STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175267	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shawnee Gardens Healthcare & Rehab Center	6416 Long Street Shawnee, KS 66216

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 41713 The facility identified a census of 115 residents. The sample included 26 residents. Based on observation, record review, and interview, the facility failed to ensure Resident (R) 17 and R41's dignity was maintained while being aided with meals. The facility failed to ensure staff maintained R92's dignity during an incontinent accident. The facility failed to ensure staff maintained R35's dignity while personal care was provided. The facility failed to ensure staff treated R108 in the Memory Unit with respect while assistance was provided during mealtime. The facility failed to ensure staff maintained R35's dignity when staff stated that R35 was a Feeder. This deficient practice placed these residents at risk of decreased self-esteem and decreased self-worth. Findings included: - On 09/16/24 at 08:30 AM R17 and R41 sat in the dining room and awaited their breakfast. Upon receiving their breakfast plates staff stood over both residents and assisted feeding them with their breakfast. On 09/16/24 at 01:15 PM, R92 sat in his wheelchair in the dining room when he had an incontinent accident where urine leaked from his brief onto the floor at lunchtime. Other residents present in the dining room noticed R92's accident and yelled out at staff that he had peed on the floor and needed to be taken to be changed. Staff in the dining room waited several minutes before removing R92 from the dining room and taking him to his room. On 09/17/24 at 07:28 AM R35 lay in bed with only an incontinent brief on and his blankets pulled down below his knees. The room door was open to the hallway while Certified Nurse Aide (CNA) PP and CNA QQ provided R35's personal care. On 09/17/24 at 09:05 AM Activity Z was on the Memory Unit assisting with breakfast. She positioned herself between R17 and R108. Activity Z then engaged in conversation about the residents eating with another staff standing by the nurse's station. Activity Z loudly stated This one, I have trouble with while pointing to R108. R108 stopped eating her breakfast and refused to allow Activity Z to feed her. Activity Z instructed R108 to continue eating repeatedly. R108 wheeled herself away from the table and sat at the table next to the television. R108 refused to finish her breakfast. On 09/17/24 at 01:00 PM CNA RR carried R35's lunch tray to his room, CNA TT yelled halfway down the hallway to CNA RR that R35 was a feeder. CNA TT asked CNA RR to stay in R35's room and feed him. (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 - Some	On 09/18/24 at 01:19 PM, CNA NN stated residents should be toileted before being brought to the dining room for a meal. CNA NN stated staff should not stand up while assisting a resident to eat. On 09/18/24 at 01:44 PM, CNA M stated staff were expected to sit with the residents during mealtimes and feed them. Staff should never call out residents as being difficult or point them out on the unit. On 09/18/24 at 01:4 PM, Licensed Nurse (LN) G stated staff were expected to sit with the residents during mealtimes and feed them. On 09/18/24 at 03:11 PM Administrative Nurse D stated she expected nursing staff to treat all residents with dignity and respect. Administrative Nurse D stated staff should not stand next to residents while assisting with meals. Administrative Nurse D stated nursing staff should never yell down the hallway saying a resident was a feeder or ignore a resident who had an incontinent accident. Administrative Nurse D stated privacy should be always respected while care is provided. The Promoting/Maintaining Resident Dignity policy implemented 01/01/20 documented: It was the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality. Staff conversation should be resident-focused, and resident centered. Speak respectfully to the residents; avoid conversations about the residents that may be overheard. Maintain resident privacy. Each resident would be provided equal access to quality care regardless of diagnosis, severity of condition, or payment source. The facility failed to ensure staff protected and maintained R17, R41, R92, R108, and R35's dignity. This placed these residents at risk of decreased self-esteem and decreased self-worth.

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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** 49634 The facility identified at a census of 115 residents. The sample included 26 residents. One resident was sampled for reasonable accommodations of resident needs and preferences. Based on observation, record review, and interview, the facility failed to ensure Resident (R)37's call light was within his reach. This deficient practice left R37 vulnerable for unmet care needs due to the inability to call for staff assistance. Findings included: - R37's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of sleep apnea (a disorder of sleep characterized by periods without respirations), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), hypertension (HTN-elevated blood pressure), congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), bipolar disorder (a major mental illness that causes people to have episodes of severe high and low moods), depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremors, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness), chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), dysphagia (swallowing difficulty), dialysis (a procedure where impurities or wastes are removed from the blood), and end-stage renal disease (ESRD-a terminal disease of the kidneys). The Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 11 which indicated moderately impaired cognition. The MDS documented R37 was dependent on staff for eating, showering, and personal hygiene. The MDS documented R37 was impaired on both sides of his body. R37's ADL Functional/Rehabilitation Care Area Assessment (CAA) dated 01/27/24 documented R37 required staff assistance for all activities of daily living (ADLs). The CAA documented R37 was impaired in his upper and lower extremities and used a wheelchair for locomotion. R37's Care Plan dated 03/22/24 documented R37 needed assistance with ADLs, due to his diagnosis. R37's plan of care documented R37 was dependent on staff for toileting, showering, and eating. On 09/17/24 at 08:35 AM, R37 lay in his bed, on his back. His call light was on the floor on the right side of his bed. On 09/18/24 at 07:50 AM R37 sat in his room in his wheelchair. R37's call light was on the floor on the right side of his bed. On 09/18/24 at 01:22 PM, Licensed Nurse (LN) H stated all call lights should be within reach of the resident if a resident was in his room. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/18/24 at 01:28 PM, Certified Nurse's Aide (CNA) N stated call lights should be clipped to the person and staff should let the resident know where staff clipped the call light, or let the resident know where the call light was placed. On 08/18/24 at 03:11 PM Administrative Nurse D stated call lights should be placed within the resident's reach always. The facility's Accommodation of Needs policy documented the facility will treat each resident with respect and dignity and will evaluate and make reasonable accommodations for the individual needs and preferences of a resident, except when the health and safety of the individual or other residents would be endangered. The facility failed to ensure R37's call light was within his reach. This deficient practice left R37 vulnerable for unmet care needs.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 45668 The facility reported a census of 115 residents. The sample included 26 with 26 residents reviewed for care plan revisions. Based on observations, interviews, and record review, the facility failed to revise Resident (R)106's Care Plan to reflect his current toileting needs after discontinuation of his Foley catheter (a tube inserted into the bladder to drain urine into a collection bag). This deficient practice placed R106 at risk for impaired care due to uncommunicated care needs. Findings Included: - R106's Medical Diagnosis section within the Electronic Medical Record (EMR) noted diagnoses of intracranial hemorrhage (sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by rupture of an artery to the brain), aphasia (condition with disordered or absent language function), chronic kidney disease, and agitation. R106's Quarterly Minimum Data Set (MDS) completed 08/30/24 revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating no cognitive impairment. The MDS revealed no upper or lower extremity impairments. The MDS noted he could independently complete his activities of daily living (ADLs). The MDS indicated no indwelling urinary catheter was in place. The MDS noted he was always continent of bowel and bladder. R106's Functional Abilities Care Area Assessment (CAA) completed 03/04/24 indicated he was mostly independent with his ADLs but required staff assistance for a few things. The CAA noted a plan of care would be implemented to address his functional ability needs. R106's Care Plan initiated on 02/27/24 indicated he was admitted to the Memory Care Unit due to poor safety awareness, impaired cognitive function, and thought processes related to dementia (a progressive mental disorder characterized by failing memory and confusion). The plan indicated he had behaviors of agitation and paranoia. The plan instructed staff to provide positive interactions, conversations about his feelings, and behavior monitoring. The plan noted R106 was independent with most of his ADLs but instructed staff to provide set-up and clean-up assistance when needed. The plan indicated R106 had a Foley catheter in place but was able to provide self-care (02/27/24). The plan of care lacked instruction to staff regarding R106's toileting needs and the level of assistance required. R106's EMR under Orders revealed he was admitted to the facility with a Foley catheter on 02/23/24 but the Foley catheter was discontinued on 02/26/24. On 09/17/24 at 10:05 AM R106 reported he had not had a urinary catheter since he was first admitted to the facility. R106 reported he completed his own toileting and personal hygiene without assistance. On 09/18/24 at 01:30 PM, Certified Nurse's Aide (CNA) M stated the care plans should include the basic care needs of each resident and be updated with changes. She stated that R106 had not had a urinary catheter since she had worked with him for the past few months. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/18/24 at 01:50 PM Licensed Nurse (LN) G stated R106 did not have a Foley catheter and his care plan should have been updated. She stated staff should be reviewing the plans daily and reporting any discrepancies found to nursing leadership. On 09/18/24 at 03:12 PM Administrative Nurse D stated the care plans should be reviewed quarterly, annually, and with changes. She stated staff should report issues related to inappropriate care interventions or inaccurate data on the care plans so it can be corrected. The facility's Care Plan Revision revised 11/2017 indicated the facility will consistently review and update care plans to reflect the most accurate treatment and care needs of each resident. The facility failed to revise R106's plan of care to reflect his discontinued Foley catheter and current toileting needs. This deficient practice placed R106 at risk for impaired care due to uncommunicated care needs.