STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175338	A. Building B. Wing	06/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Baldwin Healthcare & Rehab Center, LLC	1223 Orchard Lane Baldwin City, KS 66006

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 45668 The facility identified a census of 53 residents. The sample included 16 residents with one resident reviewed for dignity. Based on observation, interview, and record review, the facility failed to provide a dignified care environment for Resident (R)40, R41, and R256. This deficient practice placed the residents at risk for impaired dignity and quality of life. Findings Included: - On 06/10/24 at 07:52 AM an inspection of the hallway behind the activity room revealed a clear file box attached to the wall. A grievance form completed by Resident (R)256's resident representative was placed in the clear box with the details of the grievance visibly displayed. On 06/10/24 at 12:19 AM R41 sat in his Broda chair (specialized wheelchair with the ability to tilt and recline) in the dining room. R40's indwelling urinary catheter (a tube inserted into the bladder to drain urine into a collection bag) tubing ran down the right side of his chair and hung in the lower back of his chair. R41's urinary collection bag lacked a privacy (dignity) cover. Urine was visible in the collection bag. On 06/11/24 at 07:21 AM R40 approached the nurse's station on his electric mobility scooter. R40's urinary catheter ran down the right side of his leg and his urine collection was attached to the handlebars of his electric scooter. R40's catheter bag had no privacy cover or dignity bag. Visible urine pooled in the tubing and collection bag as he sat at the nurse's station. On 06/11/24 at 01:05 PM Social Service Staff X stated R256's grievance form was accidentally placed in the wrong box by a new kitchen staff member. She stated the grievances should be placed in the locked grievance box in the main hallway. On 06/12/24 at 12:05 AM Certified Nurse's Aide (CNA) M stated all indwelling catheters should have a privacy bag to ensure the resident's dignity was maintained. She stated grievance forms should be confidential and turned directly in to the social service staff. On 06/12/24 at 12:15 PM Licensed Nurse (LN) H stated the indwelling catheter should be placed below the level of the bladder and with a dignity bag. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/12/24 at 12:35 PM Administrative Nurse D acknowledged staff placed R256's grievance form in the wrong box and had already re-educated the staff about the correct grievance process. She stated every resident with an indwelling catheter should be placed in a dignity bag when out in public areas. The facility's Promoting and Maintaining Resident Dignity 09/2020 indicated the facility would protect and promote each resident's rights and promote an environment that maintains or enhances dignity. The facility failed to provide a dignified care environment for R40, R41, and R256. This deficient practice placed the residents at risk for impaired dignity and quality of life.

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49634 The facility identified a census of 53 residents. The sample included 16 residents. One resident was sampled for reasonable accommodations of resident needs and preferences. Based on observation, record review, and interview, the facility failed to ensure that resident (R)1 had foot pedals on her wheelchair while being pushed. This deficient practice left R1 vulnerable to preventable accidents and injuries due to unmet care needs. Findings included: - R1's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), pain, hypertension (HTN-elevated blood pressure), functional urinary incontinence, dysphagia (swallowing difficulty), bipolar disorder (major mental illness that caused people to have episodes of severe high and low moods), and congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid). The Admission Minimum Data Set (MDS) dated [DATE] recorded a Brief Interview for Mental Status (BIMS) score of 12 which indicated moderately impaired cognition. The MDS recorded R1 was dependent on staff for all activities of daily living (ADLs) except eating, for which she was independent. R1 required the assistance of one staff member for sit-to-stand and chair/bed-to-chair transfers. The MDS stated R1 was dependent on staff for wheelchair mobility. R1's Cognitive Loss Care Area Assessment (CAA) dated 08/05/23 documented R1 had short-term and long-term memory issues. R1 had impaired decision-making abilities. R1 was monitored for signs and symptoms of all medication. Staff was to speak to her using short, simple sentences to ensure an adequate understanding of what was being said to her. R1's family was encouraged to visit and decorate her room with familiar belongings. Activities are provided to keep her engaged in activities of her choice. R1 was to be redirected and tasks were broken down to ensure she was able to help with her activities of daily living (ADLs). R1's Care Plan dated 11/11/23 documented R1 needed assistance with ADLs related to CHF. The plan of care documented R1 required extensive assistance of two staff with a stand-up lift when moving between surfaces during care. The plan of care documented R1 was dependent on staff for wheelchair mobility. On 06/10/24 at 07:42 AM, an unidentified staff member pushed R1 in the wheelchair down the 100 halls. R1 did not have foot pedals. R1 had her left foot raised, and her, right foot was dragging on the floor. On 06/10/24 at 01:39 PM R1 was pushed without foot pedals in the 100 halls, she stated she was on her way to play bingo, in the dining room. R1 had her left foot raised and her right foot was dragging on the floor. On 06/12/24 at 12:02 PM Certified Nursing Aide (CNA) stated if a resident is being pushed by a staff member, their wheelchair pedals should be on their wheelchair. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/12/24 at 12:15 PM Licensed Nurse (LN) H stated all residents should have foot pedals if being pushed by staff. On 06/12/24 at 12:28 PM Administrative Nurse D stated residents should not be pushed by staff unless they have foot pedals on their wheelchairs. The facility policy Accommodation of Needs policy documented the facility will treat each resident with respect and dignity and will evaluate and make reasonable accommodations for the individual needs and preferences of a resident, except when the health and safety of the individual or other residents would be endangered. The facility failed to provide foot pedals for R1's wheelchair. This deficient practice left R1 vulnerable to preventable accidents and injuries due to unmet care needs.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41037 The facility identified a census of 53 residents. The sample included 16 residents with one resident reviewed for a baseline care plan. Based on observation, record review, and interviews, the facility failed to develop a person-centered baseline care plan for Resident (R) 304 to include his hemodialysis (a procedure where impurities or wastes were removed from the blood) provider, days of the week, and time for dialysis. This deficient practice placed R304 at risk of impaired care related to uncommunicated care needs. Findings included: - R304's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of chronic kidney disease, pulmonary edema (accumulation of extravascular fluid in the lung tissues), and heart failure. R304 was admitted on [DATE] and transferred to the hospital on 05/23/24. The Admission Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 13 which indicated intact cognition. The MDS documented R304 had received dialysis services during the observation period. R304's Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA) dated 05/23/24 documented he was dependent on staff assistance for activities of daily living (ADL) and had an indwelling catheter (tube placed in the bladder to drain urine into a collection bag). R304's baseline Care Plan dated 05/15/24 documented the facility would monitor lab work and report to the physician as needed. The plan of care documented the nursing staff would monitor vital signs per facility protocol and notify the physician of significant abnormalities. The plan of care documented nursing staff would monitor, document, and report as needed any signs or symptoms of infection to access the site for redness, swelling, warmth, or drainage. The baseline care plan lacked the dialysis provider, days of the week, and times for dialysis. R304's EMR under the Orders tab revealed the following physician orders: R304's dialysis was provided on Monday, Wednesday, and Friday. Departure time at 12:40 PM and chair time 02:00 PM dated 05/15/24. Complete pre and post-dialysis communication form: Obtain weight and vital signs before and after dialysis. Notify the physician if systolic blood pressure (SBP-relating to the phase of the heartbeat when the heart muscle contracts and pumps blood from the chambers into the arteries greater) (>) 190 millimeters of mercury (mmHg) or less (<) 80 mmHg, diastolic blood pressure (DBP-minimum level of blood pressure measured between contractions of the heart; the bottom number of a blood pressure reading) >105mmHg or < 45mmHg, heart rate >110 or <45, temperature >100 degrees, and oxygen sats <88% in the evening every Monday, Wednesday, and Friday for post dialysis. Ensure that his binder was brought back, dated 05/15/24. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Complete pre and post-dialysis communication form: Obtain weight and vital signs before and after dialysis. Notify the physician if SBP >190mmHg or < 80mmHg, DBP >105mmHg or <45mmHg, heart rate >110 or <45, temperature >100 degrees, and oxygen saturation <88% every Monday, Wednesday, and Friday for pre-dialysis to be completed prior to leaving for chair time of 02:00 PM. Assure this information was in the white dialysis binder for R304 and the binder was sent with R304 dated 05/15/24. Remove the dialysis dressing at bedtime every dialysis day. Notify the physician as indicated for bleeding or discomfort every night every Monday, Wednesday, and Friday dated 05/15/24. No blood pressure was obtained from the right arm. Monitor port site on right chest every shift. Notify the physician and director of nursing immediately of swelling, numbness, decreased temperature, increased pain, prolonged bleeding, redness, or fluid leakage. Insert a progress note of any changes to the port site on the left upper extremity dated 05/15/24. A review of R304's EMR under the Misc tab of the Dialysis Communication Form revealed two forms. The communication form dated 05/15/24 lacked a post-dialysis assessment documented. The communication form dated 05/20/24 lacked evidence of pre-dialysis assessment and the dialysis provider had documented under the post-dialysis section of the communication form. The dialysis communication sheet dated 05/20/24 had documented by the dialysis provider that R304's condition was poor, and his access site had bleeding. R304's clinical record lacked evidence of physician notification or post-assessment. The EMR lacked evidence of a dialysis communication sheet for 05/17/24. R304's EMR lacked evidence of communication with the dialysis provider. R304's May 2024 Medication Administration Record (MAR) and Treatment Administration record (TAR) lacked documentation of a pre-dialysis assessment dated [DATE]. On 06/12/24 at 12:02 PM, Certified Nurse Aide (CNA) M stated she did not have access to the resident's care plan. CNA M stated there was a resident information sheet at the nurse's desk. CNA M stated she was not sure how often the sheets were