STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175344	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sandpiper Healthcare & Rehabilitation Center	5808 W 8th Street North Wichita, KS 67212

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27168 The facility had a census of 74 residents. The sample included 18 residents with two residents reviewed for transfers. Based on record review and interviews, the facility failed to provide written notification within a practicable timeframe of a facility-initiated transfer to Resident (R) 25 and R6. The facility further failed to notify the State Long Term Care Ombudsman (LTCO) of facility-initiated transfers/discharges for R25 and R6. This deficient practice placed the residents at risk of uninformed care choices and impaired rights. Findings included: - R25's Electronic Medical Record (EMR) recorded diagnoses 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), Methicillin-resistant Staphylococcus aureus (MRSA-a type of bacteria resistant to many antibiotics), osteomyelitis (local or generalized infection of the bone and bone marrow), metabolic encephalopathy (ME-neurological disorder that occurs when a chemical imbalance in the blood affects the brain), and discitis (a rare but serious infection and inflammation of the intervertebral disc in the spine.) R25's Quarterly Minimum Data Set (MDS), dated [DATE] recorded R25 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS recorded R25 required staff assistance with most activities of daily living (ADLs). The MDS recorded the resident received a diuretic (a medication to promote the formation and excretion of urine) and opioid (a class of controlled drugs used to treat pain) medication during the observation period. The Activities of Daily Living (ADLs) Care Area Assessment (CAA), dated 05/21/24, recorded R25 required assistance with ADLs due to impaired balance during transfers, and functional impairment in activity due to weakness and obesity. The CAA recorded the resident had chronic pain. R25's Care Plan, dated 09/10/24 recorded that R25 exhibited an alteration in comfort due to demobilization from a recent hospital stay due to metabolic encephalopathy, discitis, and osteomyelitis. The staff would monitor for pain and try nonpharmacological attempts first and if unsuccessful administer pharmacologic interventions. The care plan documented the resident required chronic use of antibiotics and staff would monitor for ongoing signs of infection and notify the physician as needed. The care plan recorded the resident had a diagnosis of MRSA in her spine wound and staff would wear personal protective equipment (PPE) when providing care. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Nurse's Note dated 09/25/24 at 07:40 AM documented R25 called 911 and reported pain. Emergency Medical Services arrived at 06:59 AM and transported the resident to the hospital. The 10/04/24 hospital transfer notes documented that R25 had worsening discitis and an abscess (cavity containing pus and surrounded by inflamed tissue). The resident's hospital stay included a laminectomy (a surgical procedure that removes part or all of the vertebra) of thoracic (mid-spine) level 7-9 and a spinal fusion at thoracic level 5-11. R25's clinical record lacked evidence a written notice of transfer was provided to the resident. The facility was unable to provide evidence the facility notified the LTCO of the resident's transfer/discharge from the facility. On 11/05/24 at 03:45 PM, observation revealed R25 lying in bed on her back. Licensed Nurse (LN) K administered Vancomycin (antibiotic) 2.25 grams per intravenous (IV-administered directly into the bloodstream via a vein) solution per a peripherally inserted central catheter (PICC-a thin, flexible tube that is inserted into a vein in the upper arm and threaded into a large vein above the heart) line for spinal osteomyelitis. On 11/05/24 at 01:00 PM, Administrative Staff B stated the facility sent a report monthly to the LTCO that included the residents who were discharged home but stated she did not include residents who were discharged to the hospital. The facility's Transfer and Discharge policy, dated 01/09/24, documented it was the policy of the facility to permit each resident to remain in the facility, and not transfer or discharge the resident from the facility except in limited situations when the health and safety of the individual or the other residents are endangered. For emergency transfers, the resident would be provided a notice of bed hold policy as well as the representative at the time of transfer, but no later than 24 hours of the transfer the social service director, or designee would provide the notice of transfer to a representative of the state long term care ombudsman by way of a monthly list. The facility failed to provide a written notification of transfer to R25 as soon as practicable. The facility further failed to notify the State LTCO of transfers/discharges for R25. This deficient practice placed R25 at risk for uninformed care choices and impaired rights. 