STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175287	A. Building B. Wing	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eureka Nursing Center	1020 N School Street Eureka, KS 67045

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 46960 The facility reported a census 48 residents. Based on observation, interview, and record review, the facility failed to provide a clean home-like and sanitary environment for the 11 residents who resided in the special care unit. Additionally, the facility failed to provide a sanitary environment for two residents who had cracked fall mats with uncleanable surfaces in their rooms. Findings included: - On 07/11/24 at 01:25 PM, an environmental tour with Maintenance Director U revealed: On the special care unit, an odor of urine existed throughout the special care unit and extended approximately 10-12 feet beyond the locked doors to the main hallway. On 07/11/24 at 01:30 PM, Maintenance Director U reported the odor of urine in and around the special care unit was due to a resident who would urinate in random places and nursing staff have performed multiple interventions to combat the smell of urine. On 05/21/24 at 09:50 AM, Administrative Nurse E revealed multiple interventions had been attempted to mitigate the smell of urine historically back to September of 2022 with varying degrees of success. Administrative Nurse E confirmed that the pervasive odor of urine did not provide a sanitary home-like environment for the 11 residents who lived on the special care unit. The facility failed to provide a policy related to the elimination of urine odors. The facility failed to provide a clean home-like and sanitary environment for the 11 residents who resided in the special care unit. 28560 - Observation, during the initial tour of the facility on 07/09/24 at 10:48 AM, revealed Resident (R)2 had a fall mat by her bed that contained multiple cracks and areas of worn surface. Observation, during the initial tour on 07/09/24 at 11:11 AM, revealed (R) 20 had two fall mats on each side of her bed. The mats had numerous cracks and worn areas that made the area uncleanable. (continued on next page)

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

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview, on 07/10/24 at 11:57 AM, with Administrative Nurse E, confirmed the fall mats for R20 and R2 were worn and cracked, making sanitation difficult and actual effectiveness of the mats decreased. The facility lacked a policy for fall mat maintenance. The facility failed to ensure a sanitary, safe and homelike environment for these two residents with cracked and worn fall mats.

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46960 The facility reported a census of 48 residents with 13 residents selected for review. Based on observation, interview, and record review, the facility failed to accurately complete the Minimum Data Set (MDS) for three sampled residents, Resident (R)2 and 28 related to antiplatelet medication use, and R34 related to contractures (abnormal permanent fixation of a joint or muscle) not documented as impairments under section G and section GG on the MDS assessments. This placed the residents at risk for uncommunicated care needs. Findings included: - The Electronic Health Records (EHR) documented R28 had the following diagnoses that included atherosclerotic heart disease (also known as coronary artery disease [CAD- abnormal condition that may affect the flow of oxygen to the heart]) and hyperlipidemia (condition of elevated blood lipid levels). The 04/01/24 Annual MDS documented a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. R28 was independent for all cares except bathing which required supervision and setup. The assessment documented R28 received an anticoagulant medication (a class of medication that prevents or reduces the ability for blood to form clots) and did not receive an antiplatelet medication (a class of medication that prevents or reduces the ability of platelets [a type of blood cell] to stick together). The 04/01/24 Care Area Assessment (CAA) lacked documentation related to anticoagulant or antiplatelet medication use. The 01/04/24 Quarterly MDS documented a BIMS score of 15 which indicated intact cognition. R28 was independent for all cares except bathing which required minimal assistance. The assessment documented that R28 received an anticoagulant medication and did not receive an antiplatelet medication. The 07/11/24 Care Plan documented on 11/09/22, for staff to hold aspirin (an antiplatelet medication) for all dental procedures. The Physician Orders revealed aspirin tablet, 325 milligrams (mg), to be given by mouth, every morning for CAD, ordered 04/02/22. The 04/01/24 to 07/11/24 Medication Administration Record (MAR) and Treatment Administration Record (TAR) documented appropriate administrations of aspirin but lacked any documentation of any anticoagulant medications. The Progress Notes reviewed from 04/01/24 to 07/11/24 lacked any documentation related to anticoagulant or antiplatelet medication use. