| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175297 | A. Building<br>B. Wing | 12/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Topeka Presbyterian Manor | 4712 SW 6th Ave<br>Topeka, KS 66606 |

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|---|---|
| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Reasonably accommodate the needs and preferences of each resident.<br><br>45668<br><br>The facility had a census of 63 residents. The sample included 18 residents with two reviewed for accommodation of needs related to assistive devices. Based on observation, record review, and interview the facility failed to utilize and ensure the appropriate use of foot pedals during wheelchair transports for Resident (R) 1, R41, and R47. This placed the residents at risk for preventable accidents and injuries.<br><br>Findings Included:<br><br>- On 12/09/24 at 07:30 AM, R1 (resident with upper and lower extremity impairments) was wheeled out of his room to the medication cart by the nurse's station. R1's foot pedals were not in place as staff pushed him down the hall. At 07:35 AM, staff applied his foot pedals and wheeled him to breakfast.<br><br>On 12/10/24 at 08:32 AM, R41 (severely cognitively and physically impaired resident) sat upright in his Broda chair as an unidentified staff pushed his chair down the hallway toward the edge of the dining room close to his room. R41's feet slid along on the floor as staff pushed his chair.<br><br>On 12/10/24 at 08:56 AM, R41 sat upright in his Broda chair by the dining room near his room. R41's feet were not appropriately positioned in his Broda chair and his feet slid on the ground as staff wheeled him down the hallway.<br><br>On 12/11/24 at 08:00 AM, Licnesed Nurse (LN) G pushed R47 down the Cedar View hallway. R47's wheelchair had no foot pedals in place, and her feet slid on the ground as she was pushed.<br><br>On 12/11/24 at 11:45 AM, LN G stated all the residents had foot pedals and staff should ensure they were in place before transporting the residents.<br><br>On 12/11/24 at 12:55 PM, Certified Nurse Aide (CNA) Q stated staff was expected to verify the foot pedals were in place and the residents were in the proper positioning before wheeling them anywhere.<br><br>On 12/11/24 at 02:01 PM, Administrative Nurse D stated staff were expected to ensure the foot pedals were utilized while transporting residents.<br><br>(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 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The facility did not provide a policy related to accommodation of needs or assistive devices for wheelchairs.<br><br>The facility failed to utilize and ensure the appropriate use of foot pedals during wheelchair transports for R1, R41, and R47. This placed the resident at risk for preventable accidents and injuries. |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49634<br><br>The facility identified a census of 63 residents. The sample included 18 residents with four residents reviewed for activities of daily living (ADL) care. Based on observation, record review, and interviews, the facility failed to ensure staff assisted Resident (R) 4 with grooming. This deficient practice placed R4 at risk for impaired dignity and a further decline in ADL.<br><br>Finding Included:<br><br>- R4's Diagnosis section within the Electronic Medical Record (EMR) noted diagnoses of ischemia (decreased supply of oxygenated blood to a body part), heart disease (the heart does not pump as well as it should), myocardial infarction (heart attack), hypertension (high blood pressure), cognitive decline, kidney disease stage four (severe damage to the kidneys and a significant decline in function), and obesity (excessive body fat).<br><br>R4's Quarterly Minimum Data Set (MDS) dated [DATE] noted a Brief Interview of Mental Status (BIMS) score of four which indicated severe cognitive impairment. The MDS indicated R4 needed partial to moderate assistance with bathing, and setup and clean up with personal hygiene. The MDS documented R4 needed set up and clean up for toileting.<br><br>R4's Cognitive Loss/Dementia Care Area Assessment (CAA) completed 05/07/24 indicated R4 had some issues with recall ability and orientation. R4 would sometimes refuse her shower. The CAA documented R4 had expressive dysphagia (swallowing difficulty) due to Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure).<br><br>R4's Communication CAA completed 05/07/24 indicated R4 hears without any difficulty and was able to make her needs known. R4's CAA indicated she had difficulty finding words and finishing her thoughts, and she had poor memory and decision-making.<br><br>R4's Care Plan dated 06/24/21 documented R4 needed staff assistance with set up to limited assistance with ADLs and staff would document R4 would receive appropriate assistance with ADLs such as grooming, repositioning, toileting, eating, transferring, and bathing. R4's plan of care documented she had no preference of when her shower time would be, or what day.<br><br>R4's medical record consistently documented refusals for showering.<br><br>On 12/09/24 at 12:01 PM, R4 sat in her wheelchair at the dining room table, R4's hair was matted at the back of her head, and the top of her hair was sticking straight up.<br><br>On 12/09/24 at 01:24 PM, R4 stated she would take a shower. R4 stated that she was unable to comb her own hair.<br><br>On 12/11/24 at 11:15 AM, Licensed Nurse (LN) J stated that R4 gets her hair styled at the salon twice a week and the next day her hair does not look like she has gone to the salon. She stated it was the responsibility of the staff member to get R4 ready to go to lunch and ensure she was clean, and her hair was combed before they took her from her room.<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 12/11/24 at 12:34 PM, Certified Nurse's Aide (CNA) Q stated all nursing staff were responsible for ensuring the residents were clean, their hair was combed, and they had on clean clothes before each resident left their room.<br><br>On 12/11/24 at 03:24 PM, Administrative Nurse D stated it was the expectation of the facility that each staff member be responsible for ensuring the residents look presentable before the resident leaves their room.<br><br>The facility failed to provide a policy for activities of daily living.<br><br>The facility failed to ensure staff assisted R4 with grooming. This deficient practice placed resident R4 at risk for impaired dignity and a further decline in ADL. |

