STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175299	A. Building B. Wing	01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sterling Village	204 W Washington Avenue Sterling, KS 67579

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** 32360 The facility had a census of 26 residents. The sample included 12 residents, with seven reviewed for falls. Based on observation, record review, and interview, the facility failed to follow two residents' care plans: Resident (R) 128, who sustained a tibia (bone of the lower leg) fracture (break) during ambulation, and R4, who slid off the bed while on a bed pan. This placed the residents at risk for further falls and avoidable injury. Findings included: - The Electronic Medical Record (EMR) for R128 documented diagnoses of Alzheimer's disease (a progressive mental deterioration characterized by confusion and memory failure), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), hypertension (high blood pressure), and pain. The Annual Minimum Data Set (MDS), dated [DATE], documented R128 had severely impaired cognition. R128 was dependent upon staff for toileting and lower body dressing. R128 received partial staff assistance for personal hygiene, mobility, transfers, and upper body dressing. R128 refused to ambulate. The MDS documented R128 had upper functional impairment on one side and had no falls. The Fall Care Area Assessment (CAA) dated 05/06/24, documented that R128 was on Hospice (specialized care that mainly aims to provide comfort and dignity to the patients by providing physical comfort and emotional, social, and spiritual support for people nearing the end of life), had functional limitations in her upper extremities and no functional limitations in her lower extremities, and used a walker and wheelchair. The Quarterly MDS, dated [DATE], documented R128 had long and short-term memory loss with moderately impaired decision-making skills and was dependent upon staff for toileting, and lower body dressing. R128 required substantial staff assistance for transfers and partial assistance for upper body dressing, personal hygiene, and mobility. R128 did not ambulate. The MDS further documented R128 had upper functional impairment on one side and had two or more falls with injury. The Fall Assessments dated 07/23/24 and 09/29/24 documented R128 was at risk for falls. (continued on next page)

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The Care Plan, dated 08/15/24, initiated on 01/04/24, directed staff to encourage R128 to use her call light and wait for staff assistance, place her motion sensor pointed towards the bed, and make sure to change batteries. The update, dated 02/05/24, documented a scooped mattress was placed on R128's bed. The update, dated, 02/09/26, directed staff to ambulate R128 short distance with one to two staff and a walker and please use a gait belt. The update, dated 05/21/24, directed staff to take R128 out to the west dining room when she had increased confusion and hallucinations so staff could keep an eye on her. The update, dated 08/12/24, documented R128 no longer ambulated as she consistently lifted her feet into the air. The Fall Investigation, dated 09/28/24 at 10:35 AM, documented Certified Nurse Aide (CNA) N assisted R128 to the bathroom and R128 went down to her knees. CNA N assisted R128 back to a standing position and assisted her to the toilet. R128 was weak and complained of right knee pain. The investigation documented the root cause of the fall was CNA N did not follow R128's care plan to not ambulate the resident and the gait belt was used incorrectly. The Witness Statement, dated 10/02/24, documented CNA N reported she had gone to get R128 up and out of bed so she could eat breakfast. CNA N removed the covers then sat R128 up onto the side of the bed, grabbed her walker, counted to three, and stood R128 up. CNA N stated she stood behind her as R128 ambulated to the bathroom. CNA N stated she hovered her hands around R128's waist as she walked with her. R128's right knee gave out and CNA N quickly put her arms under the resident's armpits, and R128's right knee touched the ground. CNA N further stated she held her body off of the ground except for her right knee. The toilet was close to them, so she rotated her to the toilet, sat her down, and went to get assistance. The Nurse's Note, dated 09/28/24 at 07:02 PM, documented Hospice was notified and stated they would come to the facility to evaluate R128 and would send an email to the family to ask if they wanted an X-ray (a type of electromagnetic radiation that can pass through objects and create images of their internal structures). The note documented R128's family declined an X-ray unless things seemed to get worse. The note documented R128's right knee had swelling, and she complained of right knee pain. The Nurse's Note, dated 09/29/24 at 04:09 PM, documented R128's right knee was swollen, bruised, and tender to the touch. The Nurse's Note, dated 09/29/24 at 06:00 PM, documented R128's grandson was in the facility and felt R128's right knee should be X-rayed. The staff documented the physician would be notified to see if the portable X-ray Service could come to the facility to X-ray her right knee. The X-Ray Report, dated 10/02/24, documented R128 had an acute fracture of the right tibia. The Physician's Order, dated 07/31/24, directed staff to administer Acetaminophen (pain medication), 650 milligrams (mg), by mouth, as needed, every 24 hours for pain. The Physician's Order, directed staff to not allow R128 to bear any weight due to the fracture in the right leg below the knee. The EMR documented R128 passed away on 10/10/24. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 01/23/25 at 10:30 AM, Certified Medication Aide (CMA) T stated R128 was on hospice, cognitively impaired, and non-ambulatory before the fall. CMA T further stated R128 was bedbound after the fall. On 01/22/25 at 04:25 PM, Administrative Nurse D stated she interviewed the CNA and discovered the CNA was not holding on to the gait belt when she ambulated the resident. Administrative Nurse D stated as they were walking, R128's right knee buckled and the CNA tried to keep her from falling by grabbing under her armpits, but her right knee hit the ground. Administrative Nurse D stated the CNA had not followed R128's care plan. The facility's Falls and Fall Risk, Managing policy, dated 2001. documented based on previous evaluations and current data, and staff would identify interventions related to the resident's specific risks and causes to try to prevent the resident from failing and to try to minimize complications from falling. If interventions have been successful in preventing falling. Staff would continue the interventions or reconsider whether these measures are still needed if a problem that required the intervention has been resolved. If the resident continued to fall, staff would reevaluate the situation and whether it was appropriate to continue or charge current interventions. As needed, the attending physician would help the staff reconsider possible causes that may not previously have been identified. The staff and/or physician would document the basis for conclusions that specific irreversible risk factors exist that continue to present a risk for falling or injury due to falls. The facility failed to follow R128's care plan which resulted in a tibia fracture This deficient practice placed the resident at risk for further falls and avoidable injury. - The Electronic Medical Record (EMR) for R4 documented diagnoses of diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), hypertension (high blood pressure), pain, congestive heart failure (CHF - a condition with low heart output and the boy becomes congested with fluid), edema (swelling resulting from an excessive accumulation of fluid in the body tissues), trochanteric fracture of the right femur (a break in the thigh bone), and atrial fibrillation (rapid, irregular heart rate). The Quarterly Minimum Data Set (MDS), dated [DATE], documented R4 had intact cognition. R4 was dependent upon staff for toileting, supervision with mobility, transfers, and ambulation. R4 had upper functional impairment on one side, was at risk for falls, and had two falls with injury, and one non-injury fall. The Fall Care Area Assessment (CAA), dated 09/23/24, documented R4 was a high risk for falls, had functional limitations to her left upper extremity, had repeated falls, and muscle weakness. The Fall Risk Assessments, dated 12/24/24, 01/06/25, and 01/13/25 documented R4 was at risk for falls. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	The Care Plan dated 12/19/24, initiated on 06/07/23, directed staff to use cloth chucks (absorbent pads used to protect surfaces from stains and moisture) on her bed as she may slide off with paper chucks. The update dated 08/08/24, directed staff to encourage R4 to call for assistance to pick up items off the floor. The update dated 08/28/24, directed staff to place a motion detector in her room. The update dated 09/01/14, directed staff to use her wheelchair or long distances instead of using her walker. The update dated 09/05/24, directed staff to encourage R4 to not sit at the edge of her recliner. The update dated 01/14/25, directed staff to not use paper chucks under her as they can be slippery, and she may fall off of her bed. The Fall Investigation, dated 01/14/25, documented R had an unwitnessed fall, and slid off of the bed between her bed and the wall. The investigation documented R4 was placed on the bedpan at 07:15 AM, and at 07:42 AM, staff heard R4 yell for help. R4 was found between the wall and the bed. R4 was leaning on her left hip with her head and left hand on the bed and holding onto the bedrail with her right hand. The investigation documented the root cause of the fall was a paper chuck was placed under the bedpan and when she repositioned, she slid off of the bed. On 01/21/25 at 12:49 PM, observation revealed Consultant HH removed the foot pedals from R4's wheelchair, and Consultant GG placed a gait belt around R4's waist and placed her walker in front of her. Consultant GG and Consultant HH stood beside R4 and had her stand up, pivot, and sit down on her bed. Consultant GG stated therapy staff