STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175275	A. Building B. Wing	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicalodges Kinsley	620 Winchester Avenue Kinsley, KS 67547

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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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 50659 The facility reported a census of 22 residents. The sample included 10 residents. Based on interview and record review, the facility failed to issue accurate and complete Beneficiary Protection Notification forms to Resident (R) 16. Findings included: - On 11/04/24 review of the Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage Form CMS-20052 (SNFABN) and the Notification of Medicare Non-Coverage Form 10123(NOMNC- the form used to notify Medicare A participants of their rights to appeal and the last covered date of service). The SNFABN had the incorrect dates on the form and lacked cognitively intact R16's signature, the family member signed the form. The facility lacked a signed NOMNC for R16. During an interview on 11/14/24 at 07:45 AM, Administrative Staff A reported there was no NOMNC issued for R16 when discharged from therapy. She reported R16 started therapy 06/06/24 and last cover day was 06/27/24 from therapy. A SNFABN was given to resident with the incorrect dates of 07/22/24 to pay out of pocket. The SNFABN form was signed on 07/16/24 by family member and was not sure why R16 did not sign the form. Administrative Staff A reported that was the old Social Service Designee who is no longer worked at the facility as she had problems completing the required paperwork. The facility did not provide a policy for Medicare Advance Beneficiary and Medicare Non-Coverage Notices, as requested. The facility failed to ensure the correct and complete Beneficiary Protection Notification forms were issued to R16, as required.

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition 50659 The facility reported a census of 22 residents with 10 residents sampled. Based on observation, interview, and record review the facility failed to identify a significant change and complete an assessment for two residents reviewed for significant change assessments. Resident (R) 19 had a decline with ambulation, toileting hygiene, transfers, bed mobility and dressing. R11 had a decline with ambulation, transfers, toileting hygiene, and bed mobility. This deficient practice had the potential to lead to uncommunicated needs, which could lead to negative impacts on the resident's physical, mental and psychosocial well-being. Findings included: - Resident (R)19's Electronic Health Record (EHR) revealed a diagnosis, which included dementia (progressive mental disorder characterized by failing memory, confusion). The 06/26/24 Admission Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of five, which indicated severely impaired cognition. R19 had a total mood severity score of 00, indicating no depression and he had no behaviors noted. R19 required set up for eating and required supervision assistance with ADLs such as ambulation 150 feet, toileting, dressing, footwear, and personal hygiene. R19 was independent with ambulation 10 feet, transfers and bed mobility. He required moderate assistance with bathing. History of falls and R19 did not use a wheelchair. The Functional Abilities/Functional Rehabilitation Care Area Assessment (CAA) dated 06/26/24, documented R19 triggered the functional CAA due to needing assistance from staff. The Cognitive Loss/Dementia CAA dated 06/26/24, documented R19 triggered the cognitive CAA due to having a low BIMS score. The 09/20/24 Quarterly MDS documented R19 had a BIMS score of five, which indicated severely impaired cognition. R19 had behaviors noted 1-3 days of kicking, hitting, wandering, refusal of care, pushing, and grabbing captured in the seven day lookback. R19 required maximal assistance with bed mobility, transfers, oral care, and personal hygiene. No ambulation was captured in the seven day lookback period. R19 was dependent for toileting hygiene. Bathing, dressing, and footwear were not assessed on the MDS. One fall non-injury. The Care Plan documented the following: Staff were instructed to provide more assistance for completing ADLs if R19 had pain, dated 06/20/24. Staff were instructed to provide one staff assistance for dressing and personal care. Additionally, staff were instructed to provide two staff assistance with transfers and R19 was independent with wheelchair mobility, dated 10/16/24. (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Physician Orders Physical Therapy evaluation and treat, date ordered 10/08/24. The 08/04/24 at 06:20 PM Progress Note documented R19 had increased confusion and was unable to dress himself, he required assistance with toileting hygiene and adjustment of clothes, R19 was unable to follow verbal cues when instructed what he needed to do. R19 was unsteady with ambulation and would attempt to stand up and sat back down. The 08/05/24 at 05:38 PM Progress Note documented provider reported R19's urinalysis was unremarkable, therefore suspected behavior represented a progression of known dementia. The 08/19/24 at 12:05 PM Progress Note documented R19 confused and would not cooperate with staff when they attempted to provide care with ADLs. The floor had a large amount of urine on it as if he had sat on the side of the bed and urinated. The 09/29/24 at 05:05 PM Progress Note documented R19 found o floor in front of his wheelchair at the nurse's station. The 10/03/24 at 11:27 AM Progress Note documented a request had been made by therapy to obtain an order for physical therapy