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| F 0679<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide activities to meet all resident's needs.<br><br>49634<br><br>The facility identified a census of 63 residents. The sample included 18 residents. Based on observation, record review, and interviews, the facility failed to provide consistent weekend activities on Saturdays to promote socialization. This deficient practice placed the affected residents at risk for decreased psychosocial well-being, boredom, and isolation.<br><br>Findings included:<br><br>- A review of the facility's Activity Calendar for October, November, and December 2024 was completed.<br><br>The Activity Calendar for October recorded the following Saturday activities: for 10/05/24 were Chronicles and Current Events, afternoon bingo, deep breathing, exercise, and balance; and on 10/12/24 the activity was afternoon bingo, exercise, balance, and deep breathing. The Activities Calendar recorded no activities for 10/19/24, and 10/26/24.<br><br>The Activity Calendar for November 2024 recorded no activity on 11/02/24, and 11/09/24. The Activity Calendar listed 11/16/24 was a musical performance. The Activity Calendar on 11/23/24 listed deserts for Thanksgiving open house, and no activities on 11/30/24.<br><br>The Activities Calendar for December 2024 revealed each Saturday had no activities listed.<br><br>On 12/10/24 at 08:59 AM, Resident Council members reported on weekends, starting in October, there were not many activities. The council reported they could go to church services on Sundays. The Resident Council stated there were no consistent activities on Saturday and residents stayed in their rooms and watched TV. The Resident Council stated the weekends get very long and boring.<br><br>On 12/11/24 at 11:06 AM, Activities Staff Z verified the facility did not have consistent weekend activities. She stated the facility was working on getting volunteers from the churches and staff for activities on the weekends.<br><br>On 12/11/24 at 12:54 PM, Certified Nursing Aide (CNA) Q stated she was unsure if there were weekend activities. She stated she had never done any weekend activities for the residents.<br><br>On 12/11/24 at 03:24 PM, Administrative D stated the facility had volunteers on Sundays, and the nursing staff could do weekend activities. She stated the facility had activities that nursing staff could hand out to the residents on the weekends.<br><br>The facility's Life Enrichment Programs policy reviewed on 10/13/21 documented that group life enrichment programs would be provided which are designed to meet, in accordance with the comprehensive assessment, the interest and the physical, mental, and psychosocial well-being of each resident. Residents would be encouraged to participate in group life enrichment of interest and encouraged to develop new interests.<br><br>(continued on next page) |

