03/07/25 Annual Minimum Data Set (MDS) documented R21 was in a vegetative state; R21 was dependent on staff for her care. The MDS noted R21 received no range of motion (ROM- the full movement potential of a joint, usually its range of flexion and extension) exercise during the assessment period. The 03/07/25 Care Area Assessment (CAA) did not trigger for R21 for ADLs. R21's Care Plan dated 04/10/25 documented that she was dependent on staff for all of her care due to a persistent vegetated status with arm and foot contractures. The plan noted an intervention dated 05/17/21 which directed that heel boots should be worn. R21's Care Plan dated 04/10/25 directed to maintain proper positioning by using stuffed animals to preserve R21's skin integrity related to contractures. The care plan lacked interventions related to wrist braces. During an observation on 05/14/25 at 10:40 AM, Certified Nurse Aide (CNA) T transferred R21 with the assistance of another CNA. They positioned R21 in bed. There were two papers on the wall just above the resident's head with a picture of a wrist brace on it labeled left and right. CNA T reported that R21 was supposed to wear the wrist splints, but she did not know where the splints were. CNA T said the facility did not have restorative aides, and the CNAs did not do ROM or any restorative programs. During an observation on 05/15/25 at 08:52 AM, R21 lay in bed with no boots or hand braces. R21's arms were propped on a stuffed animal and her wrist dangled in a flexed position. R21 tightened and flexed further. R21's feet were contracted in a foot drop (inability or difficulty in moving the ankle and toes upward) position. During an interview on 05/14/25 at 12:34 PM, Licensed Nurse (LN) KK stated that R21's splints had a broken strap, so staff sent it to therapy. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/15/25 at 08:59 AM, Therapy Staff LL stated he found the splints buried in a drawer in R21's room. Therapy LL said therapy worked with some residents repeatedly because the facility did not have a restorative program. Therapy LL said the facility was aware of the problem and was implementing a plan to start a restorative program. Therapy LL provided a list of residents who would benefit from a restorative program to Administrative Nurse E. During an interview on 05/15/25 at 11:22 AM, Administrative Nurse E stated the facility had not had a restorative program for a long time. Administrative Nurse E stated the facility had taken steps to initiate a restorative program and identified residents who needed restorative services. Administrative Nurse E stated the facility had not completed any restorative assessments or evaluations yet, because they did not have any staff that have had training. Administrative Nurse E said the facility needed to get the CNAs trained before the CNAs could proceed. Administrative Nurse E said the nurse did get an order to get R21 therapy services to evaluate for hand splints and positioning and then took the sign down for the hand splints. During an interview on 05/15/25 at 12:13 PM, Administrative Nurse C stated the facility did not have a restorative program and has not for a long time. She was unsure how long. They have identified it as a concern and they are working on initiating a restorative program. The facility's Restorative Guideline dated 2024, documented each resident will be screened or evaluated for inclusion in the appropriate restorative program when the need is identified.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. The facility identified a census of 42 residents. The sample included 15 residents with one reviewed for enteral nutrition (provision of nutrients through the gastrointestinal tract when the resident cannot ingest, chew, or swallow food). Based on observation, record review, and interviews, the facility failed to ensure Resident (R) 21, a resident fed by enteral means, received the appropriate treatment and services to prevent complications of enteral feeding when staff failed to monitor R21's weight routinely and/or as ordered. This placed the resident at risk for continued weight loss and malnutrition. Findings included: - A review of R21's Electronic Medical Record (EMR) revealed a diagnosis of a persistent vegetative state (state of wakefulness accompanied by a complete lack of cognitive function). The 03/07/25 Annual Minimum Data Set (MDS) documented R21 was in a vegetative state; R21 was dependent on staff for her care. The MDS noted R21 weighed 145 pounds and she had no weight loss or gain since the last MDS. The MDS recorded R21 had a feeding tube and received her nutrition from it. R21's 03/07/25 Nutritional Care Area Assessment (CAA) triggered secondary to swallowing issues, enteral diet, and the presence of a Stage 2 (partial-thickness skin loss into but no deeper than the dermis including intact or ruptured blisters) pressure ulcer on her left buttock. The CAA noted R21's risk factors included weight instability and a care plan would be developed to improve and