updated. CNA M stated she was not sure if the information sheets included dialysis information. On 06/12/24 at 12:15 PM, Licensed Nurse (LN) H stated she was not sure if the care plan included dialysis information. LN H stated some dialysis information was on the MAR and TARs. LN H stated if the dialysis provider was not listed on the MAR or TAR she would check the transportation log for that information. LN H stated she was not sure how an agency would know to check the transportation log for the dialysis provider. LN H stated Administrative Nurse E was responsible for initiating and completing the baseline care plan. On 06/12/24 at 12:28 PM, Administrative Nurse D stated she expected the baseline care plan to include dialysis information. Administrative Nurse D stated the baseline would include the dialysis provider's, phone number and address. Administrative Nurse D stated Administrative Nurse E would initiate and complete the care planning. Administrative Nurse D stated everyone had access to the care plan or Kardex (a nursing tool that gives a brief overview of the care needs of each resident). The facility's Baseline Care Plan policy dated 02/01/20 documented the facility would develop and implement a baseline care plan for each resident that included the instructions needed to provide effective and person-centered care of the resident that meets professional standards of quality care. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility failed to develop a baseline care plan for R304 to include his physician orders for the hemodialysis provider, days of the week, and time for dialysis. This deficient practice placed R304 at risk of impaired care related to uncommunicated care needs.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41713 The facility identified a census of 53 residents. The sample included 16 residents. Based on observation, record review, and interview, the facility failed to ensure Resident (R) 51's comprehensive care plan was updated to include staff direction on the collaboration between the dialysis (a procedure where impurities or wastes were removed from the blood) clinic and the facility. The facility failed to ensure the care plan was updated with interventions to direct staff on the days, times, location, and contact numbers of R51's dialysis treatment clinic. This placed R51 at risk for complications related to dialysis due to uncommunicated care needs. Findings included: - The Electronic Medical Record (EMR) for R51 documented diagnosis of end-stage renal disease (ESRD-a terminal disease of the kidneys) and type 2 diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made, or the body cannot respond to the insulin). R51's Admission Minimum Data Set (MDS) dated [DATE] documented R51 had a Brief Interview for Mental Status (BIMS) score of 14 which indicated intact cognition. R51 had impairment on both sides of his lower extremities and required the use of a walker and/or wheelchair to assist with mobility. R51 required partial/moderate to substantial/maximal assistance with his activities of daily living (ADLs) and functional abilities. R51 required dialysis treatment. R51's Functional Abilities Care Area Assessment (CAA) dated 05/29/24 documented R51 required substantial to maximal assistance with care and was occasionally incontinent of bowel and bladder and remained a fall risk due to weakness and discomfort. R51 received hemodialysis. R51's Care Plan initiated on 05/20/24 directed staff to not draw blood or take blood pressure in the arm with the graft. Staff was directed to monitor the fistula (abnormal passage from an internal organ to the body surface or between two internal organs) to the right forearm. Staff was directed to monitor R51's intake and output. Monitor labs and report to the doctor as needed. Staff was directed to monitor vital signs per facility protocol and notify the physician of significant abnormalities. Staff was to monitor, document, and report as needed any signs or symptoms of infection to access the site for redness, swelling, warmth, or drainage. R51's Care Plan lacked staff direction on the location, days, times, chair time, and contact number for the dialysis clinic. R51's Order Summary in the EMR documented the following orders and or treatments: Dialysis Center: Resident receives dialysis services on Monday, Wednesday, and Friday with a departure time of 10:00 AM and a chair time of 11:00 AM dated 05/21/2024. Dialysis: Print a new medication list/order summary to send to dialysis the first week of every month and put the medication list in a personalized dialysis binder every Monday, Wednesday, and Friday for Dialysis communication, dated 05/20/2024. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dialysis: Remove dialysis dressing at bedtime every dialysis day Monday, Wednesday, and Friday; notify physician as indicated for bleeding or discomfort for monitoring, dated 05/20/2024. A high-protein snack was to be provided every Monday, Wednesday, and Friday upon arrival from dialysis. Document on the Treatment Administration Report (TAR) an A for accepted or R for refused one time a day every Monday, Wednesday, and Friday, dated 05/24/2024. Monitor the fistula/graft site for signs/symptoms of infection, edema, and bleeding upon return from dialysis and notify the physician if any signs are noted. If the site was bleeding apply pressure for 15 minutes and notify the physician and if the bleeding did not stop, twice daily and as needed, dated 05/20/2024. No blood pressure was obtained from the right arm. Monitor the fistula site at specify location every shift. Assess thrill and bruit. Notify the physician immediately of left upper extremity swelling, numbness, decreased temperature, increased pain, prolonged bleeding, redness, distended fistula, or fluid leakage. Insert progress note of any changes to fistula site to