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/21/24 at 11:32 AM, Administrative Nurse F confirmed the above information and stated that it was a clerical error in documenting an antiplatelet medication as an anticoagulant. Her expectation was for all MDS assessments to be accurate. Additionally stated that the facility did not have a policy for MDS completion and used the Resident Assessment Instrument (RAI) manual as a guide. The facility failed to accurately complete the MDS for R28 related to antiplatelet medication use. This placed the resident at risk for uncommunicated care needs. 50659 - The Electronic Health Records (EHR) documented R2 had the following diagnoses that included anemia (inadequate number of healthy red blood cells to carry adequate oxygen to body tissues) and diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made, or the body cannot respond to the insulin). The 12/26/23 Annual Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. R2 was independent with eating and wheelchair mobility. R2 required moderate assistance with activities of daily living (ADLs), with bed mobility, toileting hygiene, and dressing. R2 was frequently incontinent of bladder. The assessment documented R2 received an anticoagulant medication (a class of medication that prevents or reduces the ability for blood to form clots) and did not receive an antiplatelet medication (a class of medication that prevents or reduces the ability of platelets [a type of blood cell] to stick together). The 12/06/23 Care Area Assessment (CAA) lacked documentation related to anticoagulant or antiplatelet medication use. The 05/21/24 Quarterly MDS documented a BIMS score of 12, which indicated moderately impaired cognition. R2 was independent with eating and wheelchair mobility and required moderate assistance with ADL's. R2 received an anticoagulant medication and did not receive an antiplatelet medication. The 07/10/24 Care Plan lacked any intervention for aspirin. The Physician Orders revealed aspirin tablet enteric coated, 81 milligrams (mg), to be given by mouth, every morning, for heart health, ordered 05/08/24. The 04/01/24 to 07/11/24 Medication Administration Record (MAR) and Treatment Administration Record (TAR) documented appropriate administrations of aspirin but lacked any documentation of any anticoagulant medications. The Progress Notes reviewed from 04/01/24 to 07/11/24 lacked any documentation related to anticoagulant or antiplatelet medication use. On 05/21/24 at 11:32 AM, Administrative Nurse F confirmed the above information and stated that it was a clerical error in documenting an antiplatelet medication as an anticoagulant. Her expectation was for all MDS assessments to be accurate. Additionally stated that the facility did not have a policy for MDS completion and used the Resident Assessment Instrument (RAI) manual as a guide. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility failed to accurately complete the MDS for R2 related to antiplatelet medication use. This placed the resident at risk for uncommunicated care needs. - The Electronic Health Records (EHR) documented R34 had the following diagnoses that included arthritis (inflammation of a joint characterized by pain, swelling, redness and limitation of movement) and anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear). The 08/02/23 Annual MDS documented a Brief Interview for Mental Status (BIMS) score of five, indicating severely impaired cognition and a total severity score of two, indicating minimal depression. R34 required extensive assistance with activities of daily living (ADLs), with bed mobility, toileting hygiene, and dressing. R34 required supervision for eating. R34 was frequently incontinent of bladder. No impairments or contractures of upper extremities captured on the MDS. The 08/02/23 Functional ADL Care Area Assessment (CAA) documented R34 required assistance with ADL's related to arthritis and weakness. The Quarterly MDS, dated [DATE], documented a BIMS score of 12, indicating moderately impaired cognition. No behaviors, no impairments of upper extremities. The Care Plan dated 07/10/24, revealed R34 had a right -hand contracture (abnormal permanent fixation of a joint or muscle) and arthritis. Therapy provided the resident with a hand splint and a carrot (a specialized splint used in therapy for managing hand contractures.) Right resting hand splint to be applied every morning and remove at sleep. The Physician Orders dated 07/10/24 lacked any documentation of hand splint of hand carrot to be applied. The 04/01/24 to 07/11/24 Medication Administration Record (MAR) and Treatment Administration Record (TAR) lacked documentation of hand splint to be applied. The Progress Notes reviewed from 04/01/24 to 07/11/24 lacked any documentation related to contractures or hand splint and carrot. On 07/09/24 at 01:22 PM, R34 is seated in her wheelchair at the nurse's station with a left hand brace on her left hand and a soft carrot splint in her right hand. On 07/10/24 at 07:37 AM, On 07/10/24 at 07:37 AM, R34 seated in the dining room and lacked placement of the left hand splint and the right hand soft carrot. On 07/10/24 at 09:35 AM, Licensed Nurse G (LN) and Certified Nurse Aide (CNA) MM assisted R34 to her recliner. R34 had the soft carrot splint on her right hand, however lacked a left hand splint. On 07/10/24 at 09:43 AM, LN G stated R34 has refused to wear the left hand splint and stated it is as tolerated. LN G stated staff were required to carry Jot sheets that have all the care needs for each individual resident, and they are updated as care is changed. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/10/24 at 09:59 AM, CNA M stated the nurse or therapy should apply the hand splints. CNA M reported the jot sheet lacked anything regarding the splint. On 07/11/24 at 02:00 PM, Administrative Nurse F confirmed the above area of concern of impairment not captured on the MDS's. Her expectation was for all MDS assessments to be accurate. Additionally stated that the facility did not have a policy for MDS completion and used the Resident Assessment Instrument (RAI) manual as a guide. The facility failed to accurately the MDS for R34 related to contractures not documented as impairments under section G and section GG on the MDS assessments. This placed the residents at risk for uncommunicated care needs.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50659 The facility identified a census of 48 residents, which included 13 residents sampled and reviewed for care plan development. Based on interview, observations, and record review, the facility failed to develop a comprehensive person-centered care plan for one resident. Resident (R) 47 comprehensive person-centered care plan was not completed in a timely manner of 21 days from admission, as required. 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: - R 47's Electronic Health Record (EHR) revealed diagnoses that included Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), anxiety, and dementia (progressive mental disorder characterized by failing memory, confusion). The Admission Minimum Data Set (MDS) dated [DATE], documented a Brief Interview for Mental Status (BIMS) of 11, indicating moderately impaired cognition. The resident had a total mood severity score of 00, indicating no depression and no behaviors noted. R47 was independent with activities of daily living (ADLs). R47 required supervision with verbal cues when ambulating independently in the facility. R47 was continent of bowel and bladder. The Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) dated 05/22/24 did not trigger. The Cognition CAA documented R47 had a BIMS of 11 and the resident was no longer safe to live alone in her home. The Care Plan dated 07/09/24, lacked staff interventions to provide person-centered care. Review of the Progress Notes from 05/15/24 to 07/09/24 lacked a documentation in regard to completion of a care plan. On 07/09/24 at 10:03 AM, R47 was in her room and anxious when speaking, wringing her hands together and kept moving around her room. On 07/09/24 at 11:30 AM, Administrative Nurse F stated R47 admitted to the facility on [DATE] and verified R47's person-centered care plan was not developed within seven days of the required MDS. The facility's policy for Comprehensive Care Plans, dated 03/28/24 documented: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframe's to meet a resident's medical, nursing, mental and psychosocial needs identified in resident's comprehensive assessment. The comprehensive care plan will be developed within seven days after the completion of the comprehensive MDS. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility failed to develop a comprehensive person-centered care plan for one resident. R47 comprehensive person-centered care plan was not completed in a timely manner of 21 days from admission. 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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28560 The facility reported a census of 48 residents, with 13 residents sampled, including six residents reviewed for accidents. Based on observation, interview, and record review, the facility failed to review and revise the care plan for one Resident (R)30's controlled ankle movement (CAM) boot. Findings included: - Review of Resident (R)30's medical record revealed diagnoses that included chronic obstructive pulmonary disease (COPD- progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), diabetes (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), polyneuropathy (malfunction of nerves in multiple areas of the body), and right above the knee amputation (surgical removal). The Annual Minimum Data Set (MDS), dated [DATE], assessed the resident with a Brief Interview for Mental Status (BIMS) score of 14, which indicated normal cognitive function. The resident had impairment on one side of his lower extremity and no impairment in his upper extremities. The resident was dependent on staff for transfers, donning and doffing footwear, and bathing. The resident utilized a wheelchair for mobility. The Activity of Daily Living (ADL) Functional/Rehabilitation Potential Care Area Assessment (CAA), dated 11/07/23, assessed the resident required staff assistance for ADL and a previous near fall when a strap on the mechanical lift broke, but staff were able to lower him to the floor without injury. The resident was at risk for difficult transfers due to his right above knee