32360 - The Electronic Medical Record (EMR) for R6 documented diagnoses of diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made, or the body cannot respond to the insulin), schizoaffective (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and legal blindness. The Quarterly Minimum Data Set (MDS), dated [DATE], documented R6 had intact cognition. R6 required substantial assistance with showers, dressing, mobility, and transfers. R6 received insulin (a hormone that lowers the level of glucose in the blood) daily. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R6's Care Plan, dated 09/10/24 and initiated on 05/13/24, documented R6 exhibited an alteration in generalized discomfort due to decreased mobility and was able to voice pain as necessary. The update dated 06/13/24 documented R6 was dependent upon staff for transfers and did not ambulate. The update, dated 08/02/24, directed staff to use a two-person assist and a walker for transfers. The Progress Note dated 10/05/24 at 02:08 PM, documented R6 was admitted to the hospital for pain. R6's clinical record lacked evidence the resident was provided a written notice when she was transferred to the hospital. The facility was unable to provide evidence the facility notified the LTCO of the transfer. On 11/06/24 at 08:15 AM, observation revealed R6 sat in her wheelchair and listened to a podcast on her phone. R6 stated she had been at the hospital due to pain in her back and had not received any type of written notice when she had been sent to the hospital. On 11/06/24 at 09:46 AM, Administrative Staff E verified she did not have verification that any written notice was provided to R6 when she went to the hospital. Administrative Staff E further stated she did not send a notice of R6's transfer to the LTCO and was unaware she was supposed to for hospital transfers. On 11/06/24 at 12:50 PM, Administrative Nurse D stated she was unaware if a written notice of transfer was provided to R6 when she went to the hospital. The facility's Transfer and Discharge policy, dated 01/09/24, documented that each resident was permitted to remain in the facility and not transfer or discharge the resident except in limited situations when the health and safety of the individual or other residents were endangered. The policy further documented that for emergency transfers, the resident was provided, as well as the representative a notice of transfer. The Social Service Director or designee shall provide notice of transfer to a representative of the state long-term care ombudsman via a monthly list. The facility failed to provide R6 written notice as soon as practicable for R6's facility-initiated transfer to the hospital and also failed to notify the LTCO. This placed R6 at risk of uninformed care choices and impaired rights.

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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 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27168 The facility had a census of 74 residents. The sample included 18 residents. Based on observation, record review, and interview, the facility failed to provide Resident (R)26 and R6 with written information regarding the facility bed hold policy when they were transferred to the hospital. This placed the resident at risk of not being permitted to return and resume residence in the nursing facility and in the same room. Findings included: - R25's Electronic Medical Record (EMR) recorded diagnoses 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), Methicillin-resistant Staphylococcus aureus (MRSA-a type of bacteria resistant to many antibiotics), osteomyelitis (local or generalized infection of the bone and bone marrow), metabolic encephalopathy (ME-neurological disorder that occurs when a chemical imbalance in the blood affects the brain), and discitis (a rare but serious infection and inflammation of the intervertebral disc in the spine.) R25's Quarterly Minimum Data Set (MDS), dated [DATE] recorded R25 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS recorded R25 required staff assistance with most activities of daily living (ADLs). The MDS recorded the resident received a diuretic (a medication to promote the formation and excretion of urine) and opioid (a class of controlled drugs used to treat pain) medication during the observation period. The Activities of Daily Living (ADLs) Care Area Assessment (CAA), dated 05/21/24, recorded