right upper extremity every shift, dated 05/21/2024. Obtain daily weight everyday shift for weight management, dated 06/06/2024. On 06/12/24 at 08:03 AM R51 sat in his wheelchair as he propelled himself to the dining room for breakfast. On 06/12/24 at 12:02 Certified Nurse Aide (CNA) M said she did not have access to the care plan, but the aides did have access to the Kardex (a nursing tool that gives a brief overview of the care needs of each resident) that had what amount of care each resident needed. CNA M stated she knew R51 was on dialysis and was to keep track of how much he ate and to let the nurse know of any changes to the arm the fistula was in. On 06/12/24 at 12:10 PM, Licensed Nurse (LN) H stated R51's care plan should be updated to include the location of the dialysis center, when he went, and how to get a hold of the clinic. LN H stated residents on dialysis each had dialysis books. LN H stated each time R51 went to dialysis a communication sheet was sent with him. LN H stated that Administrative Nurse E was responsible for updating the care plans. LN H stated the nurses could add interventions, but Administrative Nurse E was the primary person to make changes to the care plan. On 06/12/24 at 12:26 PM Administrative Nurse D stated Administrative Nurse E was the staff member responsible for creating the care plans and developing the comprehensive care plans after the MDS was completed. Administrative Nurse D stated R51's care plan should have been updated with all the information about when, where, what time, and the chair time for his dialysis so staff was aware of that information. Administrative Nurse D stated that typically the residents' main screen in the EMR should have special instructions documented regarding the dialysis. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy Comprehensive Care Plans implemented 02/01/20 documented: that it was the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident. The comprehensive care plan would be developed within seven days after the completion of the comprehensive MDS assessment. The comprehensive care plan would describe at a minimum any specialized services that were to be furnished to maintain the resident's highest practicable physical, mental, and psychosocial well-being. The facility failed to ensure R51's comprehensive care plan was updated with interventions to direct staff on the days, time, and location and contact number of R51's dialysis treatment clinic. The facility failed to ensure R51's comprehensive care plan was updated to include staff direction on the collaboration between the dialysis This placed R51 at risk for complications related to dialysis due to uncommunicated care needs.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 45668 The facility had a census of 53 residents. The sample included 16 residents with two reviewed for accidents. Based on observation, record review, and interview the facility failed to secure hazardous cleaning chemicals in a safe, locked area, and out of reach of the seven cognitively impaired, independently mobile residents. This placed the affected residents at risk for preventable accidents. Findings Included: - On 06/10/24 at 07:10 AM an inspection of the facility's south hall revealed an unattended shower room with the entry door propped open. An inspection of an unlocked closet inside the shower room revealed a full-gallon bottle of bleach, purple disinfectant wipes, and several cleaning spray cans left on the shelf inside the closet. All the cleaning products identified contained the warning, Keep out of reach of children, hazardous to humans can cause eye irritation, harmful if swallowed. An unsecured closet had a sign with Door should be locked at all times on it. An unidentified staff member secured the closet door at 07:12 AM. On 06/12/24 at 12:04 PM Certified Nurses Aid (CNA) H indicated hazardous cleaning chemicals should always be supervised or locked up when not in use to prevent exposure to the residents. She stated cleaning products were stored in locked closets or the secured laundry room. On 06/12/24 at 12:15 PM Licensed Nurse H stated staff were to ensure the shower rooms were not left unsecured. She stated the cleaning closets should remain locked. On 06/12/24 at 12:31 PM Administrative Nurse D stated staff were expected to ensure areas with hazardous chemicals remained locked. She stated staff were expected to monitor the use of cleaning chemicals and keep them out of reach from the residents. The facility's Cleaning and Disinfection of Resident-Care Equipment dated 03/2020 indicated resident care equipment will be cleaned and sanitized in accordance with Centers for Disease Control (CDC) standards. The policy noted all approved cleaning materials will be utilized and stored in a safe manner to prevent chemical exposure to the residents and staff. The facility failed to secure chemicals in a safe, locked area, and out of reach of the seven cognitively impaired, independently mobile residents. This placed the affected residents at risk for preventable accidents.