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| F 0679<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | The facility failed to provide consistent weekend activities for the residents to promote socialization. This deficient practice placed the affected residents at risk for decreased psychosocial well-being, boredom, and isolation. |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49634<br><br>The facility identified a census of 63 residents. The sample included 18 residents with two residents reviewed for treatment and services to prevent and heal pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, because of pressure, or pressure in combination with shear and/or friction). Based on observation, record review, and interviews, the facility failed to ensure Resident (R)32's low air-loss mattress was set at the appropriate weight for pressure reduction. This placed R32 at increased risk for pressure ulcer development and delayed healing.<br><br>Findings Included:<br><br>- R32's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of hemiplegia (paralysis of one side of the body) on the left dominant side, muscle wasting, muscle weakness, difficulty in walking, dysphagia (swallowing difficulty), obesity (excessive body fat), aphasia (condition with disordered or absent language function), anemia (an inadequate number of healthy red blood cells to carry adequate oxygen to body tissues), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), major depressive disorder (major mood disorder that causes persistent feelings of sadness), and Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure).<br><br>The Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 13 which indicated intact cognition. The MDS documented that R32 had an impairment on one side of her body. The MDS documented R32 was dependent on staff for upper and lower body dressing, and toileting. The MDS documented R32 needed substantial to maximum assistance with showers and oral hygiene and was dependent on staff to roll right to left. The MDS documented R32 was at risk for pressure ulcers and had a pressure-reducing device on her bed and in her chair.<br><br>R32's Pressure Ulcer/ Injury Care Area assessment dated [DATE] documented R32 was at risk for skin issues and pressure injuries. R32 spends most of her time in her bed. R32 had a low air-loss mattress in place and a turning schedule. R32's CAA documented she was incontinent of bowel and bladder.<br><br>R32's Care Plan dated 08/16/19 documented R32 was at risk for pressure ulcers and skin impairments, due to decreased mobility and incontinence. R32's plan of care documented she had a low air-loss mattress and staff should set the firmness of her mattress between 190-210 pounds. Staff were to assist R32 with repositioning when she was in bed and in her wheelchair. R32's plan of care dated 07/24/23 documented she should wear a resting splint to her left hand, and staff were to inspect her hand for redness daily.<br><br>R32's Braden Scale for Prediction Pressure Sore Risk dated 11/05/2024 documented a score of 10 indicating a high risk for pressure ulcers.<br><br>R32's EMR under Treatment Administration Record (TAR) documented the following physicians' orders:<br><br>Barrier cream to buttocks after each incontinent episode/brief change, apply three times daily dated 06/19/24.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | R32's medical record lacked evidence of monitoring of R32's low air-loss mattress.<br><br>R32's EMR under Vital Stats documented a weight of 201.8 dated 12/07/24.<br><br>On 12/09/24 at 09:05 AM, R32 lay on her bed on her right side. R32's low air-loss mattress pump (Protect-Aire 2000) was set at 320 (pounds) and had a setting to adjust in 30-pound increments.<br><br>On 12/11/24 at 1:28 AM, Licensed Nurse (LN) K stated she monitored the low air loss pump to ensure the mattress was plugged in and was set at the correct weight. LN K was unable to find where the bed was being monitored in R32's EMR. LN K stated the nurse in charge when the low air-loss mattress was put in place should have put monitoring of the mattress on the TAR. LN K stated the pump should be set by the current weight of the resident.<br><br>On 12/11/24 at 12:48 PM, Certified Nursing Aid (CNA) Q stated if she went into a room and the pump was beeping, she would ensure the bed was plugged in and let her charge nurse know. She stated she does not turn the settings on the residents' low air-loss pump.<br><br>On 12/11/24 at 03:24 PM, Administrative Nurse D stated nursing checks each mattress every day. Administrative Nurse D stated nurses sign off on the Treatment Administration Record (TAR) each shift, stating the mattress was plugged in and the pump was set at the correct weight.<br><br>The facility's Skin Integrity policy dated 09/05/24 documented that all residents were considered to have some risk for the development of pressure ulcers/injuries. Nursing staff would evaluate skin integrity and tissue tolerance, implement preventative measures as indicated, and treat skin breakdown. The primary care provider admission orders authorize approval to begin using established skin and treatment guidelines. Licensed nurses performed dressing changes. Licensed nurses may delegate minor skin tear treatment and preventative treatments in closed areas who have received appropriate skin care training.<br><br>The facility failed to ensure R32's low air-loss mattress was set at the correct weight setting to prevent pressure ulcers. This placed R32 at increased risk for pressure ulcer development. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45668<br><br>The facility had a census of 63 residents. The sample included 18 residents with eight reviewed for accidents. Based on observation, record review and interview the facility failed to secure electrical panels and cleaning chemicals in a safe, locked area, and out of reach of the ten cognitively impaired, independently mobile residents. The facility additionally failed to provide adequate supervision for Resident (R) 33 and follow R43's care-planned fall interventions related to her wheelchair placement. This placed the affected residents at risk for preventable accidents and injuries.<br><br>Findings Included:<br><br>- On 12/09/24 at 07:05 AM, a walk-through of the Cedar View halls was completed with the following observations:<br><br>An inspection of an unsecured housekeeping closet in the 580's hallway revealed numerous heavy-duty 3M brand cleaning products on the wall. The room also contained multipurpose sprays and floor cleaners. The cleaning products contained the warning label, Keep out of reach of children, hazardous to humans can cause eye irritation, harmful if swallowed.<br><br>An inspection of an unsecured soiled linen closet in the 580's hallway revealed a bottle of crystal spray spot cleaner on a shelf. The bottle contained the warning label, Keep out of reach of children, hazardous to humans can cause eye irritation, harmful if swallowed. The room also contained three unlocked electrical panels with the warning high voltage - the danger of electric shock.<br><br>On 12/09/24 at 07:05 AM, an inspection of an unsecured storage closet in the 560's hallway revealed three unlocked electrical panels with the warning high voltage - the danger of electric shock.<br><br>On 12/09/24 at 07:31 AM, Maintenance Staff U stated all the storage rooms and closets should be locked. He then checked the closet doors and secured them.<br><br>On 12/11/24 at 11:45 AM, an inspection of the Spa room on the 560's hallway revealed the door was unsecured. An inspection of the room revealed an unlocked cabinet with unsecured purple sanitary bleach wipes.<br><br>On 12/11/24 at 11:50 AM, Licensed Nurse (LN) G stated the Spa room should be always locked and residents should not be in the room without a staff member present. She stated the utility rooms and janitor closets should always be locked.<br><br>On 12/11/24 at 02:47 PM, Administrative Nurse D stated the utility rooms and closets were to remain locked. She stated residents should not have access to areas containing potential hazards. She stated staff were expected to check the rooms and ensure they remained secured.<br><br>The facility did not provide a policy related to accidents and hazards as requested on 12/11/24.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | The facility failed to secure electrical panels and cleaning chemicals in a safe, locked area, and out of reach of the ten cognitively impaired, independently mobile residents. This placed the affected residents at risk for preventable accidents and injuries.<br><br>- The Diagnosis section within R33's Electronic Medical Records (EMR) noted diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), history of fractures (broken bones) related to falls, hearing loss, age-related physical debility, fatigue, urinary retention, and age-related macular degeneration (progressive deterioration of the retina).<br><br>R33's Quarterly Minimum Data Set (MDS) completed 03/21/24 documented a Brief Interview of Mental Status (BIMS) score of nine indicating moderate cognitive impairment. The MDS documented she required partial to moderate staff assistance with toileting, bathing, dressing, personal hygiene, and transfers. The MDS indicated she was fully dependent on staff assistance for walking or ambulation. The MDS documented she had a history of falls since her last assessment.<br><br>R33's Quarterly MDS dated [DATE] documented a BIMS score of three indicating severe cognitive impairment. The MDS indicated she was fully dependent on staff assistance for transfers, bed mobility, bathing, toileting, personal hygiene, and dressing. The MDS documented she had one fall since her last assessment. The MDS documented bed rails were not in use.<br><br>R33's Functional Abilities Care Area Assessment (CAA) completed 04/29/24 indicated she was at risk for falls related to her medical diagnoses and cognitive impairment. The CAA documented she had visual and hearing impairments. The CAA documented she required extensive to total assistance from staff for her activities of daily living (ADLs) and transfers.<br><br>R33's Fall CAA completed 04/29/24 indicated she had one fall since and was at risk due to her impaired vision, hearing, cognition, and mobility.<br><br>R33's Care Plan initiated on 12/19/23 indicated she was at risk for falls and required extensive to total assistance from staff for grooming, toileting, bathing, transfers, and repositioning. The care plan instructed staff to follow her implemented toileting plan, assist with ADLs, ensure her bed was in the lowest position, and encourage her to use her call light for assistance. The care plan documented she had a positional rail (grab bar) mounted on the right side of her bed.<br><br>A note dated 04/14/24 at 07:49 PM, in R33's EMR under Notes, documented staff heard R33 yelling for help in the unit's shower room. The note indicated staff assessed R33 for injuries and assisted her into her recliner. The note revealed no injuries.<br><br>The facility's Root Cause Analysis Investigation completed on 04/15/24 indicated R33 was seen in her recliner before her fall. The report indicated that R33 walked into the shower room and fell while attempting to toilet herself.<br><br>On 12/10/24 at 12:45 PM, R33 sat in her Broda chair (specialized wheelchair with the ability to tilt and recline) in front of the fireplace area. The recliner area was located directly access from the shower room. An inspection of the shower room revealed a sign on the back stating Leave door locked at all times.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 12/11/24 at 11:45 AM, an inspection of the Spa room on the 560's hallway revealed the door was unsecured. An inspection of the room revealed an unlocked cabinet with unsecured purple sanitary bleach wipes.<br><br>On 12/11/24 at 11:50 AM, Licensed Nurse (LN) G stated R33 required supervision even before her fall. She stated that R33 was impulsive and often attempted to transfer herself or walk without staff present. She stated the shower room should be locked at all times and residents should never be allowed to go in alone due to the chance of falls or accidents.<br><br>On 12/11/24 at 02:01 PM, Administrative Nurse D stated R33 was impulsive and walked herself to the shower room. She stated the shower room should have been locked and residents were not allowed to enter them alone. She stated she put R33 on a toileting program to prevent her from seeking out a bathroom. She stated staff were educated to leave the doors locked.<br><br>The facility's Falls policy dated 10/08/24 documented that residents would be identified for risk of falls and interventions implemented to reduce the risk of falls. Fall risk screening tool would be completed on admission, quarterly for healthcare, and annually for assisted living and when there was a significant change of condition and as applicable, after a fall. Residents' high-risk status would be documented on the comprehensive plan of care or service plan.<br><br>The facility failed to ensure consistent supervision for R33 resulting in a fall in an unsecured shower room. This deficient practice placed R33 at risk for preventable accidents and injuries.<br><br>49634<br><br>- R43's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), kidney failure (a condition where one or both kidneys no longer work on their own), chronic obstructive pulmonary disease (COPD - a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), hypertension (high blood pressure), major depressive disorder (major mood disorder that causes persistent feelings of sadness), Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremors, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness), and chronic respiratory failure with hypoxia (when there was not enough oxygen in the blood).<br><br>The Significant Change in Status Minimum Data Set (MDS) for R43 dated 10/09/24 recorded a Brief Interview for Mental Status (BIMS) score of 12, which indicated moderately impaired cognition. The MDS documented R43 was dependent on staff for personal hygiene, toileting, and dressing. The MDS documented R43 was at risk for falls and had one non-injury fall.<br><br>R43's Fall Care Area assessment dated [DATE] documented R43 scored at high risk for falls. R43 had a non-injury unwitnessed fall on 10/09/24. R43 was started on hospice services. The CAA documented R43 required extensive assistance of one staff with transfers, had daily incontinence, and required total assistance with toileting needs. R43's CAA documented R43 used a wheelchair for mobility and required total assistance from one staff.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175297 | A. Building<br>B. Wing | 12/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Topeka Presbyterian Manor | 4712 SW 6th Ave<br>Topeka, KS 66606 |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | R43's Care Plan dated 07/11/22 documented staff were to encourage R43 to wear long sleeves or arm protectors due to the high risk of bruising. R43's plan of care documented staff were to encourage R43 to allow staff to put footwear on in the mornings. R43's plan of care documented staff would ensure R43's wheelchair was next to her. R43's plan of care dated 11/04/24 documented staff were to put R43 in her chair or in her bed after each meal.<br><br>R43's EMR under ID Notes dated 10/09/24 documented nursing staff were called to R43's room by a Certified Nurse Aide (CNA). Upon arrival, the nurse noted R43 was sitting in front of her wheelchair on top of the wheelchair foot pedals. R43 denied hitting her head and stated there was someone in her recliner but was unable to elaborate. R43 stated she did not have to go to the bathroom. The nurse and CNA assisted R43 to her recliner. R43 was able to bear weight and assist with the transfer. Staff notified R43's physician and hospice provider and the CNA staff assisted R43 with her evening cares.<br><br>On 12/10/24 at 02:14 PM, R43 sat in her easy chair. R43's pedals to her wheelchair sat by her chair. R43's wheelchair was folded up inside her bathroom and out of her reach.<br><br>On 12/11/24 at 11:15 AM, Licensed Nurse (LN) J stated all staff had access to the resident's care plan. LN J stated all staff working the hall were responsible for ensuring the safety of all residents. LN J stated the CNAs had a paragraph on their daily charting that tells the CNA pertinent information about each resident.<br><br>On 12/11/24 at 12:54 PM, CNA Q stated she was able to see each resident's care plan. She stated that on most days, she does not have time to read each resident's care plan. She stated the charge nurse on her hall would let her know if there was anything specific she needed to know about each resident she was caring for.<br><br>On 12/11/24 at 03:24 PM, Administrative Nurse D stated all nursing staff had access to the residents' care plans. Administrative Nurse D stated she expected staff to read the resident's care plan and take care of the resident as the care plan stated.<br><br>The facility's Falls policy dated 10/08/24 documented that residents would be identified for risk of falls and interventions implemented to reduce the risk of falls. Fall risk screening tool would be completed on admission, quarterly for healthcare, and annually for assisted living and when there was a significant change of condition and as applicable, after a fall. Residents' high-risk status would be documented on the comprehensive plan of care or service plan.<br><br>The facility failed to ensure R43's wheelchair was placed next to her per her plan of care to prevent further falls. This deficient practice placed R43 at risk for falls and fall-related injuries. |