transferred the resident during the day as part of her therapy which she received five days per week. Consultant GG swung her legs up onto the bed as Consultant HH raised the head of her bed and placed two pillows behind her head. On 01/23/25 at 10:34 AM, Certified Medication Aide (CMA) T stated staff checked on R4 every 15 to 30 minutes, offered activities, and made sure she had anything she needed before staff left her room. R4 liked to get up on her own and not wait for any staff assistance, so a motion detector was placed in her room. CMA T stated her last fall was from sliding off the bed and the intervention was to not use paper on her bed, only cloth. On 01/23/25 at 01:42 PM, Administrative Nurse D stated staff should not leave a resident on the bedpan for longer than 30 minutes and should follow the care plan when assisting her. Administrative Nurse D further stated staff had placed a paper chuck on the bed and a cloth chuck on top of the paper chuck and have continued reeducation on following resident care plans. The facility's Falls and Fall Risk, Managing policy, dated 2001. documented based on previous evaluations and current data, staff would identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. If interventions have been successful in preventing falling. Staff would continue the interventions or reconsider whether these measures are still needed if a problem that required the interventions has resolved. If the resident continued to fall, staff would reevaluate the situation and whether it was appropriate to continue or charge current interventions. As needed, the attending physician would help the staff reconsider possible causes that may not previously have been identified. The staff and/or physician would document the basis for conclusions that specific irreversible risk factors exist that continue to present a risk for falling or injury due to falls. The facility failed to follow R4's care plan of not using paper chucks under the resident, which resulted in R4 sliding off of the bed. This placed the resident at risk for further falls and avoidable injury.

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32360 The facility had a census of 26 residents. The sample included 12 residents, with one reviewed for hydration. Based on observation, record review, and interview, the facility failed to monitor Resident (R) 4's physician-ordered fluid restriction. This placed the resident at risk of complications related to fluid overload. Finding included: - The Electronic Medical Record (EMR) for R4 documented diagnoses of congestive heart failure (CHF - a condition with low heart output and the body becomes congested with fluid), edema (swelling resulting from an excessive accumulation of fluid in the body tissues), diabetes mellitus (DM - when the body cannot use glucose, no enough insulin is made, or the body cannot respond to the insulin), hypertension (high blood pressure), and pain. The Quarterly Minimum Data Set (MDS), dated [DATE], documented R4 had intact cognition. R4 required supervision with mobility, transfers, ambulation, and set-up assistance with eating. R4 had upper functional impairment on one side, was occasionally incontinent of urine, and had pain. R4 received a diuretic (medication to promote the formation and excretion of urine) medication. R4's Care Plan dated 12/19/24, initiated on 06/7/23, documented R4 had the potential for fluid volume deficit related to diuretic therapy. The care plan directed staff to administer medications as ordered, weigh her as ordered, monitor for fluid overload, and ensure R4 was on a 2000 milliliter (ml) per 24-hour fluid restriction. The care plan directed staff to educate R4 on the risks versus benefits as she at times chose to go over the ordered fluids in 24 hours. The Physician's Order, dated 06/22/24, directed a fluid restriction of 2000 ml in 24 hours every shift for fluid monitoring. The Treatment Administration Record (TAR) for November 2024 lacked documentation staff monitored R4's fluid restriction on the following days: 11/14/24- dayshift 11/22/24-dayshift 11/26/24-dayshift 11/27/24-dayshift The Treatment Administration Record (TAR) for December 2024 lacked documentation staff monitored R4's fluid restriction on the following days: 12/06/24-dayshift 12/09/24-dayshift (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12/13/24-nightshift 12/14/24-nightshift 12/19/24-nightshift 12/24/24-dayshift 12/25/24-dayshift 12/26/24-dayshift 12/27/24-dayshift 12/29/24-dayshift 12/31/24-dayshift The Treatment Administration Record (TAR) for January 2025 lacked documentation staff monitored R4's fluid restriction on the following days: 01/2/25-dayshift 01/05/25-dayshift 01/17/25-dayshift 01/18/25-dayshift 01/20/25-dayshift 01/21/25-dayshift 01/01/25-nightshift 01/04/25-nightshift On 01/22/25 at 08:30 AM, R4 was in bed eating her breakfast and had an empty plastic jug and a small empty juice glass in front of her. R4 asked Certified Nurse Aide (CNA) O if she could have more to drink as she had already drank all of her water and juice. CNA O went to the medication cart and asked Certified Medication Aide (CMA) S if she could have more water. CNA O stated she seemed to be more thirsty on her new medication, and she was given 150 ml extra to drink. CMA S stated she would talk with the nurse about R4's fluid restriction. On 01/23/25 at 10:34 AM, CMA S stated nursing staff were responsible for documenting R4's fluid amounts per shift and the charge nurse monitored the total at the end of the day. CMA S further stated R had been hard to keep compliant with the restriction as she would try to get extra fluids herself or other staff. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/23/25 at 01:42 PM, Administrative Nurse D stated nursing staff were very good at documenting R4's fluid totals at the end of the shift and the nurse was to look at the amounts and document them in the TAR. Administrative Nurse D verified there were blanks in the documentation and also stated that she had worked over the weekend and probably did not document the totals for the shift she had worked. The facility's Encouraging and Restricting Fluids policy, dated 10/10, documented staff to verify that there was a physician's order for a fluid restriction and review the care plan to assess for any special needs of the resident. Staff were to follow specific instructions concerning fluid intake or restrictions and were to be accurate when recording the fluid intakes. Staff record fluid intake in ml's and encourage the resident's family and visitors to stay within the limit of his or her intake. The facility failed to monitor R4's physician-ordered fluid restriction. This placed R4 at risk of complications related to fluid overload.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32358 The facility had a census of 26 residents. The sample included 12 residents with five reviewed for unnecessary medications. The facility failed to ensure the Consultant Pharmacist (CP) reviewed each resident's drug regimen monthly and reported irregularities to the attending physician, the facility medical director, and the director of nursing monthly for Residents' (R) 4, R8, R9, R11, and R22. Findings included: - R9's Electronic Medical Record (EMR) documented that R9 had diagnoses of major depressive disorder (major mood disorder that causes persistent feelings of sadness), psychotic disturbance (any major mental disorder characterized by a gross impairment in reality perception), and mood disturbance (category of mental health problems, feelings of sadness, helplessness, guilt, and wanting to die were more intense and persistent than what may normally be felt from time to time). R9's Significant Change Minimum Data Set (MDS), dated [DATE], documented R9 had a Brief Interview of Mental Status (BIMS) score of four which indicated severe cognitive impairment. The MDS documented R9 dependent on staff with most activities of daily living (ADL). The MDS documented R9 receive and antiplatelet (medications that prevent platelets from clumping together and forming blood clots), antidepressant (a class of medications used to treat mood disorders), diuretic (a medication to promote the formation and excretion of urine), opioid (a class of controlled drugs used to treat pain), hypoglycemic (medication used to lower blood sugar), and anticonvulsant (medications used to prevent or control seizures (convulsions) medications during the observation period. R9's Psychotropic Care Area Assessment (CAA), dated 10/25/24, documented that R9 had a diagnoses of hypertension (elevated blood pressure), diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), and chronic pain. R9's Care Plan, revised 11/04/24, documented all medications and gradual dose reductions (GDRs) would be reviewed monthly and as needed (PRN) by the pharmacist. R9's EMR from 01/01/24 to 01/01/25 lacked monthly CP regimen reviews for the last year. On 01/22/25 at 07:45 AM, observation revealed R9 resting in bed with eyes closed. On 01/23/25 at 08:28 AM, Administrative Nurse D verified the lack of monthly CP regimen reviews and stated the medical records personnel usually received e-mails from the CP with the reviews and then would pass the information on to her in the morning meetings. Administrative Nurse D stated it had been a while since she had received any information regarding monthly CP regimen reviews. The facility's Medication Regimen Review Policy, revised May 2019, documented the CP would review the medications of each resident at least monthly. The facility failed to ensure the CP completed monthly medication regimen reviews for R9. This placed him at risk for receiving inappropriate doses of medications. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- R11's EMR documented R11 had diagnoses of psychotic disturbance, mood disturbance, hypertension (elevated blood pressure), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin). R11's Quarterly MDS, dated [DATE], documented R11 had a BIMS of three which indicated severe cognitive impairment. The MDS documented R11 received an antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality), antidepressant (a class of medications used to treat mood disorders), and antiplatelet (medications that prevent platelets from clumping together and forming blood clots) during the observation period. R11's Care Plan, revised 01/05/25, instructed staff to review my medications with the physician and CP and for duplicate medications consult with CP. A review of R11's EMR from 01/01/24 to 01/01/25, revealed a lack of monthly CP medication regimen reviews. 