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41037 The facility identified a census of 53 residents. The sample included 16 residents with two residents reviewed for hemodialysis (a procedure using a machine to remove excess water, solutes, and toxins from the blood in people whose kidneys can no longer perform these functions naturally). Based on observation, record review, and interviews, the facility failed to obtain communication from the dialysis center and assess the pre-dialysis and post-dialysis status for Resident (R) 304. This deficient practice placed R304 at risk of potential adverse outcomes and physical complications related to dialysis. Findings included: - R304's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of chronic kidney disease, pulmonary edema (accumulation of extravascular fluid in the lung tissues), and heart failure. R304 was admitted on [DATE] and transferred to the hospital on 05/23/24. The Admission 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 R304 had received dialysis services during the observation period. R304's Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA) dated 05/23/24 documented he was dependent on staff assistance for activities of daily living (ADL) and had an indwelling catheter (tube placed in the bladder to drain urine into a collection bag). R304's Care Plan dated 05/15/24 documented the facility would monitor lab work and report to the physician as needed. The plan of care documented the nursing staff would monitor vital signs per facility protocol and notify the physician of significant abnormalities. The plan of care documented nursing staff would monitor, document, and report as needed any signs or symptoms of infection to access site: redness, swelling, warmth, or drainage. The plan of care dated 05/21/24 documented that the facility would monitor the port site on the right upper chest. R304's EMR under the Orders tab revealed the following physician orders: R304's dialysis was provided on Monday, Wednesday, and Friday. Departure time at 12:40 PM and chair time 02:00 PM dated 05/15/24. Complete pre and post-dialysis communication form: Obtain weight and vital signs before and after dialysis. Notify the physician if systolic blood pressure (SBP-relating to the phase of the heartbeat when the heart muscle contracts and pumps blood from the chambers into the arteries greater) (>) 190 millimeters of mercury (mmHg) or less (<) 80 mmHg, diastolic blood pressure (DBP-minimum level of blood pressure measured between contractions of the heart; the bottom number of a blood pressure reading) >105mmHg or < 45mmHg, heart rate >110 or <45, temperature >100 degrees, and oxygen sats <88% in the evening every Monday, Wednesday, and Friday for post dialysis. Ensure that his binder was brought back, dated 05/15/24. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Complete pre and post-dialysis communication form: Obtain weight and vital signs before and after dialysis. Notify the physician if SBP >190mmHg or < 80mmHg, DBP >105mmHg or <45mmHg, heart rate >110 or <45, temperature >100 degrees, and oxygen saturation <88% every Monday, Wednesday, and Friday for pre-dialysis to be completed prior to leaving for chair time of 02:00 PM. Assure this information was in the white dialysis binder for R304 and the binder was sent with R304 dated 05/15/24. Remove the dialysis dressing at bedtime every dialysis day. Notify the physician as indicated for bleeding or discomfort every night every Monday, Wednesday, and Friday dated 05/15/24. No blood pressure was obtained from the right arm. Monitor port site on right chest every shift. Notify the physician and director of nursing immediately of swelling, numbness, decreased temperature, increased pain, prolonged bleeding, redness, or fluid leakage. Insert a progress note of any changes to the port site on the left upper extremity dated 05/15/24. A review of R304's EMR under the Misc tab of the Dialysis Communication Form revealed two forms. The communication form dated 05/15/24 lacked a post-dialysis assessment documented. The communication form dated 05/20/24 lacked evidence of pre-dialysis assessment and the dialysis provider had documented under the post-dialysis section of the communication form. The dialysis communication sheet dated 05/20/24 had documented by the dialysis provider that R304's condition was poor, and his access site had bleeding. R304's clinical record lacked evidence of physician notification or post-assessment. The EMR lacked evidence of a dialysis communication sheet for 05/17/24. R304's EMR lacked evidence of communication with the dialysis provider. R304's May 2024 Medication Administration Record (MAR) and Treatment Administration record (TAR) lacked documentation of a pre-dialysis assessment dated [DATE]. On 06/12/24 at 07:58 AM, Administrative Staff A stated R304 had received dialysis services on 05/15/24, and 05/17/24, and only received about half of a dialysis session related to his access site had collapsed on 05/20/24. Administrative Staff, A stated confirmed R304's EMR lacked evidence of a post-dialysis assessment on 05/20/24. Administrative Staff A stated R304 had been transported to the dialysis provider on 05/22/24 and the provider had refused to treat R304. On 06/12/24 at 12:15 PM, Licensed Nurse (LN) H stated she would assess a resident's dialysis access site at least daily and document the assessment on the MAR. LN H stated the nurse would complete a pre-dialysis assessment and a post-dialysis assessment for a resident who received hemodialysis. LN H stated the assessment information was documented on the Dialysis Communication Form and sent with the resident to the dialysis provider. LN H stated the communication sheets were scanned into the resident's EMR. On 06/12/24 at 12:28 PM, Administrative Nurse D stated most of a resident's information related to dialysis was located on the MAR or TAR. Administrative Nurse D stated she would expect there to be communication between the facility and the dialysis provider. Administrative Nurse D stated she expected the nurse to call the dialysis provider and get a verbal report from the dialysis provider if the dialysis communication sheet was not returned or lacked documentation from the provider. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Hemodialysis policy dated 01/01/20 documented that the facility would provide the necessary care and treatment, consistent with professional standards of practice, physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences, to meet the special medical, nursing, mental, and psychosocial needs of residents receiving hemodialysis. Ongoing assessment and oversight of the resident before, during, and after dialysis treatments, including monitoring of the resident's condition during treatments, monitoring for complications, implementation of appropriate interventions, and using appropriate infection control practices: and ongoing communication and collaboration with the dialysis facility regarding dialysis care and services. The facility failed to obtain communication from the dialysis center and assess the pre-dialysis and post-dialysis clinical status for R304. These deficient practices placed R304 at risk of potential adverse outcomes and physical complications related to dialysis.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 41713 The facility identified a census of 53 residents. The sample included 16 residents. Based on observation, record review, and interview, the facility failed to ensure nurse staffing data was posted daily. Findings included: - On 06/11/24 at approximately 07:15 AM, an initial tour of the facility revealed the posted daily nurse staffing hour data was dated 06/07/24. On 06/12/24 at 12:26 PM Administrative Nurse D stated that the staffing coordinator was responsible for posting the nurse staffing data daily and the charge nurse was responsible for posting on the weekends. Administrative Nurse D stated that the weekend staffing sheets were behind the sheet from 06/07/24. The facility policy Nurse Staffing Posting Information implemented on 12/01/19 documented it was the policy of this facility to make staffing information readily available in a readable format to residents and visitors at any given time. The facility would post the nurse staffing data at the beginning of each shift. The information would be posted in a clear and readable format and in a prominent place readily accessible to residents and visitors. The facility failed to ensure daily nurse staffing data was posted as required.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. 45668 The facility reported a census of 53 residents. The sample included 16 residents with five reviewed for unnecessary medications. Based on record review, observations, and interviews, the facility failed to follow orders related to medication monitoring when the facility administered Resident (R)50's anti-hypertensive beta-blocker (class of medication used to treat high blood pressure) medication on multiple occasions outside the physician ordered parameters without physician notification. This deficient practice placed R50 at increased risk for unnecessary medication and side effects. Findings included: - The Medical Diagnosis section within R50's Electronic Medical Records (EMR) included diagnoses of hypertension (high blood pressure), dementia (a progressive mental disorder characterized by failing memory, and confusion), restless leg syndrome, and Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness). R50's Admission Minimum Data Assessment (MDS) completed 04/06/24 noted a Brief Interview for Mental Status (BIMS) score of 12 indicating mild cognitive impairment. The MDS indicated he was dependent on staff for transfers, bed mobility, bathing, dressing, and personal hygiene. R50's Dementia Care Area Assessment (CAA) completed 04/08/24 indicated he had poor short and long-term memory and impaired decision-making abilities. The CAA encourages staff to communicate with short and simple sentences to ensure adequate understanding. R50's Functional Abilities CAA completed 04/08/24 indicated he was dependent on staff for all care. The CAA indicated he had a history of falls and was at risk for skin impairment related to his limited mobility. The CAA noted his goal was to remain at his long-term care facility. R50's Care Plan initiated 03/31/24 indicated he required maximal to total dependence from staff for bed mobility, transfers, dressing, toileting, personal hygiene, and bathing. The plan indicated he was at risk for altered cardiovascular status related to his hypertension. The plan encouraged staff to monitor him for shortness of breath, chest pain, and abnormalities related to his hypertension. R50's EMR under Physician's Orders revealed an order dated 03/30/24 to administer 50 milligrams (mg) of metoprolol (antihypertensive medication) by mouth twice daily for his hypertension. The order instructed staff to hold the medication if his systolic blood pressure (SBP-relating to the phase of the heartbeat when the heart muscle contracts and pumps blood from the chambers into the arteries) was less than (<) 110 millimeters of mercury (mmHg) or diastolic blood pressure (DBP-minimum level of blood pressure measured between contractions of the heart; the bottom number of a blood pressure reading) was less than (<) 60mmHg. R50's EMR under Medication Administration Record (MAR) between 03/31/24 through 06/11/24 (72 days reviewed) indicated his metoprolol medication was given outside the ordered physician's parameters on 05/01/24 (morning), 05/01/24 (evening). 06/02/24 (morning dose), 06/02/24 (evening dose), 06/03/24 (morning dose), 06/03/24 (evening dose), 06/09/24 (evening dose). (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/12/24 at 07:34 AM Licensed Nurse (LN) G assessed R50's blood pressure. His blood pressure was within the given parameters for his metoprolol. R50's metoprolol was administered. On 06/12/24 at 12:15 PM Licensed Nurse H stated that licensed staff should mark in the EMR that a medication was held due to the ordered parameters. She stated the physician would be notified of the held medication and a progress note would be completed. On 06/12/24 at 12:31 PM Administrative Nurse D stated staff were expected to follow the medication parameters per the physician's orders. She stated the MAR required staff to enter a specific reason the medication was held if out of parameters. The facility's Provisions of Physicians Ordered Services policy (undocumented) indicated the facility will ensure services, medications, and treatments ordered by the medical provider by accurately followed and the clinical provider be notified of changes or missed treatments. The facility failed to follow orders related to medication monitoring when the facility administered R50's anti-hypertensive beta-blocker medication on multiple occasions outside the physician-ordered parameters without physician notification. This deficient practice placed R50 at increased risk for unnecessary medication and side effects.