amputation. The Care Plan, revised 04/10/24, instructed staff to assist the resident with bathing and to ensure his sock and shoe were on prior to getting him out of bed and prior to all transfers. Staff utilized the mechanical lift for transfers. The care plan lacked a revision to include the physician's order (05/23/24) for use of a controlled ankle movement (CAM) boot except for skin checks and range of motion. A Physician's Order dated 05/23/24, revealed the removal of R30's cast and instructed staff to ensure R30 wore a CAM boot in place of the cast. The order instructed staff to remove the CAM boot for range of motion and skin inspection. The Interdisciplinary Team Review dated 06/04/24 at 07:25 AM, revealed nursing staff transferred the resident with a mechanical lift into his wheelchair, and the resident sustained an approximate 7.5 cm (length) by 6.3 cm (width) by 0.3 cm (depth) full thickness laceration to his left lower extremity. The resident's wheelchair lacked padding over an exposed piece of metal, and the resident's shin sustained a laceration from the exposed metal. R30 transferred to acute care and received sutures to the laceration. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview with R30 on 07/09/24 at 04:40 PM revealed he leaned onto his right side, in his electric wheelchair. R30 stated staff pushed him in a shower chair across the shower room threshold, and the wheel broke, and he fell forward onto the floor, and sustained a fracture in his left leg. R30 stated he had a cast on the leg for approximately 60 days, and then after the cast removed, he had a CAM boot applied. R30 stated staff should apply the boot before transferring him into his electric chair, but one time staff did not, and he received a laceration on his shin from an exposed area of sharp metal on his chair. R30 stated now the area is padded, and a cushion placed for protection. During an observation on 07/10/24 at 11:45 AM, Certified Nurse Aide (CNA) N and CNA M transferred R30 from his bed to his electric chair with a full body mechanical lift. The resident did not have the CAM boot on prior to the transfer and staff applied the CAM boot after the transfer of R30, as he sat in his electric chair. During an interview on 07/10/24 at 03:30 PM. Administrative Nurse E reported the resident obtained a laceration to his anterior shin from contact with a sharp piece of metal on his chair. The resident required several sutures, but the area was now healed. Administrative Nurse E stated she expected staff to ensure to pad the chair appropriately. Administrative Nurse E stated the resident received therapy services for wheelchair positioning. During an interview on 07/11/24 at 12:02 PM, Administrative Nurse D revealed she expected staff to apply the CAM boot prior to transfer for protection of his leg and confirmed the care plan was not updated to include the CAM boot. The facility policy Accidents and Supervision dated 03/23/24, instructed staff to provide supervision and assistive devices to prevent accidents, which included identifying hazard, evaluating, and analyzing hazards and risks, implementing interventions to reduce hazards and risks, and monitoring for effectiveness and modifying interventions when necessary. The facility policy Care Plan Revisions dated 02/01/2020, instructed staff changes in a resident's condition require changed to be made in the plan of care. Staff to review all physician orders, progress notes, and consultant notes and added to the care plan as appropriate. The facility failed to review and revise R30's care plan to include the use of the cam boot except for skin checks and range of motion, as ordered by the physician on 05/23/24.

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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 48 residents, with 13 residents in the sample selected for review. Based on observation, interview, and record review the facility failed to apply sheepskin padding to Resident (R) 34's arm rests of her wheelchair. This deficient practice had the potential to place R34 at an increased risk for additional skin injuries. Findings included: - The Electronic Health Records (EHR) documented R34 had the following diagnoses that include arthritis (inflammation of a joint characterized by pain, swelling, redness and limitation of movement) and anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear). The 08/02/23 Annual MDS documented a Brief Interview for Mental Status (BIMS) score of five, indicating severely impaired cognition. R34 required extensive assistance with activities of daily living (ADLs), with bed mobility, toileting hygiene, and dressing. R34 was frequently incontinent of bladder and had no skin issues. The 08/02/23 Functional ADL Care Area Assessment (CAA) documented R34 required assistance with ADL's related to arthritis and weakness. The 05/02/24 Quarterly MDS documented a BIMS score of 12, indicating moderately impaired cognition. R34 had no skin issues. The Care Plan dated 07/04/24, revealed R34 was to have sheepskin padding applied to wheelchair arm rests related to a skin tear obtained on 07/04/24. The Physician Orders dated 07/10/24 lacked