01/22/25 at 08:00 PM, observation revealed R11's room door closed, and staff reported the resident sleeping. On 01/23/25 at 08:28 AM, Administrative Nurse D verified the lack of monthly CP regimen reviews and stated the medical records personnel usually received e-mails from the CP with the reviews and then would pass the information on to her in the morning meetings. Administrative Nurse D stated it had been a while since she had received any information regarding monthly CP regimen reviews. The facility's Medication Regimen Review Policy, revised May 2019, documented the CP would review the medications of each resident at least monthly. The facility failed to ensure the CP completed monthly medication regimen reviews for R9. This placed him at risk for receiving inappropriate doses of medications. - R22's EMR documented R22 had diagnoses of atrial fibrillation (rapid, irregular heartbeat), use of anticoagulants (a class of medications used to prevent the blood from clotting), hypertension (HTN - elevated blood pressure), hyperlipidemia (condition of elevated blood lipid levels), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). R22's Quarterly MDS, dated [DATE], documented R22 had a BIMS of five, which indicated severe cognitive impairment. The MDS documented R22 dependent on staff with putting on and taking off footwear, required substantial, maximal staff assistance with showering, lower body dressing, personal hygiene, sitting to lying, lying to sitting, chair to bed transfers, supervision with upper body dressing, set up with eating, and independent with rolling left to right in bed. The MDS documented R22 received antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality), antidepressant (a class of medications used to treat mood disorders), anticoagulant (a class of medications used to prevent the blood from clotting), diuretic (a medication to promote the formation and excretion of urine), and antiplatelet (a class of medications that prevent blood clots from forming) medications during the observation period. R22's Care Plan, revised 11/10/24, documented the CP would review R22's medications monthly. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R22's EMR from 01/01/24 to 01/01/25 lacked documentation the CP conducted a medication regime review monthly On 01/22/25 at 07:25 AM. observation revealed R22 sat quietly in a wheelchair in the living area by the nurse's station with television on. On 01/23/25 at 08:28 AM, Administrative Nurse D verified the lack of monthly CP regimen reviews and stated the medical records personnel usually received e-mails from the CP with the reviews and then would pass the information on to her in the morning meetings. Administrative Nurse D stated it had been a while since she had received any information regarding monthly CP regimen reviews. The facility's Medication Regimen Review Policy, revised May 2019, documented the CP would review the medications of each resident at least monthly. The facility failed to ensure the CP completed monthly medication regimen reviews for R9. This placed him at risk for receiving unnecessary medications. 32360 - The Electronic Medical Record (EMR) for R4 documented diagnoses of diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), hypertension (high blood pressure), pain, congestive heart failure (CHF - a condition with low heart output and the boy becomes congested with fluid), edema (swelling resulting from an excessive accumulation of fluid in the body tissues), trochanteric fracture of the right femur (a break in the thigh bone), atrial fibrillation (rapid, irregular heart rate), and chronic obstructive pulmonary disease (COPD - a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing). The Quarterly Minimum Data Set (MDS), dated [DATE], documented R4 had intact cognition. The MDS documented R4 was dependent on staff for toileting and required supervision with mobility, transfers, and ambulation. The MDS documented R4 received insulin (a hormone that lowers the level of glucose in the blood), antidepressant (a class of medications used to treat mood disorders), anticoagulant (a class of medications used to prevent blood from clotting), diuretic (a medication to promote the formation and secretion of urine), and opioid (a class of controlled drugs used to treat pain) medication during the observation period. The Care Plan dated 12/19/24, initiated on 05/30/23, documented all medications and gradual dose reductions (gdr) would be reviewed monthly, as needed by the pharmacist consultant, and every 60 days or as needed by the physician and they would notify the facility nurse with any recommendations and or new orders. R4's EMR from 01/01/24 to 01/01/25 lacked documentation the Consultant Pharmacist (CP) conducted a medication regimen review monthly except for 02/24 and 09/24. On 01/22/25 at 08:30 AM, observation revealed R4, in bed eating her breakfast. R4 stated she was having a good day and was not in any pain. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/23/25 at 01:42 PM, Administrative Nurse D verified the lack of monthly CP regimen reviews and stated the medical records personnel usually received e-mails from the CP with the reviews and then would pass the information on to her in the morning meetings. Administrative Nurse D stated it had been a while since she had received any information regarding the monthly CP regimen reviews. The facility's Medication Regimen Review policy, revised May 2019, documented the CP would review each resident's medications at least monthly. The facility failed to ensure the CP completed monthly regimen reviews for R4. This placed her at risk for receiving unnecessary medications. - The Electronic Medical Record (EMR) for R8 documented diagnoses of 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), hypertension (high blood pressure), and pain. The Significant Change Minimum Data Set (MDS), dated [DATE], documented R8 had intact cognition. R8 required substantial assistance from staff for showers, transfers, ambulation, and set-up assistance for personal hygiene, and lower body dressing. R8 was independent with toileting and mobility. The MDS further documented R8 received antidepressant (a class of medication used to treat mood disorders), antianxiety (a class of medication that calms and relaxes people), diuretic (a medication to promote the formation and excretion of urine), and opioid (a class of controlled drugs used to treat pain) during the observation period. The Care Plan, dated 12/03/24, initiated on 08/11/22, documented R8's medications would be reviewed by the pharmacist consultant (CP) monthly, by a physician every 60 days, and by both as needed. R8's EMR from 01/01/24 to 01/01/25 lacked documentation the Consultant Pharmacist (CP) conducted a medication regimen review monthly. On 01/22/25 at 08:00 AM, Certified Medication Aide (CMA) U administered R8's medications without issue. On 01/23/25 at 01:42 PM, Administrative Nurse D verified the lack of monthly CP regimen reviews and stated the medical records personnel usually received e-mails from the CP with the reviews and then would pass the information on to her in the morning meetings. Administrative Nurse D stated it had been a while since she had received any information regarding the monthly CP regimen reviews. The facility's Medication Regimen Review policy, revised May 2019, documented the CP would review each residents medications at least monthly. The facility failed to ensure the CP completed monthly regimen reviews for R8. This deficient practice placed him at risk for receiving unnecessary medications.

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	175299	A. Building B. Wing	01/23/2025

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32358 The facility had a census of 26 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to employ a full-time certified dietary manager for the 26 residents who resided in the facility and received meals from the facility kitchen. This placed the residents at risk for inadequate nutrition. Findings included: - On 01/22/24, a review of the noon meal consisted of meatloaf, peas, mashed potatoes, and gravy On 01/22/24 at 11:00 AM, observation revealed Dietary Staff BB in the kitchen overseeing the preparation of the noon meal. On 01/21/24 at 08:28 AM, Dietary Staff BB verified he was not a Certified Dietary Manager (CDM). Dietary Staff BB stated he did not want to be a CDM, had [AGE] years of food service experience, and had agreed to overlook the kitchen until the facility hired one. On 01/22/24 at 01:55 PM, Administrative Staff A verified Dietary Staff BB had no dietary manager certification. The facility's Dietician Policy, revised 11/2022, documented that If a dietician was not employed full-time (35 or more hours per week) a director of food and nutrition services would be designated. This individual would: a. be a certified dietary manager or b. be a certified food service manager or c. be nationally certified in food service management and safety: or d. has an associate (or higher) degree in food service management or hospitality, if the course includes food service or rest management from an accredited institution or e. has worked two or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, 2020, that included topics integral to managing dietary operations including, but not limited to foodborne illness, sanitation procedures, and food purchasing, receiving: and meet state requirements for food service or diet managers and f. receives frequently scheduled consultations from a qualified dietician or qualified nutrition professional (continued on next page)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility failed to employ a full-time certified dietary manager for 35 residents who resided in the facility and received meals from the kitchen. This deficient practice placed the residents at risk for not receiving adequate nutrition.