maintain dietary and hydration status and monitor weights. The 03/07/25 Feeding Tube CAA triggered secondary to use of a feeding tube for maintenance of nutritional and hydration status. The CAA noted contributing factors included a vegetative state and a care plan would be developed and maintained to improve and maintain nutritional and hydration status, monitor labs and weights. R21's Care Plan dated 03/20/23 documented R21 had a a potential for alteration in hydration related to enteral feeding and directed staff to monitor R21's weights per physician order. R21's Care Plan dated 02/17/25 documented R21 was at nutritional risk related to a persistent vegetative state; she was dependent on staff for tube feedings to provide all nutritional and fluid needs. The plan directed staff to monitor weights. R21's EMR revealed the following physician's order: Weekly weight on shower day, every Wednesday, ordered on 04/09/24. R21's Registered Dietitian's Progress Note on 05/12/25 at 03:05 PM, documented R21 had no intake by mouth and had weekly weights. R21's EMR documented the following: (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Staff did not weigh R21 on 02/05/25. On 02/12/25, 02/19/25, and 02/26/25 the nurse documented R21 was weighed, but no documentation was recorded of R21's actual weight. On 03/05/25 and 03/19/25 staff did not weigh R21. On 03/12/25 and 03/25/25 the nurse documented that R21 was weighed, but no documentation was recorded of R21's actual weight. On 04/23/25 the nurse documented that R21 was weighed, but no documentation was recorded of R21's actual weight. On 04/16/25 and 04/30/25 the order was not documented as completed nor was a weight recorded. On 05/07/25 and 05/14/25 the nurse documented that R21 was weighed, but no documentation was recorded of R21's actual weight. R21's EMR, Under the weights section, documented a gradual decrease since 09/05/25. On 09/05/25 R21's weight was 153.3 pounds and on 04/04/25 R21's weight was 144.6 pounds. During an observation on 05/14/25 at 11:04 AM, Licensed Nurse (LN) KK wore a gown and gloves and administered medications to R21 via the feeding tube. LN KK flushed the tube before and after administering the medications. During an interview on 05/14/25 at 11:04 AM, LN KK stated that staff weighed R21 every Sunday and on her bath day. LN KK said the nurses would enter the weight in the computer after the staff obtained it. During an interview on 05/15/25 at 12:13 PM, Administrative Nurse C stated that when a resident receives enteral feedings, staff should be obtaining weights at least weekly. The facility's competency for Administering Eternal Feedings documented that staff should weigh the resident daily or three times a week as appropriate.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 42 residents. There were 15 residents in the sample, with one resident reviewed for trauma-informed care. Based on observation, interview, and record review the facility failed to develop and implement approaches to care that were both clinically appropriate and person-centered for Resident(R) 12, who had a history of personal trauma and substance abuse. This placed the resident at risk for decreased quality of life and re-traumatization. Findings included: - R12's Electronic Health Record (EHR) revealed diagnoses that included major depressive disorder (major mood disorder that causes persistent feelings of sadness), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and post-traumatic stress disorder (PTSD- a mental disorder characterized by an acute emotional response to a traumatic event or situation involving severe environmental stress). The Significant Change in Status Minimum Data Set (MDS) dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 99, and noted R12 refused to answer any questions regarding mood as well. The MDS noted R12 used a manual wheelchair and walker and required supervision/touching assistance for transfers. The MDS recorded R12 had active diagnoses of anxiety, depression, and PTSD. The Delirium Care Area Assessment (CAA) dated 03/02/25 indicated R12 had symptoms of delirium (sudden severe confusion, disorientation, and restlessness) due to the presence of an acute mental status change and/or the presence of inattention, disorganized thinking or altered mental status. The End of PPS Part A Minimum Data Set (MDS) dated [DATE], documented a BIMS score of 15, indicating intact cognition. The MDS noted R12 answered yes to having little interest or pleasure in doing things, trouble falling asleep and/or staying asleep or sleeping too much; R12 felt tired or had little energy. The MDS noted R12 required supervision/touching assistance with transfers and walking 10 feet or more. R12's Care Plan interventions, dated 03/19/21 and revised 03/14/25 noted PTSD but did not address any triggers identified and did not address R12's history of illicit drug use. The care plan did not include interventions to address the resident's adjustment difficulties and/or history of trauma. The care plan lacked any description of the resident's indications of distress and/or interventions intended to assist the resident. R12's Progress Notes from 01/01/25 to 05/15/25 lacked any documentation of past trauma. A review of R12's Physician Encounter dated 07/19/22, 10/17/23, 08/26/24, and 05/06/25 listed past marijuana use and PTSD was listed as a diagnosis. The current facility assessment dated [DATE] under the common diagnosis section, special treatments, and conditions, sub-section mental, active, and current substance use disorder listed the current resident number as zero. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/14/25 at 11:44 AM, Social Services Staff FF stated the facility used an evaluation, Social Service admission Evaluation, to identify PTSD. Social Services Staff FF reported that R12 did not have PTSD, she stated that R12 would make up false things to her. Social Services Staff FF further reported that the facility currently did not have any residents with a substance abuse history. During an interview on 05/14/25 at 12:42 PM, Administrative Staff A reported that the provider was who determined the PTSD diagnosis and said there would have been coordination between the provider and the social services designee once that diagnosis had been made. Administrative Staff A said the PTSD would have then been discussed at the Interdisciplinary (IDT) meetings in the morning, and then worked into the care plan to help drive the care for the resident. The current facility assessment dated [DATE] under the common diagnosis section, special treatments, and conditions, sub-section mental, active, and current substance use disorder listed the current resident number as zero. The facility did not provide a policy on trauma-informed care.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. The facility reported a census of 42 residents. Five Ceritifed Nurse Aide (CNA) were reviewed with three reviewed for annual performance evaluations. Based on interview and record review, the facility failed to complete annual performance reviews for two of the three CNA staff that were employed for a year or more. This placed the residents at risk for inadequate care. Findings included: - Per review of employee records, Certified Medication Aide (CMA) M was hired on 02/12/21. CMA M's annual Performance Evaluation, dated 02/13/25, was not completed with the employee's signature indicating it had been reviewed with the staff member. CMA N's employee records noted she was hired 05/08/20. CMA N's most recent Performance Evaluation, was completed on 02/27/24. On 05/14/25 at 09:21 AM, Administrative Nurse C verified the above findings and confirmed that direct care staff should receive an annual evaluation to include identified weaknesses and actions to address weaknesses to ensure the residents receive adequate care. The facility did not provide a policy related to annual performance evaluation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175254	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Diversicare of Sedgwick	712 N Monroe Avenue, Box 49 Sedgwick, KS 67135

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. The facility reported a census of 42 residents. The sample included 15 residents. Based on interviews, record reviews, and observation, the facility failed to implement professional standards of care related to infection control practices during direct care and laundry services. This deficient practice placed the residents at risk for infections. Findings included: - R21's Electronic Medical Record (EMR) revealed a diagnosis of a persistent vegetative state (state of wakefulness accompanied by a complete lack of cognitive function), tracheostomy (opening through the neck into the trachea through which an indwelling tube may be inserted), and Foley catheter (a tube inserted into the bladder to drain urine into a collection bag). The 03/07/25 Annual Minimum Data Set (MDS) documented R21 was in a vegetative state. R21 was dependent on staff for her care. The MDS noted R21 required a tracheostomy and supplemental oxygen. The MDS recorded R21 had a feeding tube and received her nutrition from it. It documented R21 had had a Foley catheter. The 03/07/25 Feeding Tube CAA triggered secondary to use of a feeding tube for maintenance of nutritional and hydration status. The CAA noted contributing factors included a vegetative state and a care plan would be developed and maintained to improve and maintain nutritional and hydration status, monitor labs and weights. R21's Care Plan dated 05/27/21 documented R21 was a risk for infection related to a surgical site for a tracheostomy. R21's Care Plan dated 05/19/21 documented R21 had a Foley catheter and directed staff to keep the drainage bag of the catheter below the level of the bladder and off the floor. During an observation on 05/13/25 at 12:30 PM, Certified Nurse Aide (CNA) T and Certified Medication Aide (CMA) N entered the room to change R21. They wore a gown and gloves per the policy. CMA N pulled some personal hygiene