any documentation for sheepskin pad to wheelchair arm rests. The Progress Notes reviewed from 04/01/24 to 07/11/24 documented the following: On 07/04/24 at 02:15 PM, Immediate intervention is to apply sheepskin to arm rests. Observation, on 07/10/24 at 09:59 AM, revealed R34's wheelchair arm rests lacked sheepskin. On 07/10/24 at 09:59 AM, Certified Nurse Aide (CNA) M verified there was no sheepskin padding on R34's wheelchair arm rests and stated that she had never seen any sheepskin on the R34's wheelchair arm rests. On 07/10/24 at 10:27 AM, Administrative Nurse E stated her expectation was the charge nurse that completed the intervention should make sure the intervention is completed as per the care plan. Stated the nurse on 07/04/24 should have applied the sheepskin padding to R34's wheelchair arm rests. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The policy Accidents and Supervision dated 03/28/24 documented: The resident environment will remain free of accident hazards as possible. Each resident will receive adequate supervision and assistive devices to prevent accidents. This includes implementing interventions to reduce hazards and risks. The facility failed to apply sheepskin padding to Resident (R) 34's arm rests of her wheelchair. This deficient practice had the potential to place R34 at an increased risk for additional skin injuries.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28560 The facility reported a census of 48 residents, with 13 residents sampled, including six residents reviewed for accidents. Based on observation, interview, and record review, the facility failed to ensure resident safety for one of the six residents, during transfer of Resident (R) 30. On 04/11/24, staff used the facility shower chair to transport R30 and in doing so the wheel on the chair broke, the resident to fell forward to the floor, and sustained a fractured tibia (one of two long bones in the lower leg). In addition, on 06/04/24 the facility staff did not ensure a safe transfer for R30 into his electric wheelchair (which had exposed metal) while using the mechanical lift, which resulted in a laceration on his anterior (front) lower leg, that required sutures. Findings included: - Review of Resident (R)30's medical record revealed diagnoses that included chronic obstructive pulmonary disease (COPD- progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), diabetes (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), polyneuropathy (malfunction of nerves in multiple areas of the body), and right above the knee amputation (surgical removal). The Annual Minimum Data Set (MDS), dated [DATE], assessed the resident with a Brief Interview for Mental Status (BIMS) score of 14, which indicated normal cognitive function. The resident had impairment on one side of his lower extremity and no impairment in his upper extremities. The resident was dependent on staff for transfers, donning and doffing footwear, and bathing. The resident utilized a wheelchair for mobility. The Activity of Daily Living (ADL) Functional/Rehabilitation Potential Care Area Assessment (CAA), dated 11/07/23, assessed the resident required staff assistance for ADL and a previous near fall when a strap on the mechanical lift broke, but staff were able to lower him to the floor without injury. The resident was at risk for difficult transfers due to his right above knee amputation. The Care Plan, revised 04/10/24, instructed staff to assist the resident with bathing and to ensure his sock and shoe were on prior to getting him out of bed and prior to all transfers. Staff utilized the mechanical lift for transfers. The care plan lacked a revision to include the physician's order (05/23/24) for use of a controlled ankle movement (CAM) boot except for skin checks and range of motion. A Nurses' Note, dated 04/11/24, revealed staff transported the resident out of the shower room in a shower chair, and the left front wheel did not swivel, which caused it to fold backward, and the chair tipped forward, at which time the resident fell forward out of the chair and sustained a fractured left tibia, which required a cast. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The Facility Investigation dated 04/11/24, revealed the shower chair left front wheel did not swivel, which caused it to fold backward when staff turned the chair and provided forward momentum, which caused the chair to tip forward, and the resident fell forward. The immediate intervention included staff education to transfer residents into the shower chair in the shower room and not transport residents in the shower chair from their room to shower room. The undated Safety/Maintenance Information for the shower chair, used in the incident, instructed staff to check the following monthly: Check the pipe and fittings for hairline fractures. 1. Check all junctures to make certain the pipe and fittings do not pull apart. 