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. 45668 The facility reported a census of 115 residents. The sample included 26 residents with eight reviewed for activities of daily living (ADLs). Based on record review, interviews, and observations, the facility failed to ensure Resident (R) 99 received supportive care and services to promote and maintain her quality of life when the facility did not implement tools and/or strategies to allow R99 to communicate her wants, needs, or feelings. This deficient practice placed the resident at risk for decreased quality of life, isolation, and impaired dignity. Findings Included: - R99's Medical Diagnosis section within the Electronic Medical Record (EMR) noted diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), general anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and cognitive communication disorder (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness). R99's Quarterly Minimum Data Set (MDS) completed 06/17/24 revealed a Brief Interview for Mental Status (BIMS) assessment was not complete due to severe cognitive impairment. The MDS indicated she sometimes could make her needs known with simple communication and sometimes understood others with simple communication. The MDS indicated she had delusions. The MDS noted she had verbal behaviors towards others. The MDS noted she exhibited refusals of care and wandering daily. The MDS indicated she could ambulate independently. The MDS indicated she had one non-injury fall since her last assessment. R99's Dementia Care Area Assessment (CAA) completed 09/25/23 indicated she was admitted to the facility's dementia Memory Care Unit due to her severe cognitive impairment, behavioral symptoms, and wandering. R99's Communication CAA completed 06/25/23 indicated she had an impaired ability to make herself understood and understand others. The CAA instructed staff to give her time for thought process during conversations. R99's Care Plan initiated 09/19/24 indicated she resided in the Memory Care Unit. The plan noted she had impaired cognitive function related to her medical diagnoses. The plan indicated she spoke [non-English language]. The plan indicated she required an interpreter. The plan instructed staff to encourage her independence while inside the building but ensure supervision while she was outside. The plan instructed staff to re-direct her while she wandered around doors and exits. The plan instructed staff to provide conversation and activities, promote consistent routines, and visualize her whereabouts frequently. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R99's EMR under Progress Note revealed a note dated 07/20/24 that indicated R99 attempted to move into and slept in her old room. The note indicated staff attempted to redirect R99 to her new room but R99 could not understand the redirection. The note indicated staff attempted to contact R99's representative to translate but was unable to reach her. The note indicated R99 eventually calmed down while she sat on the hallway couch outside her room. On 09/17/24 at 07:31 AM R99 walked around the locked Memory Care Unit. R99 entered R73's (severely cognitively impaired female resident) room while she slept in her bed. R99 made several attempts to wake R73 up while she was in her bed. Staff intervened and walked R99 out of the room and to the dining room. Staff attempted to redirect R99 in English but R99 remained confused. R99 then continued to walk around the unit. R99 then walked into R74's (severely cognitively impaired male resident) room briefly and then exited the room. Staff did not attempt to use the translator service or cue card to assess R99's needs or intentions during this event. On 09/17/24 at 12:21 PM R99 entered the dining room and sat next to R73 for lunch. Both residents began to eat their lunch. The assistive staff stepped out of the dining room to assist with another resident's behaviors leaving one support staff on the opposite side of the dining room by the kitchen. At 12:29 PM R99 attempted to assist R73 by adjusting her plate. R73 began yelling Help, help, help out for staff to intervene. Staff were not able to intervene during this event. R73 stated She's crazy, she's stupid, you're crazy, you're stupid repeatedly to R99. R99 continued to adjust R73's tray while speaking in her native language. Residents looked around the unit for assistance while yelling out. R99 eventually stood up and left the table. R99 continued to walk around the dining area. R99 then approached another table and attempted to stand the resident up by grabbing her by the arm. The staff then intervened and redirected her in English. R99 let go of the resident's arm and walked back to her room. Staff did not attempt to use the translator service or cue card to assess R99's needs or intentions during this event. On 09/18/24 at 01:30 PM, an inspection of the dementia unit cue cards revealed pictures depicting basic ADL care needs written in English. On 09/18/24 at 01:30 PM Certified Nurse's Aide (CNA) M stated staff should use the translator service, cue card, or call R99's representative to attempt to identify her needs. She stated R99 may not understand what is being told to her. She stated R99 used to be in R73's room and would often wander into the room thinking it was hers. She stated that R99's representative had attempted several times to explain this to R99. She stated R99 doesn't understand English. On 09/18/24 at 01:50 PM Licensed Nurse (LN) G stated staff should always monitor the dining rooms during meal service and intervene during behaviors. She stated R99's representative will often provide translations for R99 and staff have cue cards to show her. On 09/18/24 at 03:12 PM Administrative Nurse D stated staff should use the translator service to assess the needs of residents that do not speak English. She stated staff should always be monitoring the unit for behaviors and wandering. The facility's Communication with Limited English Proficiency revised 07/2022 indicated language assistance services will be provided to all staff and residents in need of translation services. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's ADL Care of Dementia Unit Residents revised 10/2019 indicated staff will provide the assistance and services outlined in each resident's plan of care. The plan indicated care plan intervention will be monitored on an ongoing basis for effectiveness and updated as needed. The plan indicated the facility would assess and identify the care needs of each resident in the dementia unit. The facility failed to utilize the provided translation services to identify R99's care needs. This deficient practice placed R99 at risk for decreased quality of life, isolation, and impaired dignity.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41713 The facility identified a census of 115 residents. The sample included 26 residents with eight residents sampled for activities of daily living (ADLs). Based on observation, record review, and interview, the facility failed to ensure staff provided ADL assistance for Resident (R) 92 who was dependent on staff for ADLs. The facility also failed to ensure staff provided assistance for toileting and eating for R68 and R37. This placed these residents at risk for impaired care and decreased quality of life. Findings included: - R92's Electronic Medical Record (EMR) documented diagnoses of quadriplegia (inability to move the arms, legs, and trunk of the body below the level of an associated injury to the spinal cord), dementia (a progressive mental disorder characterized by failing memory and confusion), and encephalopathy (a broad term for any brain disease that alters brain function or structure). R92's Admission Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 10 which indicated a moderately impaired cognition. R92 had impairment on both sides of his upper and lower extremities. R92 utilized a wheelchair for mobility. R92 required substantial/maximal assistance to total dependence on staff for his functional abilities. R92 was always incontinent of both bladder and bowel. R92 received an antianxiety (a class of medications that calm and relax people), and an antidepressant (a class of medications used to treat mood disorders) medication. R92's Quarterly MDS dated [DATE] documented a BIMS score of six which indicated a severely impaired cognition. R92 had impairment on both sides of his upper and lower extremities. R92 used a wheelchair for mobility. R92 required substantial/maximal assistance to total dependence on staff for his functional abilities. R92 was always incontinent of both bladder and bowel. R92 received an antianxiety and an antidepressant medication. R92's Incontinence Care Area Assessment (CAA) dated 10/18/23 documented he was incontinent of bladder and bowel. R92 was dependent on staff for toileting and toileting hygiene. R92's Care Plan last revised 04/04/24 directed staff to check and change the resident to maintain his dignity. Staff was directed to use absorbent incontinent briefs that hold moisture away from his skin. On 09/16/24 at 01:15 PM, R92 sat in his wheelchair in the dining room eating. Observation revealed R92 had urine leaking from his brief onto the dining room floor. Numerous residents were in the dining room at the time and several residents yelled to staff members that R92 needed to be taken to get changed. On 09/16/24 at 01:22 PM, staff propelled R92 back to his room. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/18/24 at 01:33 PM Certified Nurse Aide (CNA) NN stated that R92 was on two-hour checks so he should be toileted often, especially before meals. CNA NN stated she was familiar with R92, and he was always incontinent. On 09/18/24 at 01:35 PM Licensed Nurse (LN) J stated she had not worked on R92's unit frequently so she could not say what his toileting habits were. LN J stated she expected residents to be checked and changed prior to being taken to the dining room for a meal. On 09/18/24 at 03:11 PM Administrative Nurse D stated that residents all should be checked and changed or toileted prior to meals. Administrative Nurse D stated that R92 was to be checked on frequently and there should be no reason for R92 to have an accident in the dining room unless due to a sudden illness. Administrative Nurse D stated staff should have immediately attended to R92 on the day of his incident. Administrative Nurse D stated she would be re-educating staff on toileting. The Activities of Daily Living (ADLs) Policy implemented 08/08/19 documented: The facility would ensure a resident's abilities in ADLs do not deteriorate unless the deterioration was unavoidable. This included the resident's ability to toilet. A resident who was unable to carry out ADL would receive the necessary services to maintain good nutrition, grooming, and personal hygiene. The facility failed to ensure staff provided adequate ADL assistance to R92, who was dependent on staff assistance for toileting. This placed R92 at risk for impaired care and decreased quality of life. 45668 - R68's Medical Diagnosis section within the Electronic Medical Record (EMR) noted diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), major depressive disorder (major mood disorder), cognitive-communication disorder (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness), and a need for assistance with personal cares. R68's Quarterly Minimum Data Set (MDS) indicated a Brief Interview for Mental Status could not be completed due to severe cognitive impairment. The MDS indicated he had bilateral upper and lower extremity impairment. The MDS indicated he used a wheelchair for mobility and was dependent on staff for ambulation. The MDS noted he was dependent on staff assistance for bed mobility, transfers, personal hygiene, meals, toileting, dressing, and bathing. The MDS indicated he was always incontinent of bowel and bladder with no toileting program. R68's Urinary Incontinence Care Area Assessment (CAA) completed 04/22/24 indicated he was incontinent of bowel and bladder and dependent on staff for assistive care. The CAA indicated staff were to provide toileting hygiene. The CAA noted he required staff assistance for ambulation, bed mobility, transfers, meals, bathing, and personal hygiene. R68's Care plan initiated 05/06/24 indicated he required total assistance from staff for all his activities of daily living (ADLs) related to his medical diagnoses. The plan noted he was incontinent of bowel and bladder. The plan instructed staff to provide checks and changes to promote dignity, peri-care for skin breakdown, and complete incontinence assessments quarterly. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R68's EMR under Evaluations revealed a Bowel and Bladder assessment completed on 07/27/24. The assessment indicated he was always incontinent of bowel and bladder. The assessment indicated he did not qualify for a bowel and bladder training program but was a candidate for timed toileting with a score of nine. On 09/17/23 at 07:09 AM R68 sat in his Broda chair (special wheelchair with the ability to tilt and recline) next to the window in the dining room. R68 was assisted with his breakfast and remained in the same position after breakfast services. R68 remained by the window throughout the morning and into lunch. R68 was not toileted or checked for incontinence from 07:09 AM through 11:25 AM. On 09/17/24 at 11:30 AM R68 received incontinent care. On 09/18/24 at 01:30 PM Certified Nurse's Aid (CNA) M stated R68 could not communicate his toileting needs and staff should be checking on him every two hours. She stated he was a check and change resident so staff should be checking him for incontinence. She stated he was frequently incontinent of bowel and bladder. On 09/18/24 at 01:50 PM Licensed Nurse (LN) G stated staff should be providing bathroom opportunities for R68 after meals and every two hours to prevent incontinent episodes. She stated incontinence should be prevented and skin care should be provided. LN g said R68 should not be left sitting for long periods of time without restroom breaks. On 09/18/24 at 03:12 PM Administrative Nurse D stated staff were expected to provide check and change for incontinent residents per their care plans. She stated residents should be provided toileting opportunities per their quarterly bowel and bladder assessments. The facility's ADL Care of Dementia Unit Residents revised 10/2019 indicated staff will provide the assistance and services outlined in each resident's plan of care. The plan indicated care plan intervention will be monitored on an ongoing basis for effectiveness and updated as needed. The facility failed to provide R68 with the ADL assistance required for toileting. This placed the resident at risk for complications related to incontinence and impaired quality of life. 49634 (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- R37's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of sleep apnea (a disorder of sleep characterized by periods without respirations), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), hypertension (HTN-elevated blood pressure), congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), bipolar disorder (a major mental illness that causes people to have episodes of severe high and low moods), depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremors, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness), chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), dysphagia (swallowing difficulty), dialysis (a procedure where impurities or wastes are removed from the blood), and end-stage renal disease (ESRD-a terminal disease of the kidneys). The Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 11 which indicated moderately impaired cognition. The MDS documented R37 was dependent on staff for eating, showering, and personal hygiene. The MDS documented R37 was impaired on both sides of his body. R37's ADL Functional/Rehabilitation Care Area Assessment (CAA) dated 01/27/24 documented R37 required staff assistance for all activities of daily living (ADLs). The CAA documented R37 was impaired in his upper and lower extremities and used a wheelchair for locomotion. R37's Care Plan dated 03/22/24 documented R37 needed assistance with ADLs, due to his diagnosis. R37's plan of care documented R37 was dependent on staff for eating. R37's EMR under Task under Eating for eating assistance lacked documentation for the morning of 09/17/24. On 09/17/24 at 08:33 AM Certified Nurse's Aide (CNA)P stated she was the only staff available, and she said she could not use the Hoyer (total body mechanical lift) lift by herself, so the nursing staff was to feed R37 in his room. On 09/17/24 at 08:35 AM, R37 lay in his bed, on his back. His call light was on the floor on the right side of his bed, his breakfast tray was sat on his bedside table. R37 stated he asked to get up to go to the dining room for breakfast, but the CNA told him she was the only staff person, and he would have to wait. R37 stated the CNA said he would be fed his breakfast meal in his room. On 09/17/24 at 09:22 AM, R37 grabbed a fried egg on his plate and was able to get part of the egg in his mouth; the other part of the egg went on R37's bed. R37 stated he could not eat the rest of his breakfast by himself. On 09/17/24 at 09:34 AM R37 was sleeping. CNA Q removed R37's tray without waking the resident. R37's cereal, sausage, and two covered sippy cups were untouched and uneaten. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/18/24 at 01:22 PM, Licensed Nurse (LN) H stated there was always enough staff to ensure residents could get out of bed if they wished. LN H stated all nurses were responsible for ensuring the residents get the help they need. She stated all nursing staff had been trained to help a resident eat. On 09/18/24 at 01:28 PM CNA N stated if there is only one aide, the aide should go get a nurse or an aide from a different hall to assist residents that require two staff get out of bed if the resident wants to come out for meals. CNA N stated if a person needed help with eating, all nursing staff could help, as all have been trained to help residents eat. On 09/18/24 at 03:11 PM Administrative Nurse D stated if a resident wished to get out of bed and eat in the dining room, the staff should accommodate the resident's needs. She stated the facility was never short-staffed and CNA P should have asked for help. Administrative Nurse D stated there was also staff to help the residents eat their meals. The facility's Activities for Daily Living policy reviewed on 08/01/19 documented that the facility will ensure a resident's abilities in ADLs do not deteriorate unless deterioration is unavoidable; this includes bathing dressing and grooming, transfer and ambulating, eating, and speech. The facility failed to provide adequate assistance with ADL including transfers and eating for R37 who was dependent on staff for both. This deficient practice placed R37 at risk for impaired nutrition, impaired ADL, and decreased quality of life.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41713 The facility identified a census of 115 residents. The sample included 26 residents with three sample residents reviewed for pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction). Based on observation, record review, and interview, the facility failed to ensure Resident (R) 2's pressure-reducing interventions were implemented correctly when their low air-loss mattress pump was set at an inappropriate weight for the resident. This deficient practice placed R2 at risk for complications related to skin breakdown and pressure ulcers. Findings included: - The Electronic Medical Record (EMR) for R2 documented diagnoses of multiple sclerosis (MS- progressive disease of the nerve fibers of the brain and spinal cord), heart failure (a condition with low heart output and the body becomes congested with fluid), and pressure ulcer of the sacral (large triangular bone/area between the two hip bones) region. R2's Annual Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. R2 had a functional limitation in range of motion impairment on both sides of her upper and lower extremities. R92 was dependent on staff for all functional abilities. R2 was incontinent of both bladder and bowel function. R2 had a Stage 1 pressure ulcer (pressure wound that appears reddened, does not blanche, and may be painful but is not open) or a greater scar over a bony prominence. R2 was at risk for pressure ulcers and had one or more unhealed pressure ulcers. R2 had a Stage 3 (full-thickness pressure injury extending through the skin into the tissue below) pressure ulcer. R2 had a pressure-reducing device for her bed, nutrition, or hydration interventions to manage skin problems, and received pressure ulcer care. R2's Quarterly MDS dated [DATE] documented a BIMS score of 15 which indicated intact cognition. R2 had a functional limitation in range of motion impairment on both sides of her upper and lower extremities. R92 was dependent on staff for all functional abilities. R2 was incontinent of both bladder and bowel function. R2 a Stage 3 pressure ulcer. R2 had a pressure-reducing device on her bed, received nutrition or hydration interventions to manage her skin problems, and received pressure ulcer care. R2's Care Plan last revised on 07/08/24 directed staff that she had a low air loss (LAL) mattress. Staff was directed that R2 often refused to be repositioned and preferred to be on her left side. Staff was directed to avoid positioning her on her back. R2's EMR tab for Wounds/Skin documented as of 07/17/24 a resolved recurring Stage 3 pressure ulcer to her coccyx (area at the base of the spine). R2's Orders tab of the EMR documented an order dated 09/09/23 for a LAL mattress every shift for pressure reduction and prevention of skin breakdown. Check the mattress and pump function to ensure proper working order. Check to ensure the pump was set at the correct setting (the setting was based on weight). (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's Weight/Vitals tab documented the last obtained weight on 07/22/24 of 137 pounds (lb.). R2's Treatment Administration Record (TAR) for May 2024 to September 2024 had an order for a LAL mattress every shift for pressure reduction/prevention of skin breakdown; check the mattress and pump function to ensure proper working order; check to ensure correct setting (setting is based on weight) dated 09/29/23. The sign-off lacked an area to document R2's weight and or the setting of the LAL machine. A review of the low air-loss mattress manufacturer's operation guide (ProActive Protekt Aire 6000) indicated the pump and mattress were intended to reduce the incidence of pressure ulcers while optimizing comfort. The guide indicated