R25 required assistance with ADLs due to impaired balance during transfers, and functional impairment in activity due to weakness and obesity. The CAA recorded the resident had chronic pain. R25's Care Plan, dated 09/10/24 recorded that R25 exhibited an alteration in comfort due to demobilization from a recent hospital stay due to metabolic encephalopathy, discitis, and osteomyelitis. The staff would monitor for pain and try nonpharmacological attempts first and if unsuccessful administer pharmacologic interventions. The care plan documented the resident required chronic use of antibiotics and staff would monitor for ongoing signs of infection and notify the physician as needed. The care plan recorded the resident had a diagnosis of MRSA in her spine wound and staff would wear personal protective equipment (PPE) when providing care. A Nurse's Note dated 09/25/24 at 07:40 AM documented R25 called 911 and reported pain. Emergency Medical Services arrived at 06:59 AM and transported the resident to the hospital. The 10/04/24 hospital transfer notes documented that R25 had worsening discitis and an abscess (cavity containing pus and surrounded by inflamed tissue). The resident's hospital stay included a laminectomy (a surgical procedure that removes part or all of the vertebra) of thoracic (mid-spine) level 7-9 and a spinal fusion at thoracic level 5-11. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R25's clinical record lacked evidence a copy of the bed hold policy was provided to the resident and the facility was unable to provide evidence upon request. On 11/05/24 at 03:45 PM, observation revealed R25 lying in bed on her back. Licensed Nurse (LN) K administered Vancomycin (antibiotic) 2.25 grams per intravenous (IV-administered directly into the bloodstream via a vein) solution per a peripherally inserted central catheter (PICC-a thin, flexible tube that is inserted into a vein in the upper arm and threaded into a large vein above the heart) line for spinal osteomyelitis. On 11/05/24 at 08:30 AM, Administrative Staff B verified the facility had not provided the resident the bed hold notice when she was discharged /transferred to the hospital. The facility's Bed Hold Notice Upon Transfer policy, dated February 2023, documented at the time of transfer for hospitalization or therapeutic leave, the facility would provide to the resident and/or the resident representative written notice which specifies the duration of the bed-hold policy and addresses information explaining the return of the resident to the next available bed. In the event of an emergency transfer of a resident, the facility would provide within 24 hours written notice of the facility's bed hold policies, as stipulated in the State's plan. The facility would keep a signed and dated copy of the bed hold notice information given to the resident and/or resident representative in the resident's file. The facility failed to provide R25 with a copy of the facility bed hold policy when she was transferred to the hospital. This placed the resident at risk of not being permitted to return and resume residence in the nursing facility and in the same room. 32360 - The Electronic Medical Record (EMR) for R6 documented diagnoses of diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made, or the body cannot respond to the insulin), schizoaffective (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and legal blindness. The Quarterly Minimum Data Set (MDS), dated [DATE], documented R6 had intact cognition. R6 required substantial assistance with showers, dressing, mobility, and transfers. R6 received insulin (a hormone that lowers the level of glucose in the blood) daily. R6's Care Plan, dated 09/10/24 and initiated on 05/13/24, documented R6 exhibited an alteration in generalized discomfort due to decreased mobility and was able to voice pain as necessary. The update dated 06/13/24 documented R6 was dependent upon staff for transfers and did not ambulate. The update, dated 08/02/24, directed staff to use a two-person assist and a walker for transfers. The Progress Note dated 10/05/24 at 02:08 PM, documented R6 was admitted to the hospital for pain. R6's clinical record lacked evidence the resident was provided a bedhold policy when she was transferred to the hospital and the facility was unable to provide evidence upon request. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/06/24 at 08:15 AM, observation revealed R6 sat in her wheelchair and listened to a podcast on her phone. R6 stated she had been at the hospital due to pain in her back and had not received a bedhold policy when she was sent to the hospital. On 11/06/24 at 07:45 AM, Licensed nurse (LN) G stated she did not know what the bed hold policy was and did not know if one was sent with R6 when she went to the hospital. On 11/06/24 at 09:46 AM, Administrative Staff E stated that if she was working and a resident was sent to the hospital, she would send a bed hold agreement with them. Administrative Staff E stated she did not keep any verification or documentation if the agreement was sent with R6 when she went to the hospital. On 11/06/24 at 12:50 PM, Administrative Nurse D stated she was unaware if the bed hold policy was provided to the R6 at the time of transfer. The facility's Bed Hold Notice Upon Transfer updated policy, documented at the time of transfer for hospitalization s or therapeutic leave, the facility would provide to the resident and/or the resident representative written notice which specifies the duration of the bed hold policy and addresses information explaining the return of the resident the next available bed. The facility failed to provide R6 with the bed hold notice which specifies the duration of the bed hold when she was transferred to the hospital. This placed R6 at risk of not being permitted to return and resume residence in the facility and in the same room.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26768 The facility had a census of 74 residents. The sample included 18 residents with two residents reviewed for pressure ulcers (PU-localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction). Based on observation, interview, and record review the facility failed to initiate interventions to mitigate risks for the development of pressure ulcers for Resident (R) 128, who developed two facility-aquired pressure injuries. This deficient practice placed R128 at risk for further pressure-related injury and related complications. Findings included: - R128's Electronic Medical Record (EMR) documented diagnoses of atrial fibrillation (rapid, irregular heartbeat), hypertension (elevated blood pressure), anemia (an inadequate number of healthy red blood cells to carry adequate oxygen to body tissues), pneumonia (a lung infection) and history of a hip fracture. The Admission Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of seven, indicating severely impaired cognition. The MDS documented that R128 required moderate staff assistance for toileting, dressing, standing, and transfers. The MDS documented R128 was at risk for PU but did not currently have one. Interventions included pressure relief to the chair and bed and surgical wound care. The Pressure Ulcer Care Area Assessment (CAA), dated 07/23/24, triggered secondary to R128's potential for pressure ulcers. Contributing factors included functional mobility impairment and incontinence. Risk factors include pain, development of PU, skin condition, and fluid deficit risk. A licensed nurse assessed the resident's skin each week and put proper interventions in place to prevent skin breakdown. Skin was also assessed by caregivers with each bath and each time the resident was dressed. The physician was to be notified of any abnormal findings and treatment orders obtained. The dietitian was monitoring food and fluid intake and implementing dietary interventions as necessary. Caregivers assisted with repositioning at least every two hours and as needed for comfort. A care plan would be initiated to improve R128's current activities of daily living (ADL) status and functional ability, maintain his continence status, prevent pain, and decrease pressure ulcer risk. The CAA documented that no pressure injuries were noted upon admission. The Five Day MDS, dated [DATE], documented that R128 had a BIMS score of seven; R128 required moderate staff assistance for toileting, dressing, standing, and transfers. The MDS documented that R128 was at risk for PU and had one PU, not present on admission. The MDS documented a pressure relief device for R128's chair and bed as well as nutritional interventions and PU care. R128's Braden Scale (a tool used to assess risk for pressure-related injuries), dated 07/20/24, indicated R128 was at mild risk for pressure injuries with a score of 18. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R128's Care Plan documented R128 had an actual impairment to the skin integrity of both heels related to pressure (initiated 09/23/24 and revised on 10/22/024). The plan recorded an intervention dated 08/09/24 that directed staff to encourage R128 to offload his heels as he allowed. The plan documented an intervention initiated on 09/23/24 (and revised 10/22/24)that directed staff to provide R128 heel protectors or a pillow to protect his heels and a blue overlay mattress for his skin while in bed. An intervention dated 10/22/24 recorded that weekly treatment documentation would include measurement of each area of skin breakdown's width, length, depth, the type