as R19 declined in strength and difficulty noted with ambulation. During an observation on 11/12/24 R19 was seated in his chair in his room, an unidentified therapist assisted R19 to a standing position. She reported that R19 started therapy the second week of October 2024 to strengthen his legs. During an observation on 11/13/24 at 08:30 AM and 12:25 PM, R19 was seated in his wheelchair in the dining room eating his lunch. During an interview on 11/13/24 at 02:15 PM, Certified Nurse Aide (CNA) M reported R19 had a decline with ambulation and doing care by himself over a couple of months ago, she reported that was easier for R19 to get around in his wheelchair and that he does not walk unless staff walk him. CNA M reported she would communicate with the charge nurse if there was a decline of ADLs for any resident when noticed. During an observation on 11/13/24 at 02:18 PM, R19 was seated in a wheelchair in television lounge, he held onto the handrail on the wall in front of him with one hand. During an observation on 11/13/24 at 02:26 PM, R19 was found ambulating independently in the television lounge approximately 20 feet from his wheelchair, his gait was unsteady and R19 almost fell as he started to lean towards his left side. Dietary Manager C moved quickly toward R19 and assisted him back to his wheelchair. Dietary Manager C reported R19 had not ambulated like that for a few months and reported R19 used to ambulate all over the facility when he was first admitted . During an interview on 11/14/24 at 10:00 AM, CNA M reported R19 had a decline in his ADL's since he was admitted . CNA M reported R19 ambulated all over the facility and he was more independent with his ADL's, she reported that R19 started to decline in 08/2024. CNA M reported that the staff have to assist R19 with is ADLs as he could not complete them like he had in the past. CNA M revealed that if a resident had a decline for a few days, she would report that information to the charge nurse. (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/14/24 at 10:30 AM, Licensed Nurse (LN) H reported that R19 had a decline on walking and performing ADLs over the past couple of months. She said that a therapy consult would be obtained and reported that R19 had started physical therapy sometime last month. During an interview on 11/14/24 at 02:48 PM, Administrative Nurse A reported that she did not complete R19's MDS on 09/20/24 and did not agree that R19 had a decline is his ADLs. She reported that R19 could still walk and that he uses his legs to propel his wheelchair independently and that R19 can dress himself too. Reviewed the MDS completed in EHR and continued to report that R19 had no decline and she commented that she needed assistance to complete the MDS's in the facility as she had fell behind and that she should have just completed the MDS's herself so they would be correct. On 11/14/24, Administrative Staff A stated that the RAI manual is used as their policy. The facility failed to identify a significant change and complete an assessment for R19 he had a decline with ambulation, toileting hygiene, transfers, bed mobility and dressing. This deficient practice had the potential to lead to uncommunicated needs, which could lead to negative impacts on the resident's physical, mental and psychosocial well-being. - Resident (R) 11's Electronic Health Record (EHR) revealed diagnoses, which included repeated falls, fatigue, weakness, and congestive heart failure (CHF- a condition with low heart output and the body becomes congested with fluid). The 03/07/24 Admission Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 10, which indicated moderately impaired cognition. R11 had a total mood severity score of 00, indicating no depression and he had no behaviors noted. R11 required set up for eating and oral care. He required supervision assistance with activities of daily living (ADL) such as toileting hygiene, bed mobility, and transfers. R11 required moderate assistance for dressing, personal hygiene, and ambulation. He required maximum assistance for bathing, footwear, car transfer and mobility. R11 was frequently incontinent of bladder and continent of bowel. He had a history of falls and one minor injury fall. R11 had no oxygen or continuous positive airway pressure (CPAP- ventilation device that blows a gentle stream of air into the nose to keep airway open during sleep). The Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) dated 03/07/24, documented R11 triggered the functional CAA due to needing assistance from staff. The Cognitive Loss and Dementia CAA dated 03/07/24, documented R11 triggered the cognitive CAA due to having a BIMS score of 10. The 09/06/24 Quarterly MDS R11 BIMS score and depression were not assessed. No behaviors noted in lookback period. R11 required total dependence on staff for personal hygiene, toileting hygiene, bed mobility, and transfers. R11 was non-ambulatory and wheelchair mobility was not assessed. R11 had frequent incontinence of bladder and bowel. R11 had two or more injury falls. The Care Plan documented the following: Staff were instructed to provide more assistance for completing ADLs if R19 had pain, dated 04/11/24. (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Staff were instructed to provide assistance as needed for toileting, dated 04/29/24. Staff were instructed to provide peri care as needed, dated 04/29/24. Staff were instructed to utilize mechanical lift for transfers, dated 10/16/24. The Physician Orders lacked any orders for ADLs. The 03/03/24 at 08:03 PM Progress Note documented R11 found on the bathroom floor, R11 reported he lost his balance when he turned