that firmness can be adjusted based on the recommendations of the health care professional and the patient's weight. On 09/18/24 at 07:24 AM R2 laid on her LAL mattress that was set at 220 lbs. R2 stated she stayed in bed all the time and did not like to be repositioned at times. On 09/18/24 at 01:19 PM Certified Nurse Aide (CNA) NN stated she knew R2 had a LAL mattress but did not know what it should be set at. CNA NN stated that the nurse was responsible for making sure the mattress was set correctly. On 09/18/24 at 01:21 PM Licensed Nurse (LN) J stated she could not say what setting a LAL mattress should be set at, but she could find out. On 09/18/24 at 03:11 PM Administrative Nurse D stated a resident's LAL mattress should be set by what the physician has ordered or was typically determined by the resident's weight. Administrative Nurse D stated that R2's LAL mattress should be set by her weight according to her physician's order. Administrative Nurse D stated she would re-educate her nurse staff on the LAL mattresses and the correct setting they should be set. The Use of Support Surfaces policy documented: Support surfaces would be chosen by matching the potential therapeutic benefit with the resident's specific situation. Support surfaces would be utilized in accordance with the manufacturer's recommendations. For powered devices or those that require air, the licensed nurse would check each shift and as needed for proper functioning and/or inflation. Guidelines for the support surface may be utilized in obtaining a physician order. The guidelines were to be used to assist in the treatment decision-making. Due to the unique needs and the situation of individuals, the guidelines may not be appropriate for use in all circumstances. The effectiveness of the support surfaces would be monitored through ongoing assessment of the resident and the wound. The facility failed to ensure R2's low air-loss mattress pump was appropriately set to her current weight. This deficient practice placed R2 at risk for complications related to skin breakdown and pressure ulcers. placed R2 at risk for complications related to skin breakdown and pressure ulcers.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45668 The facility reported a census of 115 residents. The sample included 26 residents with five reviewed for accidents. Based on record review, interviews, and observations, the facility failed to implement the fall intervention of anti-rollback (device to prevent the wheelchair from rolling backward) devices per R41's care plan. The facility additionally failed to ensure a safe environment free from accident hazards when R36's bed was left in a high position. This placed the residents at risk for preventable accidents and injuries. Findings Included: - R41's Medical Diagnosis section within the Electronic Medical Record (EMR) noted diagnoses of dysphagia (difficulty swallowing), aphasia (difficulty speaking), hemiplegia (paralysis of one side of the body), and epilepsy (brain disorder characterized by repeated seizures). R41's Annual Minimum Data Set (MDS) completed 07/23/24 revealed a Brief Interview for Mental Status (BIMS) score of two indicating severe cognitive impairment. The MDS indicated he was dependent on staff assistance for toileting, transfers, bathing, dressing, bed mobility, and personal hygiene. The MDS noted he independently used a wheelchair for mobility. The MDS indicated he had one non-injury fall since his last assessment. R41's Falls Care Area Assessment (CAA) completed 07/23/24 indicated he was at risk for falls related to his medical diagnoses, functional limitations, and need for assistance with care. The CAA noted he had one fall since his admission. R41's Care Plan initiated on 02/27/24 indicated he required assistance with his activities of daily living related to his medical diagnosis. The plan noted he self-propelled in his wheelchair. The plan indicated he required partial to moderate assistance with toileting, bathing, dressing, bed mobility, and transfers. The plan indicated he was at risk for falls related to his limited mobility, poor safety awareness, and muscle weakness. The plan indicated he was to wear non-skid slippers on his feet, use a Dycem (non-slip mat) in his wheelchair, and required safety reminders. The plan indicated staff was to apply an anti-rollback device on his wheelchair (07/10/24). On 09/16/24 at 08:12 AM R41 wheeled himself in the dining room of the Memory Care Unit. R41 had a blue Dycem pad in between himself and the wheelchair seat. R41's wheelchair had anti-tip bars on the lower back portion of the chair but lacked an anti-rollback device. R41's wheelchair still rolled backward as he attempted to adjust himself in the wheelchair. On 09/18/24 at 01:40 PM, Certified Nurse's Aide (CNA) M stated R41 was at risk for falls due to his limited physical mobility. She stated was not sure if an anti-rollback device was ever placed on his wheelchair. On 09/18/24 at 01:55 PM, Licensed Nurse (LN) G identified R41 should have an anti-rollback device on his wheelchair per his care plan. She stated he had the anti-tip bars but was not sure if they were the same as the anti-rollback. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/18/24 at 03:12 PM Administrative Nurse D stated the care plans should be reviewed quarterly, annually, and with changes. She stated staff should report issues related to inappropriate care interventions or inaccurate data on the care plans so it can be corrected. The facility's Accidents and Supervision policy dated 11/2017 indicated the facility will assess each resident's risk related to falls and accidents. The policy indicated individualized interventions would be implemented to minimize the risks related to accidents. The policy indicated ongoing reviews will be completed to monitor the effectiveness of the interventions. The facility failed to implement the fall intervention of anti-rollback devices per R41's care plan. This placed R41 at risk for preventable falls and injuries. 41037 - R36's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), cerebrovascular accident (CVA-stroke- sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), frontotemporal neurocognitive disorder (damage of brain), hypertension (HTN-elevated blood pressure), obesity (excessive body fat), abnormal posture, lack of coordination, hemiparesis (muscular weakness of one half of the body), and hemiplegia (paralysis of one side of the body). The Significant Change Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of one which indicated severely impaired cognition. The MDS documented R36 had limited function on one side for both the upper and lower extremities. The MDS documented R36 was dependent on staff assistance for toileting hygiene, bathing, upper and lower body dressing, personal hygiene, and putting on or taking off her footwear. The MDS documented R36 was dependent on staff assistance for mobility. The Quarterly MDS dated [DATE] documented a staff interview that indicated moderately impaired cognition. The MDS documented that R36 was dependent on staff assistance for her mobility and activities of daily living except eating, for which she required verbal cues or steadying from staff. R36's Falls Care Area Assessment (CAA) dated 03/11/24 documented she was a high fall risk. She was dependent on staff assistance for her ADLs, she had poor safety judgment and decreased cognition. R36's Care Plan dated 07/07/22 documented the staff would assess her fall risk quarterly and as needed. The plan of care documented that staff would encourage her to participate in activities that promote exercise, and physical activity for strengthening and improvement of mobility. The plan of care documented the staff would ensure she wore appropriate footwear. The plan of care documented that staff would place her call light within reach and encourage her to use it if she was physically and cognitively able to do so. On 09/16/24 at 10:53 AM R36 laid on the bed sideways with her legs over the left side of the bed. R36's bed was in a high position, three feet off the floor. R36 was able to move her feet back onto the bed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/18/24 at 12:12 PM R36 laid on her bed. R36's bed was elevated three feet off the floor. R36 was not able to lower the bed when asked. R36 was rolling around on her bed from side to side. On 09/18/24 at 01:28 PM, Certified Nurse Aide (CNA) MM stated he was an as-needed worker and did not know how much assistance R36 required. CNA MM said he would ask the nurse if he needed help. On 09/18/24 at 01:35 PM, Licensed Nurse (LN) I stated that R36's bed should not be kept in a high position. LN I stated that R36's level of staff assistance varies from day to day. LN I stated R36 gets out of bed only on Tuesdays. On 09/18/24 at 03:11 PM, Administrative Nurse D stated she expected the staff to follow R36's care plan. Administrative Nurse D stated that R36's bed should not be left elevated after staff provided care. Administrative Nurse D stated that placed R36 at a risk for a fall. The facility's undated Accidents and Supervision policy documented that the resident's environment remained as free of accident hazards as possible, and each resident received adequate supervision and assistive devices to prevent accidents. This included: Identifying hazard(s) and risk(s). Evaluating and analyzing hazard(s) and risk(s). Implementing interventions to reduce hazard(s) and risk(s). Monitoring for effectiveness and modifying interventions when necessary. The facility failed to ensure a safe environment free from accident hazards when R36's bed was left in a high position. This deficient practice placed R36 at risk for injury from falls.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49634 The facility identified a census of 115 residents. The sample included 26 residents with one resident reviewed for hemodialysis (a procedure using a machine to remove excess water, solutes, and toxins from the blood in people whose kidneys can no longer perform these functions naturally). Based on observation, record review, and interviews, the facility failed to consistently communicate Resident (R) 37's medical condition with the dialysis center. This deficient practice placed R37 at risk of potential adverse outcomes and physical complications related to dialysis. Findings included: - R37's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of sleep apnea (a disorder of sleep characterized by periods without respirations), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), hypertension (HTN-elevated blood pressure), congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), bipolar disorder (a major mental illness that causes people to have episodes of severe high and low moods), depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremors, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness), chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), dysphagia (swallowing difficulty), dialysis (a procedure where impurities or wastes are removed from the blood), and end-stage renal disease (ESRD-a terminal disease of the kidneys). The Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 11 which indicated moderately impaired cognition. The MDS documented R37 was impaired on both sides of his body. The MDS documented R37 required hemodialysis during the observation period. R37's ADL Functional/Rehabilitation Care Area Assessment (CAA) dated 01/27/24 documented R37 required staff assistance for all activities of daily living (ADLs). The CAA documented R37 was impaired in his upper and lower extremities and used a wheelchair for locomotion. R37's Care Plan dated 06/01/23 documented R37 needed dialysis related to renal failure. R37's plan of care documented R37's dressing should be checked and changed daily at the access site; staff should not draw blood or take blood pressure in his right arm. R37's plan of care documented he received dialysis Monday, Wednesday, and Friday, at 10:00 AM and should have a snack sent to the dialysis center with him. R37's EMR under the Orders tab revealed the following physician's orders: Obtain dialysis wet weight prior to dialysis and dry weight upon return from each dialysis appointment on Monday Wednesday and Friday. Nursing was to contact the hemolysis center to obtain the communication sheet if the communication sheet was not returned, dated 07/26/24. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Auscultate bruit (blowing or swishing sound heard when blood flows through a shunt) and palpate thrill (a fine vibration felt that reflects the blood flow by a dialysis resident ' s shunt) every shift, notify the physician if the absence of thrill or bruit, dated 07/26/24. Nurses were to monitor the hemodialysis port site for signs of infection, edema, and bleeding upon return from dialysis and notify the physician of any signs of bleeding. Nursing was to apply pressure for 15 minutes and notify the physician if the bleeding did not stop. A review of R37's clinical record including the facility dialysis communication forms lacked evidence of pre-hemodialysis assessment for the dialysis dates of 01/15/24, 02/07/24, 04/15/24, 07/26/24, 07/31/24, 09/06/24, and 09/16/24. A review of R37's clinical record including the facility dialysis communication forms lacked evidence of post-hemodialysis assessment for the dialysis dates of 02/09/24, 04/26/24, 05/27/24, 07/03/24, 07/12/24, 07/15/24, 07/17/24, 07/29/24, 08/12/24, 08/15/24, 08/30/24, and 09/11/24. On 09/18/24 at 07:38 AM Licensed Nurse (LN) H stated the nurse on duty was to fill out the pre-dialysis communication sheets. LN H stated if the communication sheet was not returned to the resident, the charge nurse or any administrative nurse could call the dialysis facility and have them fax the sheet to the facility. On 07/10/24 at 03:05 PM Administrative Nurse D stated she expected nursing staff to fill out the pre-dialysis sheet and send the sheet with the resident. Administrative Nurse D said nursing staff were to ensure the post-dialysis communication sheet was completed and returned with the resident. Administrative Nurse D stated if the dialysis sheet was not returned, nursing was to call the dialysis center to get the sheet faxed to the facility. The facility's Hemodialysis policy dated 11/20 documented the facility will provide the necessary care and treatment, consistent with professional standards of practice, physician orders, the comprehensive person-centered care plan, and residents goals and preferences to meet the special medical, nursing, mental, psychosocial needs of resident receiving hemodialysis. The facility failed to consistently communicate R37's medical condition to the dialysis center. This deficient practice placed R37 at risk of potential adverse outcomes and physical complications related to dialysis.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 45668 The facility reported a census of 115 residents. The sample included 26 residents. Based on record review and interviews, the facility failed to post the daily staffing with census and maintain 18 months of daily posted staffing hours as required. Findings Included: - On 09/16/24 at 07:05 AM an inspection of the main lobby revealed the daily posted staffing sheet displayed next to the reception desk. The staffing sheet was dated 09/13/24 and lacked a census. On 09/17/24 at 07:10 AM an inspection of the displayed daily posted staffing revealed the correct date but lacked a census of the residents. A review of the facility's Daily Posted Staffing from 04/01/23 to 09/16/24 revealed multiple missing daily posted staffing records from 07/12/23 through 12/01/23. On 09/18/24 at 03:40 PM Administrative Nurse D stated the facility was required to post the daily staffing hours and identify the current census each day. She stated the posted data should be maintained for at least 18 months. The facility was unable to provide a policy related to posted staffing. The facility failed to post the daily staffing with the census and maintain 18 months of daily posted staffing hours as required.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shawnee Gardens Healthcare & Rehab Center	6416 Long Street Shawnee, KS 66216

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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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. 45668 The facility identified a census of 115 residents. The sample included 26 residents with one reviewed for dementia (a progressive mental disorder characterized by failing memory, and confusion) care. Based on interviews, record reviews, and observations, the facility failed to provide dementia-related care services for Resident (R)99 to promote the resident's highest practicable level of well-being. This deficient practice placed the resident at risk for decreased quality of life, isolation, and impaired dignity. Findings Included: - R99's Medical Diagnosis section within the Electronic Medical Record (EMR) noted diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), general anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and cognitive communication disorder (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness). R99's Quarterly Minimum Data Set (MDS) completed 06/17/24 revealed a Brief Interview for Mental Status (BIMS) assessment was not complete due to severe cognitive impairment. The MDS indicated she sometimes could make her needs known with simple communication and sometimes understood others with simple communication. The MDS indicated she had delusions. The MDS noted she had verbal behaviors towards others. The MDS noted she exhibited refusals of care and wandering daily. The MDS indicated she could ambulate independently. The MDS indicated she had one non-injury fall since her last assessment. R99's Dementia Care Area Assessment (CAA) completed 09/25/23 indicated she was admitted to the facility's dementia Memory Care Unit due to her severe cognitive impairment, behavioral symptoms, and wandering. R99's Communication CAA completed 06/25/23 indicated she had an impaired ability to make herself understood and understand others. The CAA instructed staff to give her time for thought process during conversations. R99's Care Plan initiated 09/19/24 indicated she resided in the Memory Care Unit. The plan noted she had impaired cognitive function related to her medical diagnoses. The plan indicated she spoke [non-English language]. The plan indicated she required an interpreter. The plan instructed staff to encourage her independence while inside the building but ensure supervision while she was outside. The plan instructed staff to re-direct her while she wandered around doors and exits. The plan instructed staff to provide conversation and activities, promote consistent routines, and visualize her whereabouts frequently. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R99's EMR under Progress Note revealed a note dated 07/20/24 that indicated R99 attempted to move into and slept in her old room. The note indicated staff attempted to redirect R99 to her new room but R99 could not understand the redirection. The note indicated staff attempted to contact R99's representative to translate but was unable to reach her. The note indicated R99 eventually calmed down while she sat on the hallway couch outside her room. On 09/17/24 at 07:31 AM R99 walked around the locked Memory Care Unit. R99 entered R73's (severely cognitively impaired female resident) room while she slept in her bed. R99 made several attempts to wake R73 up while she was in her bed. Staff intervened and walked R99 out of the room and to the dining room. Staff attempted to redirect R99 in English but R99 remained confused. R99 then continued to walk around the unit. R99 then walked into R74's (severely cognitively impaired male resident) room briefly and then exited the room. Staff did not attempt to use the translator service or cue card to assess R99's needs or intentions during this event. On 09/17/24 at 12:21 PM R99 entered the dining room and sat next to R73 for lunch. Both residents began to eat their lunch. The assistive staff stepped out of the dining room to assist with another resident's behaviors leaving one support staff on the opposite side of the dining room by the kitchen. At 12:29 PM R99 attempted to assist R73 by adjusting her plate. R73 began yelling Help, help, help out for staff to intervene. Staff were not able to intervene during this event. R73 stated She's crazy, she's stupid, you're crazy, you're stupid repeatedly to R99. R99 continued to adjust R73's tray while speaking in her native language. Residents looked around the unit for assistance while yelling out. R99 eventually stood up and left the table. R99 continued to walk around the dining area. R99 then approached another table and attempted to stand the resident up by grabbing her by the arm. The staff then intervened and redirected her in English. R99 let go of the resident's arm and walked back to her room. Staff did not attempt to use the translator service or cue card to assess R99's needs or intentions during this event. On 09/18/24 at 01:30 PM, Certified Nurse's Aide (CNA) M stated the facility provided dementia annually and she was in the last dementia class. She stated staff were expected to monitor the dining area and intervene when behaviors were present. She stated R99 needed frequent redirection due to her confusion related to her old room and wandering. On 09/18/24 at 01:50 PM Licensed Nurse (LN) G stated R99 liked to help other residents and often would become confused. She stated staff provided supervision to ensure she was not invading other resident's personal space or touching their food. On 09/18/24 at 03:12 PM Administrative Nurse D stated all staff received dementia care training to address care needs and behaviors. She stated staff were expected to assist and monitor the resident per their care planned instructions. She stated staff were expected to intervene if residents exhibited behaviors and ensure the residents understood the redirections that were provided. The facility's ADL Care of Dementia Unit Residents policy revised 10/2019 indicated staff will provide the assistance and services outlined in each resident's plan of care. The plan indicated care plan intervention will be monitored on an ongoing basis for effectiveness and updated as needed. The plan indicated the facility would assess and identify the care needs of each resident in the dementia unit. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility failed to provide dementia-related services for R99. This deficient practice placed R99 at risk for decreased quality of life, isolation, and impaired dignity.