of tissue and exudate, and any other notable changes or observations. R128's ADL Care Plan initiated on 09/23/24, directed staff to provide substantial or maximal assistance for bed-to-chair transfers, lower body dressing, putting on or taking off footwear, sitting to standing, and toilet transfers. R128's Care Plan lacked interventions to prevent the development of PU prior to 08/08/24. The Skilled Nursing Note, dated 08/08/24 at 06:17 PM, documented no noted skin concerns. The Skilled Nursing Note, dated 08/09/24 at 10:46 AM, documented that staff found a wound on the resident's left heel and notified the wound nurse. The Wound Care Note, dated 08/09/24, documented an initial visit. R128 had a pressure ulcer on his left heel. Orders included a multivitamin in the morning for wound healing, zinc sulfate for wound healing, Arginaid oral packet (protein supplement) two times a day for wound care, and vitamin C two times a day for wound healing for 30 Days. The note recorded that the left heel wound measured 4.1 centimeters (cm) x 3.2 cm x 0.1 cm, and the wound bed was 100 percent (%) eschar (dead tissue). The wound had light serous (thin, clear) drainage, no odor, and the surrounding skin was normal. The note documented the left heel wound was new and gave orders for wound care including to offload (take pressure off) the resident's heels. The Interdisciplinary Team -IDT note, dated 08/12/24, documented that R128 was not wearing heel protectors while in bed with a left hip injury and pressure sustained to the left heel resulted in a wound. The note recorded interventions that included a wound assessment and vascular studies. The note indicated that offloading was obtained. Routine wound care was implemented for optimal healing and the wound specialists would follow routinely. R128's Discharge Assessment, dated 09/17/24 documented the resident was admitted to the facility after a left hip fracture surgery. He received therapy during his stay and had a healing unstageable PU to his left heel that was facility-acquired. He required supervision with ADLs due to weakness and confusion. He ambulated with a walker and standby assistance. The Progress Note, 09/19/24 at 10:03 AM, documented R128 discharged home at 09:55 AM. The Progress Note, 09/20/24 at 03:25 PM, documented that R128's representative brought him back to the facility after being discharged for 24 hours. R128's Braden Scale, dated 09/20/24, documented he had no sensory impairment, was occasionally moist and was chair fast but also noted no mobility limitations and noted R128's nutrition was adequate. The score of 18 indicated R128 was at mild risk for pressure-related injuries. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Wound Care Note, dated 10/04/24, documented R128 had a pressure ulcer to his left heel that was improving. The Wound Care Note, dated 10/11/24 documented R128 had a PU to the right heel that was new, a deep tissue injury to his left plantar (sole or bottom) foot, and an unstageable pressure ulcer to his left heel that was improving. R128 reported that his feet hit the footboard. The footboard was removed from the bed. The right heel wound measured 3.4 cm x 2.2 cm x 0.1 cm. with 90% eschar, 10% granulation, and heavy serous drainage. The left heel wound measured 4.0 cm x 2.6 cm x 0.2 cm, with 40% eschar, 40% slough (dead tissue, usually cream or yellow in color), and 20% granulation. The new deep tissue pressure injury to the left foot, a dry intact blister, measured 3.8 cm x 2.9 cm x 0 cm. The Wound Care Note, dated 10/20/24, documented that the right heel wound measured 3.5cm x 2.6cm x 0. 1 cm with 30% slough and 70% granulation. The left heel wound measured 3.7cm x 2.3cm x 0.1cm with 40% eschar, 40% slough, and 20% granulation. The left plantar wound measured 4.6cm x 3.6cm x 0.1cm with a dry, absorbed blister. The Physician Order, dated 10/23/24, directed staff to administer Vitamin C 250 mg in the morning for wound care. The Wound Care Note, dated 10/25/24, documented R129 had an unstageable pressure ulcer to his left heel that was improving. He also had an unstageable PU to the right heel that was improving and a deep tissue injury to his left plantar foot that had resolved. The footboard had been removed from R128's bed and he wore heel protectors. He had acquired pneumonia (infection of the lungs) and had declined since then. A Physician Order, dated 11/05/24, directed staff to administer Prostat (liquid protein supplement) 30 cubic centimeters (cc) daily for 30 days in the morning for protein supplement. On 11/05/24 at 03:25 PM, observation revealed Licensed Nurse (LN) H donned personal protective equipment (PPE) and changed the wound dressings on R128's heels. LN H removed the dressing on R128's left heel