around and fell . The 05/28/24 at 01:30 PM Progress Note documented R11 found on floor in his room, he reported his knee gave out and he fell . The 06/11/24 at 10:08 AM Progress Note documented R11 found on floor in room, he reported he bent over to pick up a piece of paper. The 06/17/24 at 09:17 AM Progress Note documented R11 confused and ambulated by himself in hallway, called provider for a urinalysis (lab analysis of urine) order. The 07/19/24 at 09:53 AM Progress Note documented R11 ambulated 15 feet with restorative aide he complained of pain. The 08/04/24 at 06:35 PM Progress Note documented R11 stayed in bed longer during the morning, refused to be assisted out of bed. R11 had difficulty with transfers, complained of pain, and did not want to bear weight. Three staff assisted R11 with a transfer out of bed to wheelchair. The 08/16/24 at 09:56 AM Progress Note documented R11 would not ambulate and complained of pain in his back. The 09/19/24 at 07:13 AM Progress Note revealed R11 had declined with ambulation and required a sit-to-stand lift for transfers. During an interview on 11/12/24 at 04:56 PM R11's family member reported that R11 used to walk, and now required a mechanical lift for all his transfers. R11's family member said R11 required increased staff assistance since he moved into the facility in June of 24, with bathing, dressing and toileting. During an observation on 11/13/24 at 09:30 AM, R11 self-propelled in his wheelchair from dining room to his room, no concerns noted. During an interview on 11/14/24 at 10:00 AM, Certified Nurse Aide (CNA) L reported R11 had a decline with ambulation a few months ago, she reported that R11 is now a mechanical lift and he required more assistance with ADLs. CNA L reported she would communicate with the charge nurse if there was a decline of ADLs for any resident when noticed. (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/14/24 at 02:51 PM, Administrative Nurse A reported that she did not complete R11's MDS on 09/06/24 and did not agree that R11 had a decline is his ADLs. She reported that R11 could walk when he was admitted to facility. Administrative Nurse B reported she was unsure if R11 was a true significant change as she required assistance to complete the MDS's in the facility as she had fell behind and that she should have just completed the MDS's herself so they would be correct. On 11/14/24 Administrative Staff A stated the facility used the RAI manual as their policy for MDSs. The facility failed to identify a significant change and complete an assessment for R11 who had a decline with ambulation, toileting hygiene, transfers, bed mobility and personal hygiene. This deficient practice had the potential to lead to uncommunicated needs, which could lead to negative impacts on the resident's physical, mental and psychosocial well-being.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 50659 The facility reported a census of 22 residents with 10 residents sampled. Based on observation, interview, and record review the facility failed to complete a weekly skin assessment for one resident. Observation during the survey revealed Resident (19) with a dressing on his right elbow and no skin notes, or progress notes in the Electronic Health Record (EHR) regarding the right elbow dressing. This deficient practice had the potential to lead to uncommunicated needs, which could lead to negative impacts on the resident's physical, mental and psychosocial well-being. Findings included: - Resident (R) 19's Electronic Health Record (EHR) revealed a diagnosis of dementia (progressive mental disorder characterized by failing memory, confusion). The 06/26/24 Admission Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of five, which indicated severely impaired cognition. R19 had a total mood severity score of 00, indicating no depression and no behaviors noted. R19 required set up for eating and required supervision assistance with ADLs such as ambulating 150 feet, toileting, dressing, footwear, and personal hygiene. R19 was independent with ambulating 10 feet, transfers, and bed mobility. He required moderate assistance with bathing. R19 had a history of falls and no skin issues noted. The Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) dated 06/26/24, documented R19 triggered the functional CAA due to needing assistance from staff. The Cognitive Loss and Dementia CAA dated 06/26/24, documented R19 triggered the cognitive CAA due to having a low BIMS score. The 09/20/24 Quarterly MDS documented R19 had a BIMS score of five, which indicated severely impaired cognition. R19 had behaviors noted 1-3 days of kicking, hitting, wandering, refusal of care, pushing, and grabbing captured in the seven day lookback. R19 required maximal assistance with bed mobility, transfers, oral care, and personal hygiene. No ambulation was captured in the seven day lookback period. R19 was dependent for toileting hygiene, had one fall non-injury, with no skin issues noted. The Care Plan included a 10/17/24 intervention, which instructed staff to inspect R19's skin with bathing and daily care and report changes to the nurse. Review of the Physician Orders lacked any orders for wound care for R19. The 10/16/24 at 03:26 PM Progress Note revealed R19 had a fall earlier in the morning and a v shaped skin tear was noted on left elbow that measured at 0.8 centimeters on each side of the skin tear. The 10/17/24 at 12:37 AM Skin/Wound Assessment revealed R19 has a skin tear (a traumatic wound that occurs when the skin separates from the underlying layers) that measured two centimeters length by one and a half centimeters wide on right elbow. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The EHR did not contain further skin assessments regarding R19's right elbow dressing from 10/18/24 through 11/18/24. During an observation on 11/19/24 at 01:05 PM R19 had no dressing noted on right elbow, but a healing abrasion area red in color approximate size of three centimeters (cm) by one and a half cm. Licensed Nurse (LN) I confirmed the skin area on right elbow and reported that she did not know R19 had a skin issue. During an interview on 11/19/24 at 09:44 AM, Administrative Staff A reported the skin/wound condition assessment would be completed weekly by the charge nurse. Administrative Staff A confirmed R19's last skin wound assessment completed was on 10/17/24 and did not know why R19 would have had a dressing on his right elbow. During an interview on 11/19/24 at 01:20 PM Certified Nurse Aide (CNA) K reported that she did not know why R19 had a dressing on his right elbow the other day and stated maybe it was a skin tear. She reported she first noticed the dressing on R19's right elbow about two weeks ago. CNA K reported is a resident had a new skin issue the charge nurse would be updated. During an interview on 11/19/24 at 01:38 PM LN I reported that the charge nurse were responsible to complete the skin condition notes on every resident weekly and are they assigned to the charge nurse. LN I reported that it would be on the resident's treatment administration record in EHR for the nurse to know when to complete the skin note. LN I reported that R19 did not have that placed in the orders so it would not be on the administration record. LN I revealed a handwritten assignment sheet in a book for nurses to look for skin note calendar and reported that R19 was to have his skin note completed on Monday evening shift. She then confirmed that R19's last skin condition note was completed in the EHR on 09/11/24 and reported that the agency nurses do not always look in the book. LN I reported there were two different types of skin notes that could be documented in EHR. She reported the skin wound condition assessment would be completed if a resident had a wound that was monitored, and that assessment would be completed weekly also by the charge nurse or by Administrative Nurse B. LN I confirmed that R19's last skin wound condition note was 10/17/24. The facility's policy Wound Prevent and Management dated 12/2018, documented the following: Providing guidelines for optimal care to promote healing for residents with all identified skin alterations. Licensed nurses would be responsible for weekly assessments of skin for all residents and document finding in the EHR in skin condition note. The facility failed to complete a weekly skin assessment for R19, who was observed with a dressing on his right elbow on 11/12/24 and no recent skin notes, or progress notes in EHR regarding the dressing. This deficient practice had the potential to lead to uncommunicated needs, which could lead to negative impacts on the resident's physical, mental and psychosocial well-being.

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50659 The facility reported a census of 22 residents with 10 residents sampled and one resident reviewed for pain management and two additional residents reviewed for unnecessary medication use. Based on observation, interview, and record review the facility failed to assess pain and failed to take appropriate action to manage severe pain despite repeated complaints from Resident (R)74. Additionally, the facility lacked effective communication between nurses, doctors, and other healthcare providers regarding R74's pain management. This failure led to R74 reporting waves of severe pain over approximately a month, until her death on [DATE], and placed R74 in immediate jeopardy. Findings Included: - Review of the Electronic Health Record (EHR), documented R74 had diagnoses of incisional hernia (occurs when the abdominal muscles or connective tissue weaken or gap at the site of a surgical incision, allowing abdominal contents to protrude. This can happen weeks, months, or years after the surgery) and osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain). The [DATE] Quarterly Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 11, which indicated moderately impaired cognition. R74 was independent with transfers and bed mobility, she required set up for oral care and eating. R74 required supervision for ambulation, dressing, toileting, personal hygiene, footwear, and maximum assistance required for bathing. The resident reported her pain at a level 5 out of 10, that occurred occasionally and affected her sleep. The [DATE] Annual MDS lacked a BIMS score and lacked a staff interview; cognition was not assessed. Depression was not assessed. R74 required maximal assistance with activities of daily living (ADL) such as bathing and bed mobility. She required supervision assistance with ambulation, toileting, dressing, personal hygiene, and footwear. R74 rated her pain at a six out of 10, which occasionally affected her sleep. The [DATE] Cognitive Loss/Dementia CAA documented R74 triggered for cognitive loss related to rejection of care on occasion. The [DATE] Pain CAA triggered related to R74 had occasional pain. The resident's Care Plan documented the following: [DATE] - Staff were instructed to recognize the resident's pain tolerance and her level of discomfort as real and painful for her. [DATE] - Staff were instructed to use alternative methods for pain management such as massage, aroma therapy, warm packs, and distraction. [DATE] - Staff were educated to monitor for nonverbal cues of pain such as facial grimace, guarding, and moaning. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the Physician Orders documented the following: Acetaminophen 325 milligram (mg) tablet, give two tablets by mouth, every six hours as needed for pain, date ordered [DATE]. Acetaminophen 325 mg tablet, give two tablets by mouth, three times a day for moderate pain, date ordered [DATE]. Review of the Medication Administration Record dated [DATE] thru [DATE] documented staff administered R74's Acetaminophen on the following days: On [DATE] at 11:25 PM, reported pain level of five, with effective results noted. On [DATE] at 11:20 PM, reported pain level of five, with effective results noted. On [DATE] at 11:31 AM, reported pain level of four, with undetermined results noted. On [DATE] at 05:52 AM, reported pain level of seven, with ineffective results noted. On [DATE] at 02:46 AM, reported pain level of six, with ineffective results noted. On [DATE] at 04:11 AM, reported pain level of eight, with ineffective results noted. The [DATE] at 03:51 PM Progress Note revealed R74 complained of stomach discomfort. The on-call provider was notified and gave and order for Simethicone (medication used to relieve the painful symptoms of too much gas in the stomach and intestines) 80 mg three times, daily. The [DATE] at 11:23 PM Progress Note revealed R74 reported abdominal pain at a level of six out of 10 for last three days. R74 experienced polyuria (is when your body makes too much urine) more than baseline. R74 requested assistance to the bathroom multiple times an hour on top of having multiple incontinent episodes. R74 was very restless and unable to rest for more than 15 to 20 minutes without yelling out or pressing her call light. Urinalysis (lab analysis of urine) was to be collected on [DATE] in the morning when the lab was open. The [DATE] at12:09 PM Progress Note revealed R74 complained frequently to several staff that her stomach hurt. R74's blood pressure was elevated to ,d+[DATE] millimeters of mercury (mmHg) and staff administered an as needed dose of clonidine (medication for high blood pressure). The writer informed the provider via the telephone at 11:30 AM regarding the resident's elevated blood pressure and complaint of stomach pain. The provider did not give any new orders to address the resident's complaints of pain. The [DATE] at 08:35 AM Progress Note revealed staff sent a communication to R74 's provider regarding her continued complaints of abdominal discomfort and new complaints of nausea, confusion, dizziness, and the shakes. The provider gave an order to obtain a urinalysis and give four mg of Zofran (is a medication that prevents nausea and vomiting). The note lacked evidence the provider addressed the resident's pain. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The [DATE] at 11:32 AM Progress Note revealed a communication was sent to the resident's provider, R74 continued to not feel well, the facility received orders for R74 to have a computed tomography (CT scan- test that used x-ray technology to make multiple cross-sectional views of organs, bone, soft tissue and blood vessels) and outpatient labs. The [DATE] at 04:59 PM Progress Note revealed R74 had a partially strangulated hernia (occurs when the blood supply to the herniated (an abnormal condition or process in which an organ or other tissue protrudes through an opening tissue) has been decreased in flow) and she was sent to the hospital per provider. The [DATE] at 08:32 PM Progress Note revealed R74 returned from the hospital with no new orders. The resident had no complaints of pain upon her return. Review of the resident's record from [DATE] through [DATE] lacked any follow up progress notes after R74's hospital visit. The [DATE] at 02:53 AM Progress Note revealed staff found R74 on the floor with no injuries noted. The [DATE] at 11:44 PM Progress Note R74 used her call light up to 30 times in an hour. R74 continued to call out help me God, help me up. I cannot do those things R74 was very restless, and as needed acetaminophen was utilized multiple times, but the resident had no changes in behaviors. R74 yelled at staff for the past two days when staff attempted to help her. R74's confusion and anger increased, and her urinalysis came back negative. R74 screamed No when transferred to the wheelchair. Staff sent a fax to the resident's provider to please advise. The [DATE] at 09:01 AM Progress Note revealed R74 up was up and self-propelled around in her wheelchair with no complaints of pain expressed. The [DATE] at 03:20 PM Progress Note revealed R74 was found on the floor in her room with no injuries noted. R74 repeatedly stated God help me and she had no complaints of pain associated with fall. The [DATE] at 11:43 PM Progress Note revealed R74 continued to be very restless, would lay down in bed, and yell God help me, God help me up. When R74 was assisted up to a wheelchair R74 would continue to yell God help me, I need to lay down. R74 could not be redirected and continued to push her call light when staff was in the room. Day shift reported R74 exhibited the same behaviors, and staff administered as needed acetaminophen multiple times. The resident had no changes in behavior or relief noted. The writer noted multiple faxes were sent to the resident's provider. The [DATE] at 01:19 PM Progress Note revealed R74 was seen by the provider, noted R74 wanted to go home, and the provider ordered a urinalysis. The [DATE] at 02:22 PM Progress Note revealed R74 was not herself, she was lethargic, incontinent with loose stools, had a temperature of 98.0 degrees Fahrenheit, a pulse of 58 beats per minute, respirations at16, blood pressure measured ,d+[DATE] (low) and oxygen saturations (percentage of oxygen in the blood) was 93% on room air. R74 was slightly pale in color and her provider was notified of a suspicion of sepsis. Labs were ordered and a chest Xray if wheezing or cough was noted. Labs were obtained and sent to lab for processing. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The [DATE] at 05:09 PM Progress Note revealed lab results were received and reported to the resident's provider. New orders were given to change the resident's antibiotic to Bactrim DS twice a day for seven days and the order for Macrobid (antibiotic) was discontinued. The [DATE] at 02:33 AM Progress Note revealed R74 required three staff members to transfer her to the wheelchair as R74 was unable to assist. R74 was hunched over in her wheelchair and could not sit up erect. R74 was assisted to the toilet and was unable to stand once at the toilet, R74 leaned over sideways, and her upper body leaned up against the wall as she began to have dry heaves. R74 was assisted back to bed after she received care. R74 yelled and moaned the entire time. R74 responded that she had pain in her back. The resident's vital signs were out of limits, R74's respiration's fluctuated from 18 to 28 breaths per minute, her oxygen saturation was 86%- to91% on room air and R74 laid in her bed with her eyes closed. Review of the [DATE] Hospital Visit documentation confirmed the resident went to the hospital, the EHR lacked evidence of the residents transfer to the hospital. The hospital paperwork in R74's paper chart documented R74 was there for a little over an hour and all of her medications were discontinued except for Acetaminophen and Bactrim DS. The facility was to consult hospice for R74 for anemia (inadequate number of healthy red blood cells to carry adequate oxygen to body tissues) and gastrointestinal bleeding (bleeding into the stomach and/or digestive tract). R74's full code was changed to a do not resuscitate (DNR- or no code, a legal document or order that means the person does not desire CPR in the event of cardiac arrest). The [DATE] 09:17 AM Progress Note revealed R74 had her eyes open and made eye contact when spoken to. The [DATE] at 10:21 AM Progress Note revealed R74 passed away at 09:56 AM. The [DATE] at 10:29 AM Discharge Note revealed Hospice services were ordered, but not completed before R74 passed away. All medications were discontinued during the hospital visit during the night except for Acetaminophen and Bactrim DS. During an interview on [DATE] at 02:12 PM, Certified Nurse Aide (CNA) M reported if a resident complained of pain, staff were to notify the charge nurse. CNA M could not recall R74 complaining of pain, she did report R74 would sometimes yell out for help. During an interview on [DATE] at 01:37 PM Administrative Nurse B reported R74 received an order for hospice services when she transferred back from the hospital on [DATE] but she passed away prior to hospice consult being completed. Administrative Nurse B reported R74 could not have anything stronger than Acetaminophen for pain, when Administrative Nurse B was asked why, she could not recall why she could not have a stronger pain medication. Additionally, Administrative Nurse B reported she was instructed on what she could and could not chart in the resident's progress notes. When Administrative Nurse B was asked what kind of notes that she could not document, she commented They are old and are going to die anyways that is what was said to her when some of the providers were contacted for residents' concerns. Administrative Nurse B did not identify which provided stated that. Additionally, she reported she could not jump over the providers heads and call the medical director as the on-call providers would get mad. Administrative Nurse B confirmed that R74's progress notes lacked abdominal assessments and follow through with complaints that R74 had with her pain. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 02:45 PM, Licensed Nurse (LN) G reported if a resident did not have relief from a scheduled or as needed pain medication, the provider should be notified and updated on resident's condition and should receive new orders. LN G reported that there were some residents that would drug seek for pain medications so they may not receive new orders. The facility policy Pain Management dated ,d+[DATE] documented to provide a systematic approach for identifying residents at risk for pain and develop interventions to decrease the effect of pain on the resident's quality of life. To provide guidelines for assessment and individualized treatment plan including pharmacological and non-pharmacological interventions. The facility is to review all residents with unmanaged pain weekly. If there is a decline in the effectiveness of pain management, the plan of care is to be reviewed for appropriateness and revised as needed. The physician and responsible party are to be notified of the need to changed pain management interventions and plan of care. The facility failed to assess pain and failed to take appropriate action to manage severe pain despite repeated complaints from Resident (R) 74. Additionally, the facility lacked communication between nurses, doctors, and other healthcare providers regarding R74's pain management. This failure placed R74 in immediate jeopardy. On [DATE] at 10:25 AM, Administrative Staff A and Consultant Staff T were provided the Immediate Jeopardy (IJ) template and notified the facility failure to ensure staff identified, updated providers and responded appropriately to complaints of R74's pain that was consistently left without an effective pain medication being administered, leading to signs of distress, such as moaning, yelling and agitation which significantly impacts their quality of life and could potentially result in further complications if not addressed and R74's unrelieved pain could be a possible indicator of a returned strangulated hernia or other significant disease processes. The facility submitted an acceptable plan for removal of the immediate jeopardy on [DATE] at 02:35 PM which included the following: 1. R74 died on [DATE]. Residents will have a pain assessment including assessment of areas identified completed with physician intervention if appropriate and the care plan updated on [DATE]. 