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| F 0700<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45668<br><br>The facility identified a census of 63 residents. The sample included 18 residents with eight residents reviewed for accidents. Based on observation, record review, and interviews, the facility failed to ensure that Resident (R) 33 had a safety assessment for the use of side rails that acknowledged the risks when used with a low air-loss mattress. This deficient practice placed R33 at risk for uninformed decisions and impaired safety related to the risks associated with the use of side rails.<br><br>Findings Included:<br><br>- The Diagnosis section within R33's Electronic Medical Records (EMR) documented diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), history of fractures (broken bones) related to falls, hearing loss, age-related physical debility, fatigue, urinary retention, and age-related macular degeneration (progressive deterioration of the retina).<br><br>R33's Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of three indicating severe cognitive impairment. The MDS indicated she was fully dependent on staff assistance for transfers, bed mobility, bathing, toileting, personal hygiene, and dressing. The MDS documented she had one fall since her last assessment. The MDS documented bed rails were not in use.<br><br>R33's Functional Abilities Care Area Assessment (CAA) completed 04/29/24 indicated she was at risk for falls related to her medical diagnoses and cognitive impairment. The CAA documented she had visual and hearing impairments. The CAA documented she required extensive to total assistance from staff for her activities of daily living (ADLs) and transfers.<br><br>R33's Fall CAA completed 04/29/24 indicated she had one fall since and was at risk due to her impaired vision, hearing, cognition, and mobility.<br><br>R33's Care Plan initiated on 12/19/23 indicated she was at risk for falls and required extensive to total assistance from staff for grooming, toileting, bathing, transfers, and repositioning. The plan instructed staff to follow her provided toileting plan, assist with ADLs, ensure her bed was in the lowest position, and encourage her to use her call light for assistance. The plan documented she had a positional rail (grab bar) mounted on the right side of her bed. The plan documented she had a low air-loss mattress to prevent pressure-related injuries.<br><br>R33's EMR under Forms revealed an Assistive Device for Bed Screening form completed on 10/14/24. The screening documented that R33 had an ADL impairment and a history of falls. The screening documented she had poor trunk control, difficulty repositioning, and fluctuations in her level of consciousness. The screening documented she used the bed mobility device for transfers and repositioning. The screening failed not acknowledge the use of her low air-loss mattress.<br><br>(continued on next page) |

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| F 0700<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A review of the low air-loss mattress manufacturer's operation (Drive Model #14530 Series) manual indicated the usage of bed rails with the air mattress system should be assessed based on the risk of entrapment.<br><br>On 12/10/24 at 11:03 AM, R33's mattress sat in the low position. Her Low air-loss mattress pump, Drive Model #14530 Series, was set at 80 pounds (lbs.) per her orders. Her bed had a right-sided hand-bar style side rail toward the head of her bed.<br><br>On 12/11/24 at 11:30 AM, Licensed Nurse (LN) G stated staff looked at each resident's bed and attachment each shift to ensure the mattresses were set appropriately and each bed was safe. She stated that low air-loss mattresses were set by weight and that the bed rails should have no gaps.<br><br>On 12/11/24 at 02:01 PM, Administrative Nurse D stated the facility did not assess side rails or handrails in relation to the use of low air-loss mattresses. She stated they look at the placement of the rails and ensure no gaps exist.<br><br>The facility's Assistive Device Used for Bed policy revised 09/2024 indicated the facility would assess the need for the use of all assistive devices to ensure functionality, safety, and appropriate use. The policy indicated the facility would ensure identification of the risks and hazards associated with railing. The policy documented the use of low air-loss mattresses would be included in the evaluation of potential risks.<br><br>The facility failed to ensure that R33 had a safety assessment for the use of side rails that acknowledged the risks when used with a low air-loss mattress. This placed R33 at risk for uninformed decisions and impaired safety related to the risks associated with the use of side rails. |