2. Clean and lubricate casters [wheels] monthly to avoid rust and wheel lock up. The Shower Chair Safety Maintenance Log documented maintenance completed on 04/15/24. The facility did not provide documentation that staff completed the safety and maintenance inspections prior to 04/15/24. A Physician's Order dated 05/23/24, revealed the removal of R30's cast and instructed staff to ensure R30 wore a CAM boot in place of the cast. The order instructed staff to remove the CAM boot for range of motion and skin inspection. Furthermore , the Interdisciplinary Team Review dated 06/04/24 at 07:25 AM, revealed nursing staff transferred the resident with a mechanical lift into his wheelchair, and the resident sustained an approximate 7.5 cm (length) by 6.3 cm (width) by 0.3 cm (depth) full thickness laceration to his left lower extremity. The resident's wheelchair lacked padding over an exposed piece of metal, and the resident's shin sustained a laceration from the exposed metal. R30 transferred to acute care and received sutures to the laceration. Observation and interview with R30 on 07/09/24 at 04:40 PM revealed he leaned onto his right side, in his electric wheelchair. R30 stated staff pushed him in a shower chair across the shower room threshold, and the wheel broke, and he fell forward onto the floor, and sustained a fracture in his left leg. R30 stated he had a cast on the leg for approximately 60 days, and then after the cast removed, he had a CAM boot applied. R30 stated staff should apply the boot before transferring him into his electric chair, but one time staff did not, and he received a laceration on his shin from an exposed area of sharp metal on his chair. R30 stated now the area is padded, and a cushion placed for protection. During an observation on 07/10/24 at 11:45 AM, Certified Nurse Aide (CNA) N and CNA M transferred R30 from his bed to his electric chair with a full body mechanical lift. The resident did not have the CAM boot on prior to the transfer and staff applied the CAM boot after the transfer of R30, as he sat in his electric chair. During an interview on 07/10/24 at 09:16 AM, CNA N stated after R30's fall out of the shower chair, staff must transfer the resident in the shower room. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 07/10/24 at 03:30 PM. Administrative Nurse E reported the resident obtained a laceration to his anterior shin from contact with a sharp piece of metal on his chair. The resident required several sutures, but the area was now healed. Administrative Nurse E stated she expected staff to ensure to pad the chair appropriately. Administrative Nurse E stated the resident received therapy services for wheelchair positioning. During an interview on 07/11/24 at 12:02 PM, Administrative Nurse D revealed she expected staff to apply the CAM boot prior to transfer for protection of his leg and confirmed the care plan was not updated to include the CAM boot. During an interview on 07/11/24 at 12:15 PM, Administrative Staff A revealed the facility changed the policy for transporting residents in the shower chair after R30's fall. During an interview on 07/11/24 at 01:25 PM, Maintenance Staff U revealed he did perform monthly safety inspections of the shower chairs beginning 04/15/24, after the incident with the shower chair on 04/11/24. The facility's policy for Resident Showers dated January 2023, instructed staff that based on the resident's function and preferences, the resident may be transported to the shower room in a shower chair provided the manufacturer's instructions allow and dignity is maintained during transport. The facility's policy for Resident Showers revised 04/11/24, instructed staff to assist the resident to the shower room and help the resident sit on the shower chair . An Immediate Staff Reeducation dated 04/11/24, instructed staff to transport residents to the shower room via their wheelchair and then transfer onto the shower chair. The facility policy Accidents and Supervision dated 03/23/24, instructed staff to provide supervision and assistive devices to prevent accidents, which included identifying hazard, evaluating, and analyzing hazards and risks, implementing interventions to reduce hazards and risks, and monitoring for effectiveness and modifying interventions when necessary. The facility failed to ensure resident safety during two transfers of Resident (R)30. On 04/11/24, staff used the facility shower chair to transport R30 and in doing so the wheel on the chair broke, the resident to fell forward to the floor, and sustained a fractured tibia. In addition, on 06/04/24 the facility staff did not ensure a safe transfer for R30 into his electric wheelchair (which had exposed metal) while using the mechanical lift, which resulted in a laceration on his anterior (front) lower leg, that required sutures.