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F 0758 Level of Harm - Minimal harm or potential for actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49634 The facility had a census of 53 residents. The sample included 16 residents with five reviewed for unnecessary medications. Based on observation, record review, and interview the facility failed to ensure a gradual dose reduction (GDR) was attempted or addressed by the physician for Resident (R) 43's antipsychotic (class of medications used to treat a mental disorder characterized by a gross impairment testing) medication, who had a diagnosis of dementia (a progressive mental disorder characterized by failing memory and confusion). This placed the resident at risk for unnecessary psychotropic (alters perception, mood, consciousness, cognition, or behavior) medications and related complications. Findings included: - R43's Electronic Medical Record (EMR) documented the resident had diagnoses of dementia without behavioral disturbance, anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), major depressive disorder (major depressive disorder (major mood disorder which causes persistent feelings of sadness), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), hypertension (HTN-elevated blood pressure), hemiparesis/hemiplegia (weakness and paralysis on one side of the body), and cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain). 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 R43 depended on staff assistance for activities of daily living (ADLs), except eating for which R43 was independent, after set up. The MDS documented R43 received antipsychotic medication and no GDR was attempted during the observation period. R43's Psychotropic Drug Use Care Area Assessment (CAA) dated 12/10/23 documented R43 was admitted to hospice after COVID-19 (highly contagious respiratory virus). R43 required partial to moderate assistance with care, and she was frequently incontinent of bowel and bladder. R43 was a fall risk due to left-sided paralysis. R43 was at risk for impaired skin due to incontinence. R43 was currently receiving Risperidone (antipsychotic medication) for dementia with behaviors. R43's goal is to remain in long-term care with hospice. R43's Care Plan dated 02/15/23 documented R43 was prescribed psychotropic medication and was at risk for complications due to behavior psychosis. The plan of care directed staff to administer medications as ordered. R43's plan of care documented the facility should consult with the pharmacy and physician to consider a GDR when clinically appropriate, at least quarterly. R43's EMR under the Orders tab revealed the following physician's orders: Risperidone (antipsychotic) 0.5 milligrams (mg) give two tabs in the evening for major depressive disorder dated 12/15/22 (discontinued). (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Risperidone 0.5mg give two tabs in the evening for major depressive disorder with psychosis dated 11/17/23 (discontinued). Risperdal (risperidone) 0.5 mg by mouth, one tablet every morning, and two tablets by mouth every evening for major depression disorder with psychosis dated 02/26/24. The Monthly Medication Review (MMR), from June 2023 documented a recommendation to consider a GDR for the Risperdal. The physician marked no to the GDR and checked a dose reduction would impair the resident's function because the targeted behaviors were persistent and a dose reduction would cause psychiatric instability by exacerbating her psychiatric disorder. R43's Pharmacy Consult dated 09/20/23 and 05/15/24, documented the risperidone order was prescribed for a diagnosed condition and not being used for convenience or discipline, the physician documented yes, The risperidone order was clinically indicated to manage a resident's symptoms or condition where other cause have been ruled out, the physician documented yes. The signs, symptoms, or related causes are persistent or clinically significant enough to warrant the initiation or continuation of medication therapy, the physician documented yes. The indicated or actual benefit is sufficient to justify the potential risk or adverse consequences associated with the medication, dose, and duration, the physician documented yes. The behavior and physical symptoms targeted for the use of risperidone for this resident included psychosis and rejection of care. The Monthly Medication Review (MMR), from July 2023 through June 2024 did not identify attempts for a GDR for R1's antipsychotic medication and lacked evidence the physician documented a justification for not attempting a GDR. On 06/10/24 at 11:17 AM, observation revealed R43 sat in the dining room visiting with peers. On 06/12/24 at 12:28 PM Administrative Nurse D stated the facility relies on the pharmacist to let the physician know if a resident is due for a gradual reduction, or if the diagnosis is correctly indicated for antipsychotic medications. The facility's Gradual Dose Reduction of Psychotropic Drugs policy dated 01/01/20 documented that Residents who use psychotropic drugs receive gradual dose reductions and behavioral interventions unless clinically contraindicated, in an effect to discontinue these drugs. The facility failed to ensure a GDR was attempted for R43's antipsychotic medication, who had a diagnosis of dementia. This placed the resident at risk for unnecessary psychotropic medications and related complications.