which had a small amount of drainage on the old dressing. LN H changed gloves and disinfected her hands between soiled and clean items. The left heel wound appeared to have slough and granulation mixed, with no drainage noted. LN H applied wound dressings as ordered then wrapped the foot with gauze and ace wrap. LN H removed the right heel PU dressing and cleaned the wound. R128 jumped and stated that it hurt when LN H was cleaning it. The right heel PU and lateral foot wound had moderate drainage. LN H changed gloves and disinfected her hands between soiled and clean items. The lateral foot wound was very dark in the center with slight redness surrounding the wound. Observation revealed an air mattress on the bed, and large pressure relief boots on R128's dresser. LN H talked R128 into wearing the boots while he was in the wheelchair and applied them. LN H then removed her PPE. On 11/06/24 at 11:46 AM, LN J stated R128 was in another unit at first and when he came to the current unit, he already had the pressure ulcer. LN J stated staff were to apply the pressure relief boots at all times when R128 was up and elevate his feet and legs, or place pillows when he doesn't want to wear the boots. LN J stated that R128 already had an air mattress when he moved to the unit. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/06/24 at 12:30 PM, LN I stated staff offloaded R128's heels and applied pressure relief boots before the PU developed. LN I stated upon admission R128 required assistance from one staff for transfers due to a hip fracture and surgery. She stated the left PU developed prior to his transfer to another unit. LN I stated the facility started zinc, vitamin C, and Arginaid after the wounds developed. On 11/07/24 at 10:14 AM, Administrative Nurse E stated upon admission R128 had a Braden scale of 18 and did not qualify for additional pressure relief; he was moving well and was ambulatory. Administrative Nurse E verified that on 08/03/24 R128 had intact skin. She said staff notified her on 08/08/24 of R128's new skin issue and she notified risk management to ascertain the root cause and develop interventions to prevent another PU. Administrative Nurse E stated on 08/09/24 she notified the physician and received orders for a Doppler study (a test to measure the flow of blood through your blood vessels) and the results indicated no issues with blood flow. Administrative Nurse E stated she notified the Wound Advanced Practice Registered Nurse (APRN) to assess and treat the wound. Administrative Nurse E stated R128 was discharged on [DATE], then readmitted on [DATE], and was ambulatory at that time. She stated interventions in place at that time were heel protectors on both feet and a blue overlay air mattress for pressure relief. She stated R128 had pneumonia with hypoxia (inadequate supply of oxygen), cancer, very low hemoglobin (Hgb-measure of blood that carried oxygen to the cells from the lungs and carbon dioxide away from the cells to the lungs), and received blood transfusions. Administrative Nurse E stated the right heel PU was found on 10/09/24. The facility's Pressure Injury Prevention and Management policy, dated 01/01/2020, stated after a thorough assessment the interdisciplinary team would develop a relevant care plan to include measurable goals for prevention and management of pressure injuries with appropriate interventions. The policy stated interventions would be documented in the care plan and communicated to all relevant staff. Any changes to the facility's pressure injury prevention and management processes would be communicated to staff in a timely manner and the resident's care plan would be modified as needed. The facility failed to respond to R128's risk factors for pressure injuries with interventions to prevent the development of PU for R128. This placed R128 at risk for further pressure-related injury and related complications.

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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 - Minimal harm or potential for 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** 26768 The facility had a census of 74 residents. The sample included 18 residents with five reviewed for accidents. Based on observation, interview, and record review the facility failed to provide an environment free from accident hazards when staff failed to use the Hoyer lift (full body mechanical lift) to facilitate a safe transfer for Resident (R) 130 whose admission note indicated she required a Hoyer lift for transfers. This deficient practice placed R130 at risk for falls and potential injury. Findings included: - R130 was admitted to the facility on [DATE]. R130's Electronic Medical Record (EMR) 