wipes out and began to wipe R21. CMA N folded the soiled wipe over and wiped again from the front to the back wiping past the catheter. She obtained more wipes out of the package and wiped again several more times. CMA N touched R21's neck pillow with her soiled glove to adjust it and then obtained a clean brief with her soiled gloved hands and placed it under the resident while CNA T rolled R21. CMA N removed her gloves and applied fresh gloves without performing hand hygiene. CNA T opened a bag and CMA N placed the soiled sheets in it. CMA N spread a clean gown over R21, and CNA T rolled her to the side. CNA T then removed the soiled brief and cleaned R21's buttocks. R21's pillow fell to the floor. CNA T picked up the pillow and placed it on the bed over R21's right shoulder and tracheostomy. Then CNA T obtained a pillowcase and changed it. During an observation at 05/14/25 on 10:40 AM CNA U and CNA T transferred R21 from the bathchair to the bed. CNA T attached the catheter bag to the straps of the lift sling at shoulder height. CNA U said they were unaware that the catheter bag had to be below the bladder during transfers. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 05/13/25 at 12:30 PM, CNA T and CMA N stated they were unaware of the need to get a fresh wipe out once the wipe was soiled. They said they understood that hand hygiene needed to be completed after removing soiled gloves prior to putting on new gloves, and when gloves are soiled, they should not touch anything clean. CNA T and CMA N reported they knew the pillowcase was dirty when it went to the floor and said she should not have put it on the bed when she picked it up. During an interview on 05/14/25 at 11:04 AM, Licensed Nurse (LN) KK stated that staff were expected to use good infection control including hand hygiene after removing soiled gloves, keeping the catheter bag below the level of the bladder, not using the same wipe numerous times, and not placing items that touched the floor on the bed or resident. During an interview on 05/15/25 at 05:21 PM, Administrative Nurse C stated she expected the staff to follow infection control practices including hand hygiene after removing soiled gloves, not touching clean items with soiled gloves, and keeping the catheter bag below the level of the bladder. Administrative Nurse C stated staff should avoid using the wipes for several swipes, and should not place items from the floor on the bed or resident. The facility's Infection Control policy dated 11/01/17, documented the facility's infection control policies are intended to maintain a safe, sanitary, and comfortable environment. - During an observation on 05/13/25 at 09:40 AM, there was an open grate drain with standing water that the washing machines drained directly into in front of the washing machines. During an observation on 05/13/25 at 10:00 AM, the clean clothes folding room was shared by the dietary manager as an office and housed the time clock. The clean clothes folding table was next to the time clock and had several non-laundry items on it. During an interview on 05/13/25 at 10:00 AM, Maintenance Staff QQ reported that the clean laundry was stored and folded in a room that doubled as the dietary office. The facility's policy titled Policies and Practices - Infection Control, dated 11/01/17, did not address the storage and management of resident linen during the laundry process to prevent contamination or infection.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. The facility reported a census of 42 residents. The sample included 15 residents. Based on interviews, record reviews, and observation, the facility failed to ensure a safe environment in all areas of the facility including the laundry area. This deficient practice created the risk for contaminated laundry and fires. Findings included: - During an observation on 05/13/25 at 09:30 AM, the fluorescent light fixtures above the washers and the dryers had no covers over the bulbs. There were several light fixtures that had exposed rust on the metal housings. During an observation on 05/13/25 at 09:35 AM, the ceilings above the washers and dryers had cracked and peeling paint. During an observation on 05/13/25 at 09:40 AM, it was observed that there was an open grate drain with standing water that the washing machines drained into in front of the washing machines. During an observation on 05/13/25 at 09:45 AM, the washing machine detergent hoses were fed through an open hole in the wall with an exposed dry wall just below a vent covered in lint and dust. During an observation on 05/13/25 at 09:50 AM, the wall behind the dryers was covered in dryer lint. There were several electrical boxed on this wall. During an interview on 05/13/25 at 10:05 AM, Maintenance Staff QQ reported that he had recently crawled behind the dryers and re-taped the metal dryer vent lines because they had been blowing lint on the floor and wall. The facility did not have a policy that addressed maintenance requirements related to the laundry service areas.