2. Pain assessed every shift by licensing nursing with staff interventions if applicable date started [DATE]. 3. Immediate Quality Assurance and Performance Improvement (QAPI is a data-driven approach to improving the quality of care and services provided to patients) meeting held with the Medical Director, Administrative Staff A and Administrative Nurse B completed on [DATE]. 4. License staff will receive education on pain assessment including assessment of areas identified with pharmacological and non-pharmacological interventions and verbal notification on [DATE]. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	5. Administrative Nurse B or designee will audit pain goals and reported pain with interventions through clinical excellence on [DATE] 6. Physician and responsible party are to be notified and documentation of the need to change pain management interventions and plan of care on [DATE] 7. Results of audits findings will be reviewed during QAPI meeting monthly. The surveyor verified the above corrective actions were implemented while on-site on [DATE]. This deficient practice remained at a scope and severity of a G.

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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** 40801 The facility reported a census of 22 residents with 10 included in the sample and five residents reviewed for unnecessary medication use. Based on observation, interview and record review the facility failed to ensure the consultant pharmacist identified Residents (R) 16 lacked administration for heart medication. Findings included: - The Physicians Orders dated 06/08/24 revealed the diagnosis of atrioventricular block (a slow heart rate that occurs because of a malfunction with the heart's electrical system). The Admission Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 11, which indicated moderately impaired cognition. The resident required assistance with toileting, showers, and mobility. The Medication Administration Record (MAR) reviewed from 07/01/24 to 10/31/24 revealed an order for vericiguat (a medication used in adults for heart failure) five milligram (mg) daily. The MAR lacked documentation for 70 days of the review period, which indicated staff did not administer the medication to the resident and did not notify the physician. The Progress Notes from 07/01/24 to 10/31/24 indicated the facility was either waiting for delivery of medication or medication were not available during the times the resident did not received the ordered dose of vericiguat. The documentation also lacked a notification to the resident's physician. Review of the Pharmacy Consultant Notes from 07/01/24 to 11/06/24 lacked documentation regarding the resident not receiving her vericiguat as ordered. During an interview on 11/14/24 at 08:35 AM with Licensed Nurse (LN) H revealed if a resident did not have a medication available, she would chart the reason, notify the physician, and call the pharmacy. During an interview on 11/14/24 at 03:25 PM with Administrative Staff A and B revealed the medication, vericiguat 5 mg, was a sample medication that was provided by his physician, and the facility was unable to get the medication due to the expense. They reported they were aware the medication was not given, and further verified the physician was not aware. During an interview on 11/20/24 at 03:24 PM with Consulting Staff Pharmacist U revealed she was not aware the resident's progress notes included documentation indicating a medication was not given. Consultant Staff U only looked at the MAR and thought the 0 marked meant the medication was administered and she was unaware how to look at the progress notes (MAR) to determine if a medication was not given and/or waiting for delivery of the medication. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's policy Medication Monitoring Medication Regimen Review and Reporting dated 01/2024 the consultant pharmacist reviews the medication regimen and medical charts of each resident at least monthly to appropriately monitor the medication regimen and ensure that mediation each resident receives are clinically indicated. Identification of irregularities may occur by the consultant pharmacist utilizing a variety of sources including medication administration records (MAR), prescriber's orders, progress notes and nurse's notes. Information from the nursing care center staff and other health professionals involved in the resident's care. The facility failed to ensure the consultant pharmacies identified Residents (R) 16 lacked of administration for heart medication.