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), chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), atrial fibrillation (rapid, irregular heartbeat), anemia (an inadequate number of healthy red blood cells to carry adequate oxygen to body tissues), osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain), COVID-19 (highly contagious respiratory virus) with acute and chronic respiratory failure, sepsis (a life-threatening systemic reaction that develops due to infections that cause inflammation throughout the entire body), and neuromuscular dysfunction of bladder. The Admission Minimum Data Set (MDS) was in process. R130's baseline activities of daily living (ADL) care plan, dated 11/01/24 documented R130 required assistance with ADLs related to weakness from recent hospitalization , initiated 11/01/24. The plan noted the resident had safety concerns related to a history of falls or risk for falls (initiated on 11/01/24 and revised on 11/05/24). The plan documented R130's transfer status changed to a mechanical lift, created on 11/05/24 with an initiated date of 11/02/24. The plan documented interventions dated 11/05/24 which directed to be sure R130's call light was within reach and encourage its use, and educate family, caregivers, and the resident on safety reminders and what to do if a fall occurred. R130's baseline care plan also documented the following: Sit to Stand - (6 Independent, 5 Setup or clean-up assistance, 4 Supervision or touching assistance, 3 Partial-Moderate assistance, 2 Substantial/maximal assistance, 1 Dependent, 7 Resident Refused, 9 Not Applicable, 10 Not Attempted due to environmental limitations, 88 Not attempted due to medical condition or safety concerns.) Initiated: 11/05/24 Toilet Transfer - (6 Independent, 5 Setup or clean-up assistance, 4 Supervision or touching assistance, 3 Partial-Moderate assistance, 2 Substantial/maximal assistance, 1 Dependent, 7 Resident Refused, 9 Not Applicable, 10 Not Attempted due to environmental limitations, 88 Not attempted due to medical condition or safety concerns.) Initiated: 11/05/24. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Fall Risk Scale, dated 10/31/24, recorded a score of 40 which indicated a moderate risk for falling. The assessment noted that R130 had no fall history. R130 required a cane or walker for ambulation. She exhibited a weak gait and was aware of her own safety limits. The Progress Note, dated 10/31/24 at 03:39 PM, documented R130 arrived at 11:30 AM, via outside transportation. The note documented that R130 required a Hoyer lift for transfers. The Progress Note, dated 11/02/24 at 05:29 PM, documented a witnessed fall that happened when staff, a nurse, and a Certified Nurse Aide (CNA), were transferring the resident from her wheelchair to her recliner. The note documented the resident's legs buckled, and she had to be lowered to the floor. The note documented that R130 had non-skid shoes on, a gait belt was in use, and the floor was clear and dry. The note documented that R130 was unable to stand or participate fully in transfers. On 11/06/24 at 08:30 AM, observation revealed R130 lying in a low bed with her eyes closed. On 11/06/24 at 10:50 AM, CMA S stated he was unsure how R130 was transferred. On 11/06/24 at 02:35 PM, Administrative Nurse D stated the nameplate with a yellow dot on R130's door indicated the resident required a Hoyer lift. Administrative Nurse D said that with a new admission, the facility placed the transfer status on the door (dot). Administrative Nurse D verified that R130's Care Plan had not included that staff were to use a Hoyer lift and verified the facility was still working on a baseline care plan. The facility's Fall Prevention Program dated 01/02/20 stated each resident would be assessed for the risks of falling and would receive care and services in accordance with the level of risk to minimize the likelihood of falls. Upon admission, the nurse would indicate on the 24-hour report the resident's fall risk and initiate interventions on the baseline care plan. The facility failed to provide an environment free from accident hazards when staff failed to use the Hoyer lift to facilitate a safe transfer for R130 whose admission note indicated she required a Hoyer for transfers. This deficient practice placed R130 at risk for falls and potential injury.