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 45668 The facility identified a census of 53 residents. The facility identified 11 residents on enhanced barrier precautions (EBP-infection control interventions designed to reduce transmission of resistant organisms which employs targeted gown and glove use during high contact care). Based on record review, observations, and interviews, the facility failed to follow sanitary infection control standards related to enhanced barrier precautions, wound care, disinfection of mechanical lifts, and maintaining oxygen therapy equipment. These deficient practices placed the residents at risk for infectious diseases. Findings Included: - On 06/10/24 at 07:08 AM an inspection of Resident (R) 1's room revealed her supplemental oxygen tubing rested on the back of her wheelchair next to her canister. No clean bag or storage device was in the room to store the oxygen equipment when not in use. On 06/10/24 at 07:08 AM R7's oxygen tubing and nasal cannula lay under her bed. No clean bag or storage device was in the room to store the oxygen therapy equipment when not in use. On 06/10/24 at 07:08 AM R25's oxygen nasal cannula and tubing lay on the floor next to her room's recliner. No clean barrier bag was in the room to store the oxygen equipment when not in use. R25's room had no enhanced barrier precaution signage or personal protective equipment posted in or around her room for her wound care. On 06/10/24 at 07:15 AM an inspection of R204's room revealed no enhanced barrier precaution signage or personal protective equipment posted in or around his room related to his dialysis (a procedure where impurities or wastes were removed from the blood) care. R204's nebulizer mask (a device used to administer medication in the form of a mist inhaled into the lungs) sat directly on his room's recliner. No clean bag or storage device was in the room to store the oxygen equipment when not in use. On 06/10/24 at 07:21 AM an inspection of R49's room revealed no enhanced barrier precaution signage or personal protective equipment posted in or around his room for his wound care. On 06/10/24 at 09:10 AM R306's oxygen tubing and nasal cannula lay on his bed on top of a used incontinent pad. R306's oxygen nebulizer mask sat directly on the room's air conditioner unit. No clean bag or storage device was in the room to store the oxygen equipment when not in use. On 06/11/24 at 08:02 AM, an unidentified staff pushed the Hoyer lift (full-body mechanical lift) into R43's room and completed a transfer. Upon exiting the room staff did not sanitize the machine before parking it in the 100 Hallway. On 06/12/24 at 11:21 AM R306's nebulizer mask again sat on the room's air conditioning unit. No clean bag or storage device was in the room to store the oxygen therapy equipment when not in use. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 06/12/24 at 11:00 AM Administrative Nurse E prepped R10 for wound care. Administrative Nurse E placed the wound care supplies directly on the bedside table without a clean barrier. In the process of wound care to R10's penis, Administrative Nurse E did not perform gloves changes when switched between dirty-to-clean surfaces, placed her soiled glove in her pocket to retrieve a pen without changing gloves before continuing wound care, and did not complete hand hygiene after eventually changing her gloves. She stated mechanical lifts should be disinfected before and after use. On 06/12/24 at 12:15 PM Certified Nurses Aid (CNA) M stated oxygen therapy equipment should be stored in a clean plastic bag when not in use. She stated hand hygiene should be complete after removing gloves and when visibly soiled. She stated the mechanical lifts should be disinfected before and after use. On 06/12/24 at 12:15 PM Licensed Nurse H stated oxygen tubing and equipment needed to be placed in a bag when not in use. She stated each room should have a clean bag for each resident's equipment. She stated clean barriers should be placed before setting down supplies and equipment for wound care. She stated hand hygiene should be completed in between glove changes. On 06/12/24 at 12:31 PM Administrative Nurse D stated residents on enhanced barrier precautions should have signs posted either in their rooms or at the doorway. She stated staff were required to complete hand hygiene before entry. She stated staff were expected to wear gloves and protective gowns prior to providing high-risk care. She stated staff were expected to store the oxygen therapy equipment in a clean plastic bag when not in use. She stated clean barriers, frequent glove changes, and hand hygiene should have been completed during wound care. The facility's Enhanced Barrier Precautions policy implemented 04/2024 indicated the facility would train and provide the appropriate protective equipment. The policy indicated the facility would have discretion on how to communicate to staff which residents required enhanced barrier precautions. The facility's Infection Prevention and Control Program policy (undated) indicates the facility will ensure safe infection control practices are implemented and followed. The policy indicated shared equipment will be cleaned before and after use or when visibly soiled. The policy indicated staff will complete hand hygiene before during and after contact with residents or potentially soiled surfaces. The policy indicated therapy equipment will be stored in a manner that prevents contamination. The facility failed to follow sanitary infection control standards related to enhanced barrier precautions, sanitary wound care, disinfection of mechanical lifts, and maintaining oxygen therapy equipment. These deficient practices placed the residents at risk for infectious diseases.