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 50659 The facility reported a census of 22 residents. Based on observation, interview, and record review, the facility failed to store, prepare, and serve food in a sanitary manner to prevent possible food-borne illness to the residents of the facility. Findings included: - Observation of the kitchen and food storage areas on 11/12/24 at 12:30 PM, revealed the following areas of concern: Bowls placed upright and not covered on the cart. There were no foot operated trash cans by the hand washing area. Dry cereal container was not labeled with a date. Apple Cider vinegar was not labeled with a date. A bread bag was opened without a date. An opened and not labeled bag of cream of wheat. Several bags of pasta were opened and were not labeled with an opened date. Opened box of individually wrapped cookies that were not dated when they were opened and were past the expiration date of 11/06/24. The freezers had assorted cookie batter or muffin batter without a date or a label. The freezer had assorted ice treats that were not labeled with a date when box was opened. The refrigerator contained strawberries and vegetables not dated. An opened bag of mozzarella cheese that was not labeled or dated. An opened tube of icing that was not dated. During an interview on 11/12/14 at 12:50 PM, Dietary Manager C, confirmed the above items were concerns and she had worked with staff to label items when received and when opened. During an observation on 11/13/24 at 11:25 AM, Dietary Staff W washed her hands in the kitchen, she dried her hands off, then took the damp disposable towel and wiped the countertop of the sink off. Dietary Staff W then walked across the kitchen, lifted the lid on garbage can with her left hand, and threw out the paper towels. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview 11/13/24 at 11:28 AM with Dietary Manager C, she confirmed that wiping off the sink after washing hands was not appropriate, she reported the kitchen used to have a garbage can with a foot pedal. She had another staff member locate a garbage can with a foot control and verbally educated the kitchen staff to use the foot pedal garbage can after washing their hands. During an observation on 11/13/24 at 12:04 PM Dietary Staff W laid a knife on the cookbook while retrieving supplies to puree the custard. She then picked the knife back up off the recipe book and used that knife to cut the pieces of pie out of the pan before pureeing them. During an observation on 11/13/24 at 12:10 PM the drain for the ice maker was not off the floor it was lying directly on the drain cover on the floor that was visibly dirty. Dietary Manager C reported she was unaware that the ice machine drain had to be off the floor and confirmed the floor and drain were quite dirty and she reported she would let maintenance know. During an observation on 11/13/24 at 12:18 PM the ovens had black colored debris on the bottom of them. The air vent above the stove had grease and dust stuck to them. The curtains had grease and were covered in a thick amount of dust that were on a window right above the prep area for food. Additionally, there was a cart in front of that window with dishes that faced upright and not covered. The staff walked back and forth in front of that window. There were several cutting boards that had scratches, gouges and a melted area. The potholders were worn and the inner batting was exposed. During an Interview on 11/13/24 at 12:30 PM Dietary Manager C acknowledged the ovens and surface areas had dust and black colored debris noted on the bottom of oven. She reported that they were cleaned weekly. She reported the dishes are usually covered. Dietary Manager C confirmed that the knife should not have been placed on the recipe book that everyone touched when cooking. During an interview on 11/19/24 at 09:44 AM Administrative Staff A confirmed all the concerns in the kitchen were an issue and Dietary Manager C had started to work on the concerns. The facility's Food Storage policy dated 2011 documented food shall store at appropriate methods to ensure the highest level of food safety. Label all food items held longer that 24 hours. The label must include the name of the food and the date by which it should be consumed or discarded. Discard food that has passed the expiration date. Wrap food properly, never leave any food item uncovered and not labeled. The facility failed to store, prepare, and serve food in a sanitary manner to prevent possible food-borne illness to the residents of the facility.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 50659 The facility reported a census of 22 resident. Based on interview and record review the facility failed to submit complete and accurate staffing information to the federal regulatory agency through Payroll Based Journaling (PBJ) when the facility failed to submit staffing hour data for all nursing personnel by the required deadline. Findings included: - The PBJ report provided by the Centers for Medicare and Medicaid services (CMS) for Fiscal Year (FY) 2024 Quarter 1, documented the facility failed to have Licensed Nursing Coverage 24 hour/day on 10/01/24, 10/04/24, 11/23/24, and 12/31/24. Upon review of printed staffing days sheet provided by the facility, the date above it was revealed the facility had proof of RN hours and LN hours for the dates of 10/4/24, 11/23/24, and 12/31/24 but lacked eight hours of RN coverage on 10/01/24. Interview on 11/19/24 a 09:44 AM with Administrative Staff A reported the Director of Nursing can count as RN coverage if the census was less than 60 residents. Administrative Staff A stated 10/01/24 was the only day the facility did not have eight consecutive hours of RN coverage. Administrative Staff A reported she fills out agency sheets, then sends to the corporation and they complete the PBJ reporting. The facility failed to provide a policy regarding reporting Payroll-Based Journal, as requested on 11/20/24. The facility failed to accurately submit staffing information to the Payroll Based Journaling (PBJ) for Quarter 1 of Fiscal Year 2024.