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 49634 The facility identified a census of 115 residents. The sample included 26 residents with two medication rooms and four medication carts. Based on observation, record review, and interviews, the facility failed to ensure controlled substances were accounted for and reconciled between shifts. This placed the residents at risk for misappropriation and/or diversion of controlled substances. Findings included: - On 09/18/24 at 07:34 AM a review of the July, August, and September 2024 Narcotic Hand Off Count Sheet on the 100 halls revealed a missing signature either for the on-coming nurse or the off-going nurse for the morning shift on 07/27, 07/28, 08/03, 08/10, 09/03, 09/7, and 09/18. On 09/18/24 at 07:34 AM, a review of the July, August, and September 2024 Narcotic Hand Off Count Sheet on the 100 halls revealed a missing signature either for the on-coming nurse or the off-going nurse for the evening shift on 07/6, 7/27, 8/3, 8/5, 8/6, 8/23, 8/30, 9/2, 9/9, 9/13, and 9/16. On 09/18/24 at 07:42 AM Certified Medication Aide (CMA)R stated the narcotics were always to be counted between shifts and a signature of the nurse or CMA was to be documented. On 09/18/24 at 01:22 PM Licensed Nurse (LN)H the narcotics should be counted, and the sheet signed each shift, after ensuring the narcotic count was correct. On 09/18/24 at 03:11 PM Administrative Nurse D stated it was the facility policy that narcotic counts should be done every shift and the Narcotic Hand-Off Count Sheet be signed by the incoming nurse and outgoing nurse. The facility's Controlled Substance Administration and Accountability policy dated 01/01/20 documented that the facility was to promote safe, high-quality patient care, compliant with state and federal regulations regarding monitoring the use of controlled substances the facility will have safeguards in place to prevent loss, diversion or accidental exposure. The facility failed to ensure an accurate reconciliation of controlled medications was completed. This placed residents at risk of medication misappropriation and diversion.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41713 The facility identified a census of 115 residents. The sample included 26 residents with five sampled residents reviewed for unnecessary medications. Based on observation, record review, and interview, the facility failed to ensure the Consultant Pharmacist (CP) identified and reported a missing dosage and location of the application for Resident (R) 92's physician-ordered diclofenac (a topical medication used to treat pain and swelling). The facility further failed to ensure the CP recommendations for R35 were submitted to the physician for review. This placed the residents at risk for unnecessary medication side effects. Findings included: - R92's Electronic Medical Record (EMR) documented diagnoses of quadriplegia (inability to move the arms, legs, and trunk of the body below the level of an associated injury to the spinal cord), dementia (a progressive mental disorder characterized by failing memory and confusion), and encephalopathy (a broad term for any brain disease that alters brain function or structure). R92's Admission Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 10 which indicated a moderately impaired cognition. R92 had impairment on both sides of his upper and lower extremities. R92 utilized a wheelchair for mobility. R92 required substantial/maximal assistance to total dependence on staff for his functional abilities. R92 was always incontinent of both bladder and bowel. R92 received an antianxiety (a class of medications that calm and relax people), and an antidepressant (a class of medications used to treat mood disorders) medication. R92's Quarterly MDS dated [DATE] documented a BIMS score of six which indicated a severely impaired cognition. R92 had impairment on both sides of his upper and lower extremities. R92 used a wheelchair for mobility. R92 required substantial/maximal assistance to total dependence on staff for his functional abilities. R92 was always incontinent of both bladder and bowel. R92 received an antianxiety and an antidepressant medication. R92's Incontinence Care Area Assessment (CAA) dated 10/18/23 documented he was incontinent of bladder and bowel. R92 was dependent on staff for toileting and toileting hygiene. R92's Care Plan last revised 04/04/24 directed staff to administer medications as ordered. Staff was to monitor and document side effects and effectiveness. R92's Order Summary Report documented an order dated 10/10/23 for diclofenac sodium external gel one percent (1%) to apply to the affected area topically three times a day for pain. This order was discontinued on 10/11/23. This order lacked a dosage amount or specific location to apply. R92's Order Summary Report documented an order dated 10/11/23 for diclofenac sodium external gel 1% to apply to the affected area topically three times a day for pain. This order was discontinued on 10/27/23. This order lacked a dosage amount or specific location to apply. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R92's Order Summary Report documented an order dated 10/19/23 for diclofenac sodium external gel 1% to apply two grams (gm) to bilateral elbows area topically three times a day for pain. This order was discontinued on 05/07/24. R92's Order Summary Report documented an order dated 10/19/23 for diclofenac sodium external gel 1% to apply four gm topically to bilateral knees three times a day for pain. This order was discontinued on 05/07/24. R92's Order Summary Report documented a current order dated 05/07/24 for diclofenac sodium external gel 1% to apply to the affected area topically three times a day for pain. This order lacked a dosage amount or specific location to be applied. The CP monthly medication regimen reviews (MRR) from May 2024 to August 2024 lacked evidence the CP identified and reported the missing dosage and affected area for the diclofenac. On 09/17/24 at 02:03 PM, staff propelled R92 in his wheelchair from the outside patio back into the building. On 09/18/24 at 01:25 PM Licensed Nurse (LN) J stated she never had to do anything with the pharmacy recommendations. LN J stated that diclofenac never had an indicated dosage amount to apply that she knew of. LN J stated she would just squeeze out an amount for the area indicated and apply enough to cover the area. On 09/18/24 at 03:11 PM Administrative Nurse D stated all orders for diclofenac should indicate the amount to apply as well as the area to apply. Administrative Nurse D stated the CP did come monthly to do the MRR. R92's diclofenac order must have been overlooked by the CP for lacking a dosage or where to apply the medication. The Medication Regimen Review (M RR) policy implemented on 01/01/20 documented that the MRR was a thorough evaluation of the medication regimen of a resident. The MRR included a review of the medical record to prevent, identify, report, and resolve medication-related problems, medication errors, or irregularities. The pharmacist shall document, either manually or electronically, that each medication regimen review has been completed. The pharmacist shall document that no irregularity was identified or the nature of any identified irregularities. The facility failed to ensure the CP identified and reported R92's physician-ordered diclofenac lacked a dosage amount and specific area to be applied. This placed the resident at risk for unnecessary medication side effects. 41037 - R35's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), atrial fibrillation (rapid, irregular heartbeat), and hypertension (HTN-elevated blood pressure). (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Significant Change Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of one which indicated severely impaired cognition. The MDS documented R35 had received an antianxiety (a class of medications that calm and relax people), anticoagulant (a class of medications used to prevent the blood from clotting), antidepressant (a class of medications used to treat mood disorders), hypoglycemic (a class of medication used to treat high sugar levels in the blood in the blood), and opioid (a class of controlled drugs used to treat pain). The MDS lacked evidence a drug regimen review was completed during the observation period. The Quarterly MDS dated [DATE] documented a BIMS score of zero which indicated severely impaired cognition. The MDS documented that R35 had received anticoagulant medication, antidepressant medication, opioid medication, hypoglycemic medication, and a diuretic (a medication to promote the formation and excretion of urine). The MDS lacked evidence a drug regimen review was completed during the observation period. R35's Psychotropic Drug Use Care Area Assessment (CAA) dated 01/29/24 documented he received antidepressant medication. R35's Care Plan dated 07/22/24 documented staff would consult with the pharmacist and physician to consider a dose reduction when clinically appropriate, quarterly, and more frequently as needed. R35's EMR under the Progress Notes tab revealed a Pharmacist-Drug Regimen Review on 03/27/24 at 02:07 PM was completed and a recommendation was made to the attending physician. On 05/28/2024 at 01:37 PM a Pharmacy-Drug Regimen Review was completed, and a recommendation was made to the attending physician. A review of R35's Monthly Medication Review (MMR) from September 2023 through August 2024 provided by the facility lacked evidence the attending physician had reviewed or addressed the CP's recommendation from 03/27/24 and 05/28/24. The facility was unable to provide evidence the physician reviewed the recommendations made on 03/27/24 or 05/28/24 upon request. On 09/17/24 at 07:28 AM R35 lay in bed with only an incontinent brief on and his blankets pulled down below his knees. The room door was open to the hallway while Certified Nurse Aide (CNA) PP and CNA QQ provided personal care. On 09/18/24 at 01:25 PM Licensed Nurse (LN) J stated she never had to do anything with the pharmacy recommendations. On 09/18/24 at 03:11 PM Administrative Nurse D stated the CP did come monthly to do the MRR. Administrative Nurse D stated the facility was unable to locate documentation that R35's March 2024 and May 2024 MRR had been reviewed by the attending physician. Administrative Nurse D stated the CP emailed the monthly reviews to the director of nursing, medical records would print the recommendations off, then place the recommendations into the physician fold to be reviewed and signed. Administrative Nurse D stated once the MRR was reviewed and signed, the unit nurses would make the changes if any orders, and then return to medical records to be uploaded into the resident's EMR. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Medication Regimen Review (M RR) policy implemented on 01/01/20 documented that the MRR was a thorough evaluation of the medication regimen of a resident. The MRR included a review of the medical record to prevent, identify, report, and resolve medication-related problems, medication errors, or irregularities. The pharmacist would document, either manually or electronically, that each medication regimen review had been completed. The pharmacist would document that no irregularity was identified or the nature of any identified irregularities. The staff would act upon all recommendations according to procedures for addressing medication regimen irregularities. The facility failed to ensure the physician reviewed and addressed the CP recommendations for R35. This deficient practice placed R35 at risk for unnecessary medication use, side effects, and physical complications.