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| F 0730<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Observe each nurse aide's job performance and give regular training.<br><br>41037<br><br>The facility identified a census of 63 residents. The sample included 18 residents and five Certified Nurse Aides (CNA) were reviewed for yearly performance evaluations and the associated in-service training. Based on record review and interview, the facility failed to ensure one of the five CNA staff reviewed had yearly performance evaluations completed. This placed the residents at risk for inadequate care.<br><br>Findings included:<br><br>- A review of the facility's staffing list revealed the following CNAs were employed with the facility for more than 12 months:<br><br>CNA N, hired 09/05/23, had no yearly performance evaluation upon request.<br><br>On 12/11/24 at 09:28 AM, Administrative Staff A stated CNA N had just been there a year and her yearly performance had not been completed at this time. Administrative Staff A stated the facility was a little behind in completing their staff's yearly performance.<br><br>The facility failed to provide a policy related to yearly staff performance reviews.<br><br>The facility failed to ensure one of the five CNA staff reviewed had the required yearly performance evaluations completed. This placed the residents at risk for inadequate care. |

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| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41037<br><br>The facility identified a census of 63 residents. The sample included 18 residents with five residents reviewed for unnecessary medications. Based on observation, record review, and interviews, the facility failed to ensure Resident (R) 41 had a Centers for Medicare and Medicaid (CMS) approved indication or the required physician-documented rationale including risk versus benefits and nonpharmocologcal attempts prior to the use of the antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) medication Zyprexa. This placed R41 at risk for unnecessary medication administration and possible adverse side effects.<br><br>Findings included:<br><br>- R41's Electronic Medical Record (EMR) documented diagnoses of vascular dementia with irritation (a condition where a person experiences increased motor activity, restlessness, aggressiveness, and emotional distress), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and delirium (sudden severe confusion, disorientation, and restlessness).<br><br>R41's Significant Change Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of three which indicated a severely impaired cognition. R41 had a limitation in range of motion with impairment on one side of the upper extremity. R41 required substantial assistance to complete dependence on staff for activities of daily living (ADLs) and functional abilities. R41 was receiving hospice services. The MDS documented R41 had a diagnosis of dementia (a progressive mental disorder characterized by failing memory and confusion). The MDS documented R41 had received antipsychotic medication, antidepressant (a class of medication used to treat mood disorders) medication, antianxiety (a class of medication that calms and relaxes people) medication, and opioid (a class of controlled drugs used to treat pain) medication during the observation period. The MDS documented no gradual dose reduction was completed and there was physician documentation that a gradual dose reduction was contraindicated for R41.<br><br>R41's Quarterly MDS dated [DATE] documented a BIMS score of three which indicated a severely impaired cognition. R41 had a limitation in range of motion with impairment on both sides of the upper extremity. R41 required substantial assistance to complete dependence on staff for ADLs and functional abilities. R41 was receiving hospice services. The MDS documented R41 had a diagnosis of dementia. The MDS documented R41 had received antipsychotic medication, antidepressant medication, antianxiety medication, and opioid medication during the observation period. The MDS documented no gradual dose reduction was completed and there was physician documentation that a gradual dose reduction was contraindicated for R41.<br><br>R41's Psychotropic Care Area Assessment (CAA) dated 06/24/24 documented he took antianxiety, antidepressant, and antipsychotic medications daily. He has a diagnosis of severe dementia with agitation, depression, and anxiety. R41 has had falls since the last review and scored high risk for falls. R41 was at risk for changes in mood/behaviors and the effects of medications.<br><br>(continued on next page) |

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| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | R41's Care Plan revised on 04/22/24 directed staff he took Zyprexa and needed to be monitored for side effects. Staff were directed to report any medication side effects to the charge nurse for further evaluation.<br><br>R41's Orders tab of the EMR documented an order dated 08/12/24 for Zyprexa five milligrams (mg) by mouth daily for delirium and anxiety.<br><br>R41's EMR lacked a physician documented rationale along with risks versus benefits and nonpharmacological interventions attempted and failed.<br><br>On 12/10/24 at 07:12 AM, R41 sat in his Broda chair (specialized wheelchair with the ability to tilt and recline) in the hallway across from the nurse's station asleep. R41 had a dressing on his right temple and his hair was uncombed.<br><br>On 12/10/24 at 01:56 PM, R41 sat in his Broda chair yelling out as staff walked by without addressing him.<br><br>On 12/11/24 at 03:25 PM, Administrative Nurse D stated she expected the physician to document the risk versus benefit rationale for the use of antipsychotic medications. Administrative Nurse D stated that R41's restlessness had increased, and the resident was admitted to hospice services.<br><br>The Psychoactive Psychopharmacological Medications policy revised 07/05/22 documented that psychoactive medications would not be used for discipline or for convenience and would not be used unless necessary to treat medical symptoms. Psychoactive medications would be monitored by the interdisciplinary team (IDT) through the care planning process. The benefits and side effects of these medications would be discussed with the primary care provider, so drug selection and dosages were adjusted as necessary to provide the best therapeutic effect for the resident.<br><br>The facility failed to ensure R41 had a CMS-approved indication or the required physician documented rationale including risks versus benefits for the use of Zyprexa. This placed R41 at risk for unnecessary medication administration and possible adverse side effects. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>45668<br><br>The facility identified a census of 63 residents with one kitchen and three dining rooms. Based on observation, record review, and interviews, the facility failed to follow sanitary dietary standards related to maintaining a sanitary service environment for food storage and meal service. These deficient practices placed the affected residents at risk related to food-borne illnesses and food safety concerns.<br><br>Findings Included:<br><br>- On 12/09/24 at 07:21 AM, an inspection of the dining room for Cedar View revealed dirty plates stored on the table next to the kitchenette's serving window from the previous evening's meal service. The table contained a stack of domed plate covers stored in an upward position. Inspection of the condiment shelf in the dining room to the right of the service window revealed a large, uncovered container of instant food thickener with no lid on the top shelf. Thickener residue covered the top of the countertop.<br><br>On 12/09/24 at 08:40 AM, an inspection of the Cedar View dining room revealed that the thickener container had been moved to the table next to the service window. The container remained uncovered, with no lid present.<br><br>On 12/09/24 at 08:50 AM, Certified Nurse Aide (CNA) M received a plate from the kitchenette and placed a dome cover on top of the plate. The dome cover sat directly on top of the food pushing it downward. The plate was then delivered to Resident (R) 29 in her room.<br><br>On 12/09/24 at 08:55 AM, CNA M assisted R56's positioning and returned to the service window. CNA M received R56's breakfast plate and placed a dome lid on it. CNA M placed the food in front of R56 with the dome still on it and walked away from the table. CNA M then walked across the dining room to R56's table. CNA M repositioned and wheeled R23 over to R56's table while R23 slept. CNA M then sat at the table and assisted a male resident with his meal without completing hand hygiene before assisting R23.<br><br>On 12/10/24 at 07:03 AM, an inspection of the Cedar View dining area revealed dirty plates and drink glasses on the table next to the service window. The food thickener container remained uncovered with no lid.<br><br>On 12/10/24 at 07:10 AM, Dietary Staff BB cleaned up the dining room service area. He put a dome cover on top of the food thickener container and stated staff should keep this covered at all times when not in use. He stated staff should be attempting to keep the area clean and organized.<br><br>On 12/10/24 at 10:01 AM, the thickener container was moved to the second shelf on the condiment table. No lid or cover was placed on it.<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 12/11/24 at 12:55 PM, CNA Q stated staff were expected to complete hand hygiene before, during, and after assisting residents in meal service. She stated staff should be hand sanitizing in between delivering meal trays and assisting residents at the table.<br><br>On 12/11/24 at 01:02 PM, Licensed Nurse (LN) G stated staff should be using the hand sanitizer dispenser before touching meal trays and after moving the residents to the tables. She stated staff were expected to ensure the dining areas remained clean and sanitary. She stated staff should be storing the plates inside the kitchenette when the dietary staff were not available to keep the area clean.<br><br>On 12/11/24 at 02:46 PM, Administrative Nurse D stated staff were expected to complete hand hygiene in between assisting residents and providing meals.<br><br>The facility's Equipment: Storage, Cleaning and Sanitizing policy (undated) indicated food service areas would remain clean and sanitary. The policy indicated the facility would ensure all food and supplies would be stored appropriately to ensure quality and maximize the safety of the food.<br><br>The facility failed to follow sanitary dietary standards related to maintaining a sanitary service environment for food storage and meal service. These deficient practices placed the affected residents at risk related to food-borne illnesses and food safety concerns. |