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50659 The facility reported a census of 48 residents, with 13 residents in the sample, and one resident reviewed for trauma. Based on observation, interview, and record review the facility failed to develop and implement approaches to care that were both clinically appropriate and person centered for R47, who had a history of personal trauma. Findings included: - R 47's Electronic Health Record (EHR) revealed diagnoses that included Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), anxiety, and dementia (progressive mental disorder characterized by failing memory, confusion). The Admission Minimum Data Set (MDS) dated [DATE], documented a Brief Interview for Mental Status (BIMS) of 11, indicating moderately impaired cognition. The resident had a total mood severity score of 00, indicating no depression and no behaviors noted. R47 was independent with activities of daily living (ADLs). R47 required supervision with verbal cues when ambulating independently in the facility. R47 was continent of bowel and bladder. The Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) dated 05/22/24 did not trigger. The Cognition CAA documented R47 had a BIMS of 11 and the resident was no longer safe to live alone in her home. The Care Plan dated 07/09/24, lacked any interventions to address the resident's past trauma. The care plan further failed to address the resident's adjustment difficulties and/or history of trauma. The care plan lacked any description of the resident's indications of distress and/or interventions intended to assist the resident to reach and maintain his highest level of mental and psychosocial wellbeing. Review of the Progress Notes from 05/15/24 to 07/09/24 lacked any documentation of past trauma. Review of the 'Who I Am .My Social History psycho-social review dated, 05/15/24 completed by Social Service Staff X interviewed R47's durable power of attorney (DPOA- legal document that named a person to make healthcare decisions when the resident was no longer able to) documented R47's family member tried to rape her when she was a child. DPOA also stated R47's ex-husband was physically abusive towards her. Review of the History of Trauma Care Plan dated 05/16/24, was located in the medical records file in medical records room on 07/09/24 documented, R47's family member tried to rape her. R47's ex-husband was physically abusive towards her. Staff directed to assist with recovery and avoid re-traumatization. On 07/09/24 at 10:03 AM, R47 was in her room and anxious when speaking, wringing her hands together and kept moving around her room. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/09/24 at 11:30 AM, Administrative Nurse F revealed the baseline care plan lacked any interventions for R47's past trauma. Administrative Nurse F stated the history of trauma care plan was not located in the care plan book with base line care plan. Revealed the form was located in a file drawer in medical records office and stated the form should have been with the care plan. On 07/10/24 at 03:15 PM, Certified Nurse Assistant (CNA) P stated that unsure if staff received posttraumatic stress disorder (PTSD- mental disorder characterized by an acute emotional response to a traumatic event or situation involving severe environmental stress) training and stated it could be on the online training software. CNA P stated was not aware of any current resident with any past traumas. On 07/10/24 at 03:20 PM, CNA Q could not recall any training on PTSD, and stated she did not know of any resident that had PTSD or any trauma. On 07/10/24 at 10:27 AM, Administrative Staff B agreed that the PTSD was not on the current plan of care. On 07/11/24 at 12:41 PM, Social Service Staff X agreed that the PTSD was not on resident's baseline care plan or the care plan that is incomplete on electronic health record. The facility's policy for Trauma Informed Care, dated 03/28/24 documented: It is the policy of this facility to provide care and services which, in addition to meeting professional standards, are delivered using approaches which are culturally competent, account for experiences and preferences and address the needs of trauma survivors by minimizing triggers and/or re-traumatization. Trauma may include: Rape, and physical abuse. The facility failed to develop and implement approaches to care that were both clinically appropriate and person centered for R47, who had a history of personal trauma. 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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 28560 The facility reported a census of 48 residents. Based on observation, interview, and record review, the facility failed to have Registered Nurse (RN) coverage for at least eight continuous hours on 08/21/23, 08/22/23, 08/23/23, 08/30/23, 09/01/23, 09/04/23, 09/06/23, 09/08/23, 09/18/23, 09/20/23, 10/01/23, 10/04/23, 10/28/23, 12/01/23, 12/04/23, 12/13/23, 12/20/23, 12/23/23, 12/24/23, 12/24/23, 12/25/23, 12/26/23, 01/01/24, 01/03/24, 01/06/24, 01/07/24, 01/08/24, 01/10/24 and 01/12/24, a total of 29 days, as required. The facility may permit the DON to serve as a charge nurse only when the facility had an average daily occupancy of 60 or fewer residents. This placed the residents in the facility at risk for unsupervised nursing care and services. Findings included: - Review of the Payroll Based Journal (PBJ) for 04/01/23 through 03/31/24, revealed the facility did not have the required eight consecutive hours of RN coverage, as required, on 08/21/23, 08/22/23, 08/23/23, 08/30/23, 09/01/23, 09/04/23, 09/06/23, 09/08/23, 09/18/23, 09/20/23, 10/01/23, 10/04/23, 10/28/23, 12/01/23, 12/04/23, 12/13/23, 12/20/23, 12/23/23, 12/24/23, 12/24/23, 12/25/23, 12/26/23, 01/01/24, 01/03/24, 01/06/24, 01/07/24, 01/08/24, 01/10/24 and 01/12/24. Review of the Daily Staff Postings from 04/01/23 through 03/31/24, revealed the facility lacked Registered Nurse (RN) coverage on 29 days. On 07/11/24 at 10:01 AM, Administrative Staff A confirmed the facility lacked RN coverage on the days indicated on the PBJ report. The facility utilized the Facility Assessment for required RN coverage. The facility failed to ensure eight consecutive hours of RN nursing coverage to ensure adequate nursing cares provided to the residents of the facility for a total of 29 days.