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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** 41713 The facility identified a census of 115 residents. The sample included 26 residents with five sample residents reviewed for unnecessary medications. Based on observation, record review, and interview, the facility failed to ensure Resident (R) 92's physician ordered diclofenac (a topical medication used to treat pain and swelling) had an indicated dosage or an indicated location to apply the medication. This placed R92 at risk of unnecessary medication administration and possible adverse side effects. Findings included: - R92's Electronic Medical Record (EMR) documented diagnoses of quadriplegia (inability to move the arms, legs, and trunk of the body below the level of an associated injury to the spinal cord), dementia (a progressive mental disorder characterized by failing memory and confusion), and encephalopathy (a broad term for any brain disease that alters brain function or structure). R92's Admission Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 10 which indicated a moderately impaired cognition. R92 had impairment on both sides of his upper and lower extremities. R92 utilized a wheelchair for mobility. R92 required substantial/maximal assistance to total dependence on staff for his functional abilities. R92 was always incontinent of both bladder and bowel. R92 received an antianxiety (a class of medications that calm and relax people), and an antidepressant (a class of medications used to treat mood disorders) medication. R92's Quarterly MDS dated [DATE] documented a BIMS score of six which indicated a severely impaired cognition. R92 had impairment on both sides of his upper and lower extremities. R92 used a wheelchair for mobility. R92 required substantial/maximal assistance to total dependence on staff for his functional abilities. R92 was always incontinent of both bladder and bowel. R92 received an antianxiety and an antidepressant medication. R92's Incontinence Care Area Assessment (CAA) dated 10/18/23 documented he was incontinent of bladder and bowel. R92 was dependent on staff for toileting and toileting hygiene. R92's Care Plan last revised 04/04/24 directed staff to administer medications as ordered. Staff was to monitor and document side effects and effectiveness. R92's Order Summary Report documented a current order dated 05/07/24 for diclofenac sodium external gel 1% to apply to the affected area topically three times a day for pain. This order lacked a dosage amount or specific location to be applied. On 09/17/24 at 02:03 PM, staff propelled R92 in his wheelchair from the outside patio back into the building. On 09/18/24 at 01:25 PM Licensed Nurse (LN) J stated diclofenac never had an indicated dosage amount to apply that she knew of. LN J stated she would just squeeze out an amount for the area indicated and apply enough to cover the area. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/18/24 at 03:11 PM Administrative Nurse D stated all orders for diclofenac should indicate the amount to apply as well as the area to apply the medication. The facility failed to provide a policy regarding physician's orders as requested. The facility failed to ensure R92's physician-ordered diclofenac indicated a dosage amount and specific area to be applied. This placed the resident at risk for unnecessary medication administration and side effects.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. 45668 The facility identified a census of 115 residents. The sample included 26 residents. Based on observations, interviews, and record reviews, the facility failed to accommodate dietary preferences. This deficient practice placed the residents at risk for impaired nutrition and decreased psycho-social well-being. Findings Included- - On 09/16/24 at 09:01 AM the breakfast cart arrived on the unit of the Memory Care Unit. Resident (R)75 stated multiple times that she would like pancakes for breakfast. R75 was told by staff that pancakes were not available and that she would have to eat what was served to her. R75 was provided her meal. After she ate what was on her plate R75 requested toast. She was told by staff that toast was not available and given a bowl of Cheerios cereal. R75 complained she was not given an option for her meal or side items. On 09/16/24 at 09:50 AM upon completion of serving the residents in the Memory Care Unit, staff announced that seconds were not available for the residents. On 09/16/24 at 02:45 PM, R75 asked the unit staff for coffee. R75 was told that coffee was not available. R75 was told by staff she would have to wait until the dinner cart arrived at the unit. On 09/17/24 at 08:40 AM R60 entered the dining room of the Memory Care Unit and sat at the table closest to the kitchen. R60 was given a bowl of Cheerios. R60 asked for another type of cereal. R60 was told they only had Cheerios available. R60 ate the Cheerios. On 09/16/24 at 11:35 AM the Resident Council reported the facility did not provide options or alternative meals for breakfast. The council stated, You get what you get. The council reported pancakes were only served on Saturdays. On 09/18/24 at 07:40 AM R107 entered the dining area on the locked Memory Care Unit and asked for a cup of coffee. R107 was told by staff that coffee was not available and that the breakfast cart would be up eventually. At 08:45 the breakfast cart arrived on the unit with the coffee. On 09/18/24 at 01:30 PM, Certified Nurse Aide (CNA) M stated coffee was always available on the unit, but staff had to call down to the kitchen for it. She stated alternative menus were only for lunch and dinner and the residents could not request different breakfast items. She stated the kitchen would often not send everything up and staff had to call down sometimes for items or drinks. On 09/18/24 at 03:30 PM Administrative Nurse D stated staff were expected to communicate with the kitchen if items were needed or requested by the residents. She stated the units should always have drinks, snacks, and other alternative options available for the residents. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 09/18/24 at 12:40 AM Dietary Staff BB stated the facility could not provide alternatives for the breakfast meals. She stated pancakes, coffee, and cereal options can be provided at any time. She stated staff should call down to the kitchen if additional items were needed. The facility's Food Preferences policy (undated) indicated the facility would assess each resident's dietary needs, choices, and preferences to ensure adequate nutritional options are identified. The policy indicated the facility would accommodate the resident's preferences based on nutritional needs, choices, and intake requirements. The facility failed to accommodate the dietary preferences of the residents. This deficient practice placed the residents at risk for impaired nutrition and decreased psycho-social well-being.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45668 The facility identified a census of 115 residents. The sample included 26 residents. Based on observations, interviews, and record reviews, the facility failed to conduct a thorough facility-wide assessment to determine the resources necessary to care for residents competently during both day-to-day operations and emergencies. This deficient practice placed all 115 residents residing in the facility at risk for inadequate care. Findings Included: - An inspection of the Facility assessment dated [DATE] provided by the facility revealed the following: The assessment did not identify the facility's resident capacity. The assessment did not identify the means of input gathered from the residents and their representatives when formulating the assessment data. The assessment did not identify the specific staffing needs of each unit based on the type of resident population within the unit. The assessment did not identify the competencies and skill sets needed by nursing staff to provide care for the facility's resident population. On 09/19/2024 at 03:20 PM Administrative Nurse D stated the facility assessment was recently revised this month. The facility did not provide a policy related to its facility assessment as requested on 09/18/24. The facility failed to conduct a thorough, facility-wide assessment to determine what resources were necessary to care for residents competently during both day-to-day operations and emergencies. This failure affected all 115 residents residing in the facility at risk for inadequate care.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41037 The facility identified a census of 115 residents. The sample included 26 residents with three residents reviewed for hospice services. Based on observation, record review, and interviews, the facility failed to ensure collaboration regarding Resident (R) 20 and R5's care between the nursing home and the hospice 24 hours a day, seven days a week including documentation of a description of the services, medication, and equipment provided to these residents by hospice. This deficient practice created a risk of missed opportunities for services and delayed physical, mental, and psychosocial needs for these residents. Findings included: - R20's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), major depressive disorder (major mood disorder that causes persistent feelings of sadness), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), and chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing). The Significant Change Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of zero which indicated severely impaired cognition. The MDS documented no staff interview was completed. The MDS documented R20 received hospice care during the observation period. The Quarterly MDS dated [DATE] documented a staff interview that indicated severely impaired cognition. The MDS documented that R20 received hospice care during the observation period. R20's Cognitive Loss/Dementia Care Area Assessment (CAA) dated 04/04/24 documented her BIMS score was zero and she had a diagnosis of dementia. R20's Care Plan dated 03/19/24 documented that staff assessed her for pain or discomfort, administered medications as ordered, and evaluated the effectiveness. The plan of care documented bereavement services would be provided by hospice as needed. The plan of care documented that staff would notify the hospice of any significant changes. The plan of care documented that staff would provide activities of daily living (ADL) and companionship to provide comfort. The plan of care documented staff would administer medication as ordered and provide food and fluids as she desired. R20's Care Plan dated 03/20/24 documented the facility would coordinate all care with the hospice provider. The plan of care documented weight loss would be expected. The plan of care documented the hospice provider provided a bed and a wheelchair. The plan of care lacked documentation regarding the medications covered by hospice and what personal care items were provided by hospice as well as the frequency of hospice visits. R20's EMR under the Orders tab revealed the following physician orders: (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Admit to the hospice provider on 03/19/24. R20's communication book provided by hospice lacked a current hospice care plan, physician order with admitting diagnosis for hospice, and a list of medications covered by the hospice provider. On 09/17/24 at 12:14 PM, R20 sat in her wheelchair at the dining room table as staff assisted her with her lunch. On 09/18/24 at 01:28 PM, Certified Nurse Aide (CNA) MM stated the nurse would let the staff know which residents received hospice services. CNA MM stated he was not sure if a resident's hospice information was their plan of care. On 09/18/24 at 01:35 PM, Licensed Nurse (LN) I stated the hospice provider would communicate with the staff. LN I stated the hospice information should be listed on the care plan. LN I stated everyone had access to the resident's plan of care. On 09/18/24 at 03:11 PM, Administrated Nurse D stated the facility should have developed a care plan that indicated the medication, equipment, and frequency of services provided for each resident, and the hospice provider should have a care plan as well to ensure collaboration of care. The facility's Coordination of Hospice Services documented that when a resident chooses to receive hospice care and services, the facility will coordinate and provide care in cooperation with hospice staff to promote the resident's highest practicable physical, mental, and psychosocial well-being. The facility and hospice provider will coordinate a plan of care and will implement interventions in accordance with the resident's needs goals and recognized standards of practice in consultation with the resident's attending physician and resident's representative, to the extent possible. The facility failed to ensure a collaborative process was in place to communicate necessary information regarding R20's care between the nursing home and the hospice 24 hours a day, seven days a week including documentation of these communications, which had the potential for negative outcomes for R20. 