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| F 0849<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49634<br><br>The facility identified a census of 63 residents. The sample included 18 residents with two residents reviewed for hospice. Based on observation, record review, and interviews, the facility failed to ensure coordinated care and services provided by the facility with the care and services provided by hospice for Resident (R) 43 and R38. This placed the residents at risk for inadequate end-of-life care.<br><br>Finding Included:<br><br>- R43's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), kidney failure (a condition where one or both kidneys no longer work on their own), chronic obstructive pulmonary disease (COPD - a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), hypertension (high blood pressure), major depressive disorder (major mood disorder that causes persistent feelings of sadness), Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremors, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness), and chronic respiratory failure with hypoxia (when there was not enough oxygen in the blood).<br><br>The Significant Change in Status Minimum Data Set (MDS) dated [DATE] recorded a Brief Interview for Mental Status (BIMS) score of 12, which indicated moderately impaired cognition. The MDS documented R43 was dependent on staff for personal hygiene, toileting, and dressing. The MDS documented R43 received hospice services during the observation period.<br><br>R43's Cognitive Loss/Dementia Care Area Assessment (CAA) dated 10/09/24 documented R43 had issues with recall ability at times. The CAA documented R43 was newly readmitted to hospice services and nursing would see R43's medication list, as-needed (PRN) medications, and ensure medicines were ordered for R43's mood state. The MDS documented staff would see the nurse practitioner's note for a diagnosis of dementia (a progressive mental disorder characterized by failing memory and confusion); R43 had an alteration in thought processes due to dementia.<br><br>R43's Care Plan dated 07/11/22 documented R43 required maximum assistance of one staff with activities of daily living (ADL) such as eating, bathing transfers, bathing, and toileting. Nursing staff were to encourage R43 to wear footwear in the mornings. R43's plan of care dated 10/10/24 documented R43 would receive hospice services. R43's plan of care dated 10/11/24 documented the hospice provider would coordinate services with the facility. The care plan lacked instruction on the services provided by hospice; including the frequency and type of support visits, supplies and medical equipment provided by hospice, medications covered by hospice, and the hospice contact information.<br><br>A review of the hospice-provided communication binder revealed R43 was admitted to hospice services on 10/15/24.<br><br>On 12/09/24 at 09:44 AM, R43 sat in her chair in her room, covered with a blanket.<br><br>(continued on next page) |

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| | 175297 | A. Building<br>B. Wing | 12/11/2024 |

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| Topeka Presbyterian Manor | 4712 SW 6th Ave<br>Topeka, KS 66606 |

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| F 0849<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 12/10/24 at 11:42 AM, R43 sat at the dining room table, waiting for her lunch.<br><br>On 12/11/24 at 11:15 AM, Licensed Nurse (LN) J stated anything hospice provided for a resident should be care planned, such as when the aid or nurse would come to the facility, equipment, medications, and supplies. LN J stated she does not do care plans and was unsure where staff would find the information if it was not in the resident's care plan.<br><br>On 12/11/24 at 12:54 PM, Certified Nursing Aide (CNA) Q stated she did not know if the care plan stated what hospice provided for a resident. CNA Q stated when she charted her tasks, she was able to see the resident's needs. CNA Q stated she would ask her nurse about the specific equipment hospice provided or look at the tag on the back of the resident's chair.<br><br>On 12/11/24 at 03:24 PM, Administrated Nurse D stated the resident's care plan should state what was provided by hospice, what medication, equipment, and supplies, and when the hospice staff would be in the building. Administrated Nurse D stated staff could find the information in the hospice-provided binder, but she did not believe this information was in the facility's care plan.<br><br>The facility's Care Management policy reviewed on 10/11/21 documented that management of resident care was conducted systematically and comprehensively by an interdisciplinary team knowledgeable in current concepts of geriatric care. Management used the five steps of the nurse process: assessment, diagnosis, goal setting, implantation, and evaluation; and was always consistent with the medical plan of care.<br><br>The facility failed to coordinate care between the facility and the hospice provider for R43, who received hospice services. This deficient practice placed the resident at risk for inadequate end-of-life care.<br><br>41037<br><br>- R38's Electronic Medical Record (EMR) documented diagnoses of respiratory failure (a condition that occurs when the lungs cannot get enough oxygen into the blood), chronic kidney disease (a long-term condition where the kidneys gradually lose their ability to filter blood properly), and hypertension (HTN - elevated blood pressure).<br><br>R38's Significant Change Minimum Data Set (MDS) dated [DATE] documented that she had short and long-term memory problems. R38 had impairment on one side of her upper extremity. R38 was dependent on staff for activities of daily living (ADLs) and functional abilities. R38 received hospice services.<br><br>R38's Cognitive Care Area Assessment (CAA) dated 11/19/24 documented she had impaired cognition and was non-verbal. R38 recently had a decline and was on hospice services.<br><br>R38's Care Plan revised on 11/19/24 directed staff that hospice would provide durable medical equipment (DME) of a mattress, wheelchair, briefs, and oxygen. The care plan directed staff that hospice staff was to visit per the hospice plan of care (POC). The care plan lacked staff direction on what services the hospice staff would provide and when, as well as what medications were covered.<br><br>R38's EMR under the Orders tab revealed the following physician orders:<br><br>(continued on next page) |