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 48 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 illnesses to the residents of the facility. Findings included: - Observation, on 07/09/24 at 08:55 AM, revealed the following areas of concern in the dry goods pantry: One sealed 10 -pound (lbs.) bag of macaroni that lacked an opened date. Observation, on 07/09/24 at 09:00 AM, revealed half of meat sandwich in a zip lock bag without a date on the bag. A sealed zip locked bag with four, half emptied squeeze bags of icing that measured approximately a half of cup, dated 02/02/24. The icing squeeze containers had no expiration dates noted. Interview, on 07/09/24 at 09:00 AM, with Dietary Staff BB confirmed the areas of concern. Observation, on 07/10/24 at 11:10 AM, revealed an open garbage can that was full with garbage in the kitchen near the food preparation station. Interview, on 07/10/24 at 11:40 AM, with Dietary Staff B confirmed that garbage can should be closed at all times. Observation, on 07/10/24 at 02:00 PM, during the environmental tour with Dietary Staff BB, revealed the following areas of concern: The top oven contained several areas of bubbled burned food debris on the bottom of the inside. Two large fry pan contained multiple scratches in the cooking surface. One large white cutting board had multiple scratches and several gouges noted on both sides of the board. Two white rubber spatulas had cracks and chips on the outer surfaces. During an interview on 07/02/24 at 02:30 PM, Dietary Staff BB confirmed the areas of concern. The facility failed to provide a policy on food storage. The facility failed to store, prepare, and serve food in a sanitary manner to prevent potential foodborne illness for the residents.

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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. 28560 The facility reported a census of 48 residents. Based on observation, interview, and record review the facility failed to electronically submit to Centers for Medicare and Medicaid Services (CMS) with complete and accurate direct staffing information, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS (i.e. Payroll Base Journal (PBJ), related to licensed nursing staffing information, when the facility failed to accurately report 24 hour per day Licensed Nurse coverage on 16 dates between April 1, 2023 and March 31, 2024. Findings included: - Review of the Payroll Base Journal (PBJ) Staffing Data Report for fiscal year (FY), Quarter 3 2023 (April 1-June 30) revealed a lack of License Nurse (LN) for 24 hours/seven days a week 24 hour/day on the following dates: On 04/01/23, Saturday (SA), On 04/02/23, Sunday (SU), On 04/09/23, SU, On 04/15/23, SA, On 04/16/23, SU, On 04/23/23, SU, On 04/29/23, SA, On 04/30/23, SU On 05/07/23, SU, On 05/13/23, SA, On 05/14/23, SU, On 05/21/23, SU, On 05/27/23, SA, On 05/28/23, SU, On 06/24/23, SA, (continued on next page)

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 06/25/23, SU. On 07/11/24 at 10:01 AM, Administrative Staff A stated the information on the PBJ regarding not having 24-hour Licensed Nursing available seven days a week, for 16 dates, was inaccurate. The facility utilized the Facility Assessment for their policy for completion of the PBJ. The facility failed to electronically submit to Centers for Medicare and Medicaid Services (CMS) with complete and accurate direct staffing information, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS (i.e., Payroll Base Journal (PBJ), related to licensed nursing staffing information when the facility failed to accurately report 24 hour per day Licensed Nurse coverage on 16 dates between April 1, 2023 and March 31, 2024.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 46960 The facility reported a census 48 residents. Based on observation, interview, and record review, the facility failed to provide a sanitary environment when staff stored an unlined trash can in the soiled utility room of the 400-hall. Findings included: - On 07/11/24 at 01:25 PM, Maintenance Director U identified three soiled utility rooms in the facility during an environmental tour: On the 400-hall, a trash can in the soiled utility room lacked a liner and a lid. On 07/11/24 at 01:30 PM, Maintenance Director U revealed that all trash containers should have liners and lids. The trash and soiled linen containers were to be washed out at the end of every shift. The facility failed to provide a policy related to lids or the covering on trash cans. The facility failed to provide a sanitary environment when staff stored an unlined trash can in the soiled utility room of the 400-hall.