49634 - R5's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of convulsions (a condition where a person's muscles contract and relax rapidly, causing the body to shake uncontrollably), bipolar disorder (a major mental illness that causes people to have episodes of severe high and low moods), depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), Bell's palsy (paralyzed on one side of the face), protein-calorie malnutrition, weakness, dysphagia (swallowing difficulty), and congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid). (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Significant Change Minimum Data Set (MDS) dated [DATE] documented R5 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS documented R5 had impairment of the lower extremities. The MDS documented R5 received hospice services during the observation period. R5's ADL Functional/Rehabilitation Potential Care Area Assessment (CAA) dated 07/18/24 documented R5 required staff assistance with all activities of daily living (ADLs). R5's Care Plan dated 07/12/24 documented R5 required end-of-life services related to malnutrition. The plan of care documented R5 was to maintain an adequate comfort level with staff support and hospice interventions. R5's plan of care documented nursing was to administer pain medications as ordered to assure R5's comfort level. R5's plan of care documented staff to alternate bath days with hospice, to promote and provide additional skin care, and staff were to turn and reposition R5 as she tolerated or allowed, to prevent breakdown. R5's plan of care did not include what services hospice would provide, such as medication, equipment, and supplies or hospice worker visits. A review of the hospice-provided communication binder revealed R5 was admitted to hospice services on 07/12/24. On 09/17/24 at 08:25 AM R5 lay in her bed looking at her phone. On 09/18/24 at 08:44 R5 laid in her bed on her back, filing her fingernails. On 09/18/24 at 01:28 PM, Certified Nursing Aide (CNA) N stated all hospice binders were kept at the nurses' desk, and the hospice provider's schedule was in the binder. CNA N was unsure if the facility's care plan documented what services the hospice provided to the resident. On 09/18/24 at 01:22 PM Licensed Nurse (LN) H stated nurses were to do the initial care plan, and the nurses can add to the plan of care as needed. LN H stated administrative nurses would do the plan of care for hospice. LN H was unsure what services should be in the president's plan of care. On 09/18/24 at 03:11 PM, Administrated Nurse D stated the facility should have developed a care plan that indicated the medication, equipment, and frequency of services provided for each resident, and the hospice provider should have a care plan as well to ensure collaboration of care. The facility's Coordination of Hospice Services documented that when a resident chooses to receive hospice care and services, the facility will coordinate and provide care in cooperation with hospice staff to promote the resident's highest practicable physical, mental, and psychosocial well-being. The facility and hospice provider will coordinate a plan of care and will implement interventions in accordance with the resident's needs goals and recognized standards of practice in consultation with the resident's attending physician and resident's representative, to the extent possible. The facility failed to ensure collaboration between the facility and the hospice provider for R5's end-of-life care. This deficient practice created a risk for missed or delayed services and impaired care for R5.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 49634 The facility identified a census of 115 residents. The facility identified eleven residents on Enhanced Barrier Precautions (EBP-infection control interventions designed to reduce transmission of resistant organisms that employ targeted gown and glove use during high contact care). Based on record reviews, observations, and interviews, the facility failed to implement signage or indicators within the physical environment to alert staff and visitors of the required EBP. The facility failed to sanitize shared equipment between use. The facility failed to ensure staff performed adequate hand hygiene, ensure trash was stored and contained properly, and that spills or leakage was cleaned under dining room sinks. These deficient practices placed the residents at risk for infectious diseases. Findings included: - An initial walkthrough of the facility was completed on 09/16/24 at 07:07 AM. An inspection of the 100-hall revealed two large trash bags that sat on the floor across from the nurse's station, one bag contained trash including several soiled and wet briefs, and the second trash bag contained soiled clothing. In the dining room for the 100 halls, in the cabinet area, there was a puddle of brown substance in the lower cabinet. An inspection of Resident (R)164's room revealed no protective equipment (PPE) readily available for EBP. R164 had no signage or indicators R164 was on EBP. R164 had a percutaneous endoscope gastrostomy tube (PEG-a tube inserted through the wall of the abdomen directly into the stomach). An inspection of R20's room revealed no PPE readily available for EBP. R20 had no signage or indicators R20 was on EBP. R20 had an open wound. An inspection of R50's room revealed no PPE readily available for EBP. R50 had no signage or indicators R50 was on EBP. R50 had a percutaneous endoscope gastrostomy tube. An inspection of R6's room revealed no readily available PPE for EBP.R6 had a suprapubic catheter (urinary bladder catheter inserted through the abdomen into the bladder). On 09/17/24 at 07:11 AM on the 100-hall, two large trash bags lay on the floor across from the nursing station. The bags contained several briefs and wipes in one bag, and the other bag contained soiled laundry. On 09/17/24 at 01:26 PM, Certified Nurse Aide (CNA) SS and CNA RR transferred R11 into the bed with the Hoyer (total body mechanical lift) lift. CNA RR and CNA SS did not disinfect the Hoyer lift before they transferred R11 into her bed. CNA RR and CNA SS then took the same lift to R84 and transferred R84 without cleaning or disinfecting the lift. On 09/17/24 at 01:30 PM R1 laid on her bed. CNA SS and CNA RR donned gloves and provided peri-care to R1's front side, CNA RR assisted R1 to turn onto her right side. CNA SS provided peri-care to R1's rectal area. CNA SS cleaned bowel movement from R1's rectal area. Without changing her soiled gloves, CNA SS placed a clean incontinent brief on R1 and removed R1's slacks. Wearing the same soiled gloves, CNA SS touched R1's blankets and adjusted her pillows. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 09/18/24 at 03:11 PM Administrative Nurse D stated all signs should be on the outside of residents' rooms that require EBP, and the expectation was for staff to wear the PPE which was indicated for each resident. Administrative Nurse D stated hand hygiene should be done between residents' care when going to the bathroom, serving foods, from dirty to clean, and leaving a resident's room. She stated trash of any kind should not be left on the floors, she stated trash and laundry should be put in large grey containers and kept in the soiled utility room. Administrative Nurse D stated if there is a spill anywhere all staff were to ensure the spill was cleaned quickly. The facility's Infection Prevention and Control Program dated 11/01/19 documented the facility was to establish and maintain an infection prevention and control program designed to provide a safe sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The facility failed to implement signage or indicators within the physical environment to alert staff and visitors of the required EBP. The facility failed to sanitize shared equipment between use. The facility further failed to ensure staff performed adequate hand hygiene, ensure trash was stored and contained properly, and spills or leakage was cleaned under dining room sinks. These deficient practices placed the residents at risk for infectious diseases.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. 49634 The facility identified a census of 115 residents. The sample included 26 residents with five residents reviewed for immunizations. Based on observation, record review, and interviews, the facility failed to offer and/or obtain an informed declination for Resident (R) 35 and R75's Pneumococcal Conjugate Vaccine (PCV20- vaccination for bacterial lung infections). This placed the residents at increased risk for complications related to pneumonia (a type of bacterial infection). Findings included: - R35's Electronic Medical Record (EMR) under the Immunization tab documented Refused for the PCV20 vaccination. R35's clinical record lacked evidence of an informed declination for R35 regarding the PCV20 vaccine. R75's EMR under the Immunization tab documented Refused for the PCV20 vaccination. R75's clinical record lacked evidence of an informed declination for R75 regarding the PCV20 vaccine. Upon request, the facility was unable to provide evidence of an informed declination of the PCV20 for R35 and R75. On 09/17 /24 at 10:22 AM Administrative Nurse E stated he had not had time to investigate the refusals and could not provide evidence of the informed declinations for the PCV20 for R35 and R75. The facility's Vaccine Information Statement revised 06/01/22 documented that before the administration of any vaccine, a copy of the most current, relevant vaccine information statement will be provided to the resident or legal representative. Individuals receiving vaccines, or the legal representative, will be required to sign a consent form prior tie the administration of the vaccine. The completed signed and dated record would be placed in the individual's permanent medical record. The facility failed to offer and/or obtain an informed declination for the PCV20 vaccine for R35 and R75. This placed the residents at increased risk for pneumonia.

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F 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop, implement, and/or maintain an effective training program that includes effective communications for direct care staff members. 45668 The facility identified a census of 115 residents. Based on record review and interviews, the facility failed to ensure agency staff received the required communication training. This placed the residents at risk for impaired care and decreased quality of life. Findings included: - On 09/11/24 at 11:45 AM the facility was unable to provide proof of training records for agency staff. The staff reviewed were Licensed Nurse (LN) K, LN L, and Certified Nurse's Aide (CNA) OO. On 09/11/24 at 02:40 PM Administrative Nurse D stated the facility would review the records online or be told over the phone what training or classes the agency staff completed. The facility was unable to provide the required training records as requested on 09/18/24. The facility's Nursing Services and Sufficient Staffing policy revised 10/2022 indicated the facility will provide sufficient staffing with the appropriate training, competencies, and skill sets to assure resident safety and attain the highest level of resident care. The facility failed to ensure the completion of the required communication training for staff who provided care in the facility. This placed the residents at risk for impaired care and decreased quality of life.

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F 0942 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that staff members are educated on resident rights and facility responsibilities to properly care for its residents. 45668 The facility identified a census of 115 residents. Based on record review and interviews, the facility failed to ensure agency staff received the required resident rights training. This placed the residents at risk for impaired care and decreased quality of life. Findings included: - On 09/11/24 at 11:45 AM the facility was unable to provide proof of training records for agency staff. The staff reviewed were Licensed Nurse (LN) K, LN L, and Certified Nurse's Aide (CNA) OO. On 09/11/24 at 02:40 PM Administrative Nurse D stated the facility would review the records online or be told over the phone what training or classes the agency staff completed. The facility was unable to provide the required training records as requested on 09/18/24. The facility's Nursing Services and Sufficient Staffing policy revised 10/2022 indicated the facility will provide sufficient staffing with the appropriate training, competencies, and skill sets to assure resident safety and attain the highest level of resident care. The facility failed to ensure the completion of the required resident rights training for staff who provided care in the facility. This placed the residents at risk for impaired care and decreased quality of life.

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F 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Include as part of its infection prevention and control program, mandatory training that includes written standards, policies, and procedures for the program. 45668 The facility identified a census of 115 residents. Based on record review and interviews, the facility failed to ensure agency staff received the required infection control training. This placed the residents at risk for impaired care and decreased quality of life. Findings included: - On 09/11/24 at 11:45 AM the facility was unable to provide proof of training records for agency staff. The staff reviewed were Licensed Nurse (LN) K, LN L, and Certified Nurse's Aide (CNA) OO. On 09/11/24 at 02:40 PM Administrative Nurse D stated the facility would review the records online or be told over the phone what training or classes the agency staff completed. The facility was unable to provide the required training records as requested on 09/18/24. The facility's Nursing Services and Sufficient Staffing policy revised 10/2022 indicated the facility will provide sufficient staffing with the appropriate training, competencies, and skill sets to assure resident safety and attain the highest level of resident care. The facility failed to ensure the completion of the required infection control training for staff who provided care in the facility. This placed the residents at risk for impaired care and decreased quality of life.