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| F 0849<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | May consult hospice dated 11/08/24.<br><br>On 12/10/24 at 07:11 AM, R38 sat in her recliner in her room. R38's TV was on, but the lights were turned off.<br><br>On 12/11/24 at 11:15 AM, Licensed Nurse (LN) J stated anything hospice provided for a resident should be care planned, such as when the aid or nurse would come to the facility, equipment, medications, and supplies. LN J stated she does not do care plans and was unsure where staff would find the information if it was not located in the resident's care plan.<br><br>On 12/11/24 at 12:54 PM, Certified Nursing Aide (CNA) Q stated she did not know if the care plan stated what hospice provided for a resident. CNA Q stated when she charted her tasks, she was able to see the resident's needs. CNA Q stated she would ask her nurse about the specific equipment hospice provided or look at the tag on the back of the resident's chair.<br><br>On 12/11/24 at 03:24 PM, Administrated Nurse D stated the resident's care plan should state what was provided by hospice, what medication, equipment, and supplies, and when the hospice staff would be in the building. Administrated Nurse D stated staff could find the information in the hospice-provided binder, but she did not believe this information was in the facility's care plan.<br><br>The facility's Care Management policy reviewed on 10/11/21 documented that management of resident care was conducted systematically and comprehensively by an interdisciplinary team knowledgeable in current concepts of geriatric care. Management used the five steps of the nurse process: assessment, diagnosis, goal setting, implantation, and evaluation; and was always consistent with the medical plan of care.<br><br>The facility failed to coordinate care between the facility and the hospice provider for R38, who received hospice services. This deficient practice placed the resident at risk for inadequate end-of-life care. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>45668<br><br>The facility identified a census of 63 residents. The facility identified eight residents on Enhanced Barrier Precautions (EBP-infection control interventions designed to reduce transmission of resistant organisms that employ targeted gown and glove use during high contact care). Based on record review, observations, and interviews, the facility failed to develop and implement a system to alert staff and visitors of EBP needs and additionally failed to complete hand hygiene during wound care and to ensure the sanitary storage of oxygen therapy equipment. These deficient practices placed the residents at risk for infectious diseases.<br><br>Included Findings:<br><br>- On 12/09/24 the facility identified Resident (R) 2, R5, R9, R13, R48 R50, R51, and R260 as being on EBP. An inspection of the above residents' rooms revealed personal protective equipment (PPE) stored within them though there was no signage related to EBP or the required PPE An inspection of the rooms revealed no visible indicator or signage for EBP.<br><br>On 12/09/24 at 09:22 AM, R4's nebulizer mask lay directly on her coffee table alongside her recliner.<br><br>On 12/09/24 at 10:00 AM, R51's nasal cannula and oxygen tubing hung over the end of the bed. R51's nebulizer mask lay directly on the bedside table.<br><br>On 12/09/24 at 08:35 AM, R23's nasal cannula and oxygen tubing rested directly on her bed.<br><br>On 12/10/24 at 12:24 AM, R4's nebulizer mask hung over her coffee table next to her recliner.<br><br>On 12/11/24 at 08:45 AM, an inspection of R27's room revealed her continuous positive airway pressure (CPAP- ventilation device that blows a gentle stream of air into the nose to keep the airway open during sleep) mask lay directly on top of her dresser without a barrier or clean storage bag.<br><br>On 12/11/24 at 09:07 AM, R13 lay on her bed. Licensed Nurse (LN) H washed her hands and donned a pair of gloves. She removed R13's percutaneous endoscope gastrostomy tube (PEG-a tube inserted through the wall of the abdomen directly into the stomach) site dressing. LN H disposed of the soiled dressing in the trash. Wearing the same soiled gloves, LN H applied R13's clean PEG site dressing. LN H doffed her gloves and performed hand hygiene.<br><br>On 12/11/24 at 08:20 AM, LN G stated nursing staff passed down information on which residents were on EBP and would let staff know what precautions were necessary. She stated PPE is stored inside closets of each room on the shelves. She was not aware of signage or indicators placed to let staff and visitors know of the required precautions. She stated oxygen equipment and tubing should be stored in a plastic bag when not in use.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 12/11/24 at 10:05 AM, Certified Nurse Aide (CNA) MM stated she was agency and not aware of the indicator placed in the rooms for EBP. She stated the nurses notify direct care staff in person of which residents were on EBP and the EMR displays it. She stated she was not aware of signage or indicators physically placed in the room to show EBP.<br><br>On 12/11/24 at 11:30 AM, LN G stated she was just notified the blue dots on the resident's doors indicate EBP rooms.<br><br>On 12/11/24 at 01:58 PM, LN H stated that hand hygiene should be performed between glove changes and going from a dirty field to a clean field.<br><br>On 12/11/24 at 02:24 PM, Administrative Nurse D stated all staff have been educated on EBP and the requirements of PPE. She stated the rooms were identified with blue dots on the door plates. She stated the facility recently educated all staff on infection control practices.<br><br>The facility's Hand Hygiene policy dated 09/07/22 documented all staff members would comply with current Centers for Disease Control and Prevention (CDC) hand hygiene guidelines, as effective hand hygiene reduces the incidence of healthcare-associated infections. Hand hygiene in long-term care would be prior to touching a resident, prior to aseptic procedures, after body fluid exposure, and after touching a resident's belongings.<br><br>The facility's Oxygen Therapy policy dated 10/08/21 documented that oxygen was treated as a medication ordered by the physician. The order includes the amount per minute to be delivered, the device used for delivery, and during what times to deliver oxygen therapy. When the device is not in use, store it in a plastic or other bag to keep the tubing and the device off the floor.<br><br>The Infection Control policy dated 06/14/24 documented the infection control program included identifying, investigating, controlling, reporting, and preventing infections and communicable diseases in the community including appropriate immunizations, and standard and transmission-based precautions to prevent the spread of infections. Standard precautions include hand hygiene, glove usage, gown, mask, eye protection, or face shield depending on anticipated exposure.<br><br>The facility failed to ensure the staff were aware of the EBP indicators in place for the residents. The facility additionally failed to complete hand hygiene during wound care and to ensure the sanitary storage of oxygen therapy equipment. These deficient practices placed the residents at risk for infectious diseases. |