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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. 32358 The facility had a census of 26 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to store, prepare, distribute, and serve food by professional standards for food service safety in the facility kitchen. This placed the residents who received their meals from the facility's kitchens at risk for foodborne illness. Findings included: - On 01/21/24 at 09:45 AM, observation in the kitchen revealed a two-door refrigerator had three unlabeled undated orange jello and two cottage cheese Styrofoam cups. On 01/21/24 at 08:50 AM, Dietary Staff (DS) BB verified the above finding and stated staff should label and date food before they place it in the refrigerator. DS BB discarded the items into the trash can. On 01/22/24 at 10:30 AM, observation in the kitchen revealed the following: A white upright freezer located in the hall between the kitchen and dry storage had a five-gallon container, approximately 1/4 full of orange sherbert with numerous different areas of dried orange substance on the outside of the container. An area on the ceiling located by the dry storage entrance door had a dried brown stain approximately 14 inches (in) wide by 18 in long. A lower cabinet located below the desert counter had three missing drawers. A white upper cabinet, located above the dishwasher where the clean dishes return, had an area 1 1/2 in by 1 in with peeling paint. The wall above the dirty side of the dishwasher entrance had numerous different size chips in the paint. The white pipes underneath the dishwasher had a grayish-black substance on them. The three-door freezer located in the hall between the kitchen and dry storage had an unsealed package of Polish sausage. On 01/22/25 at 11:00 AM, DS BB verified the above findings, and stated staff should make sure food item packages are sealed before placing them in the freezer. DS BB stated a work order had been put into maintenance regarding the missing cupboard drawers. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 01/22/25 at 02:51 PM, Maintenance Staff (MS) U stated that when staff see something broken, they place a work order request in the maintenance box located inside the service hall. MS U stated he was aware of the missing drawers in the kitchen cabinet, they had broken, and he had baskets to go into the drawer openings but had not installed them yet. The facility's Food Receiving and Storage Policy, undated, documented all foods stored in the refrigerator or freezer would be covered, labeled, and dated with the use by date. The facility failed to store, prepare, distribute, and serve food by professional standards for food service safety for the 26 residents who received their meals from the facility's kitchen. This deficient practice placed the 26 residents at risk for foodborne illness.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 32360 The facility had a census of 26 residents. The sample included 12 residents. Based on record review and interview, the facility failed to implement a water management program for waterborne pathogens including Legionella disease (Legionella is a bacterium that can cause pneumonia in vulnerable populations). This placed the residents in the facility at risk for infectious disease. Findings included: - On 01/22/25 at 02:51 PM, Maintenance Staff U stated he did not have any type of diagram of the facility's water system or a water management program in place to prevent the growth of Legionella or any other water-borne pathogen. On 01/23/25 at 03:30 PM, Administrative Staff A stated she was unaware that Maintenance Staff U did not have a water management program in place. The facility's Legionella Water Management Program policy, dated 07/17, documented the facility had a water management program that was overseen by the water management team. The water management program included a Legionella Risk Assessment, a detailed description, and diagram of the water system in the facility. The program also included; identification of areas in the water system that could encourage the growth and spread of Legionella or other waterborne bacteria. The water management program would have specific measures used to control the introduction and/or spread of Legion. The program included a plan for when control limits were not met or effective, and the program would be reviewed at least once a year, or sooner if needed. The facility failed to implement a water management program to test and manage waterborne pathogens. This deficient practice placed the residents who reside in the facility at risk of contracting Legion pneumonia.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 32358 The facility had a census of 26 residents. Based on record review and interview, the facility failed to ensure three of five Certified Nurse Aides (CNA) completed their required 12-hour annual in-service. This placed the residents at risk for receiving unskilled care. Findings included: - On 01/22/23, a review of CNA M, CNA N, and Certified Medication Aide (CMA) R and CMA S's annual in-service hours lacked evidence the staff had the required 12 hours of in-service training. On 01/22/24 at 09:30 AM, Administrative Staff A verified the facility lacked documentation the above staff completed their required 12-hour in-services. The Facility Assessment, revised July 31, 2024, documented the facility would ensure the continuing competence of nurse aides and annual required 12-hour in-services. The facility's Inservice Training, Nurse Aide Policy, revised in August 2022, documented the facility would complete a performance review of nurse aides every 12 months. Annual in-services ensure the continuing competency of nurse aides and are no less than 12 hours per employment year. The facility failed to ensure CNAs received their annual required 12-hour in-services. This deficient practice placed the residents at risk for receiving unskilled care.