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| F 0883<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement policies and procedures for flu and pneumonia vaccinations.<br><br>45668<br><br>The facility identified a census of 63 residents. The sample included 18 residents with five residents reviewed for influenza (a contagious respiratory illness that infects the nose, throat, and sometimes the lungs) and pneumococcal (a disease that refers to a range of illnesses that affect various parts of the body and are caused by infection) immunizations. Based on record review and interviews the facility failed to ensure Resident (R) 51 received the pneumococcal vaccine after consenting to the vaccination. This deficient practice placed R51 at risk for acquiring, transmitting, or experiencing complications from the pneumococcal disease.<br><br>Findings included:<br><br>- On 12/11/24 an review for influenza and pneumococcal immunizations was completed for R17, R27, R31, R43, and R51.<br><br>R51's Immunization tab in the EMR revealed he received a pneumococcal (PPSV23) vaccination on 12/17/14 and a pneumococcal vaccination (PCV13) on 01/20/16. The EMR lacked documentation that other pneumococcal vaccinations (PCV20 or PCV21) were offered or given.<br><br>On 12/10/24 at 08:05 AM, R51 stated he admitted to the facility in 2023 and had not received pneumococcal vaccinations since his admission. He stated someone talked to him a few months ago but he has not received any update on it.<br><br>On 12/11/24 at 01:25 PM, Administrative Nurse D provided a Pneumococcal Consent Form for R51 completed on 08/28/24. The form indicated R51 consented to receive the newer PCV20 pneumococcal vaccination on 08/28/24 but never received the vaccination.<br><br>On 12/11/24 at 02:01 PM, Administrative Nurse D stated she gave R51 his vaccination earlier in the morning (12/11/24). Administrative Nurse D was unable to explain why the vaccination had not been given since August.<br><br>The facility's Immunization-Pneumococcal revised 07/2024 indicated all residents would be screened for pneumococcal vaccinations. The policy indicated the facility would assess each resident's history, health status, and preferences.<br><br>The facility failed to ensure R51 received the pneumococcal vaccine after consenting to the vaccination. This deficient practice placed R51 at risk for acquiring, transmitting, or experiencing complications from the pneumococcal disease. |

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| F 0942<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure that staff members are educated on resident rights and facility responsibilities to properly care for its residents.<br><br>41037<br><br>The facility identified a census of 63 residents. Based on record review and interviews, the facility failed to ensure agency staff received the required resident rights training. This placed the residents at risk for impaired care and decreased quality of life.<br><br>Findings included:<br><br>- On 12/11/24 at 09:30 AM, the training record on file at the facility for agency Certified Nurses Aid (CNA) O, CNA P, and Licensed Nurse (LN) I revealed the following:<br><br>CNA O's facility-provided credentialing file lacked documented training completed for resident rights training.<br><br>LN I facility credentialing file lacked documented training completed for resident rights training. The file documented she was provided abuse, neglect, and exploitation (ANE) training.<br><br>On 12/11/24 at 12:48 PM, CNA Q confirmed she was agency staff. She stated she had completed some in-services through the staffing agency through which she was contracted.<br><br>On 12/11/24 at 01:48 PM, Licensed Nurse (LN) H confirmed she was agency staff. She stated she contracted through several different staffing agencies, and she had completed nursing competency for the agency company. LN H stated she had attended in-services at the facility occasionally during her time working at the facility.<br><br>On 12/11/24 at 03:25 PM, Administrative Nurse D stated she expected the agency that the facility used for staffing to ensure agency staff had completed the required in-services. Administrative Nurse D revealed she did not have a system in place to ensure the agency staff the facility used to care for the residents had the required in-services.<br><br>The facility's Education policy dated 08/2022 documented that the goal of the facility was to ensure all staff received appropriate training in order to ensure the safety and well-being of all residents. An electronic learning management system (ELMS) was used as the primary education provider. Additional education was provided via online webinars, conference calls, in-service meetings, and conferences.<br><br>The facility failed to ensure the required resident rights training was completed by staff who provided care in the facility. This placed the residents at risk for impaired care and decreased quality of life. |

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| F 0945<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Include as part of its infection prevention and control program, mandatory training that includes written standards, policies, and procedures for the program.<br><br>41037<br><br>The facility identified a census of 63 residents. Based on record review and interviews, the facility failed to ensure agency staff received the required infection control training. This placed the residents at risk for impaired care and decreased quality of life.<br><br>Findings included:<br><br>- On 12/11/24 at 09:30 AM the training record on file at the facility for agency Certified Nurses Aid (CNA) O, CNA P and Licensed Nurse (LN) I revealed the following:<br><br>CNA O's facility-provided credentialing file lacked documented training completed for infection control training.<br><br>CNA P's facility-provided credentialing file lacked documented training completed for infection control training. The file noted she was provided abuse, neglect, and exploitation (ANE), and resident rights training.<br><br>LN I facility credentialing file lacked documented training completed for infection control training. The file noted she was provided abuse, neglect, and exploitation (ANE) training.<br><br>On 12/11/24 at 12:48 PM, CNA Q confirmed she was agency staff. She stated she had completed some in-services through the staffing agency she was contracted through.<br><br>On 12/11/24 at 01:48 PM, Licensed Nurse (LN) H confirmed she was agency staff. She stated she contracted through several different staffing agencies, and she had completed nursing competency for the agency company. LN H stated she had attended in-services at the facility occasionally during her time working at the facility.<br><br>On 12/11/24 at 03:25 PM, Administrative Nurse D stated she expected the agency that the facility used for staffing to ensure agency staff had completed the required in-services. Administrative Nurse D stated she did not have a system in place to ensure the agency staff the facility used to care for the residents had the required in-services.<br><br>The facility's Education policy dated 08/2022 documented the goal of the facility was to ensure all staff received appropriate training in order to ensure the safety and well-being of all residents. An electronic learning management system (ELMS) was used as the primary provider of education. Additional education was provided via online webinars, conference calls, in-service meetings, and conferences.<br><br>The facility failed to ensure the completion of the required infection control training for staff who provided care in the facility. This placed the residents at risk for impaired care and decreased quality of life. |