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26768 The facility had a census of 74 residents. The sample included 18 residents with one reviewed for urinary catheter (a tube inserted into the bladder to drain the urine into a collection bag). Based on observation, interview, and record review the facility failed to provide adequate catheter care and services within the standards of care for Resident (R) 130. This deficient practice placed R130 at risk for urinary tract infection and other catheter-related complications. Findings included: - R130 was admitted to the facility on [DATE]. R130's Electronic Medical record (EMR) 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), chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), atrial fibrillation (rapid, irregular heartbeat), anemia (an inadequate number of healthy red blood cells to carry adequate oxygen to body tissues), osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain), COVID-19 (highly contagious respiratory virus) with acute and chronic respiratory failure, sepsis (a life-threatening systemic reaction that develops due to infections that cause inflammation throughout the entire body), and neuromuscular dysfunction of bladder. The Admission Minimum Data Set (MDS) was in process. R130's baseline urinary care plan, dated 11/01/24, documented a Foley catheter. Check and change to maintain dignity. Initiated: 11/05/24 Provide good peri-care after incontinent episodes and use a barrier cream to keep her skin healthy. Initiated: 11/05/24 On 11/06/24 at 08:30 AM, observation revealed R130 lying in bed with her eyes closed. Observation revealed a urinary catheter collection bag in a privacy bag hung on the side of the bed to dependent drainage. There was no EBP signage or gowns observed in the room or closet. On 11/06/24 at 02:46 PM, Certified Medication Aide (CMA) R washed her hands and applied gloves but did not don a gown. She used an alcohol wipe on R130's catheter port before and after emptying the bag, then removed her gloves and washed her hands. On 11/07/24 at 07:58 AM, observation revealed R130 lying in bed with the urinary catheter bag on the bare floor by her bed. Certified Nurse Aide (CNA) O verified the catheter bag should not be touching the floor. At that time, without wearing gloves or gown, CNA O moved the catheter bag and touched the tubing on R130's thigh to see if it was kinked. She verified there was no tubing securement device in place. CNA O also verified there were no EBP signs in the room or closet. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/07/24 at 08:40 AM, Administrative Nurse F verified there was no EBP signage in R130's room. Administrative Nurse F verified staff should have initiated EBP for the resident with a catheter, and the catheter bag should not touch the floor. Administrative Nurse F also said staff should have placed a tubing securement device on the catheter tubing. On 11/07/24 at 08:47 AM, Administrative Nurse D verified staff should have worn a gown and gloves while touching the catheter bag and tubing. Administrative Nurse D stated the catheter tubing should have been secured with a Stat-lock (tubing securement device to prevent dislodgement or pain from pulling). The facility's Catheter Care policy stated the facility would ensure that residents with indwelling catheters received appropriate catheter care and maintain their dignity and privacy. Catheter care would be performed every shift, drainage bags would be covered at all times, and staff were to document care and report any concerns to the nurse on duty. The facility failed to provide adequate catheter care and services within the standards of care for R130. This deficient practice placed R130 at risk for urinary tract infection and other catheter-related complications.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26768 The facility had a census of 74 residents. The sample included 18 residents. Based on observation, interview, and record review the facility failed to store and label biologicals adequately when staff failed to date four insulin (medications used to treat high blood glucose levels) pens when opened and failed to remove or dispose of four expired bottles of stock medications. This deficient practice placed Residents (R)9, R27, R71, and R228 at risk of receiving expired, ineffective insulin and other residents at risk of receiving expired ineffective stock medications. Findings included: - On [DATE] at 08:28 AM, observation of the 300-hall medication cart revealed the following: R9's glargine (long-acting insulin) pen without an open date or the discard date. R27's glargine pen without an open date or the discard date. R71's glargine pen without an open date or the discard date. R228's glargine pen without an open date or the discard date. Four expired stock medication bottles: Senna Plus (laxative) expired ,d+[DATE] Thiamin/vitamin B (vitamin supplement) expired ,d+[DATE] Bisacodyl (laxative) expired ,d+[DATE] Allergy relief expired ,d+[DATE] On [DATE] at 08:28 AM, Licensed Nurse (LN) I verified the expiration dates and undated insulin pens. She stated staff were to date the insulin pens when opened. The facility's Medication Storage policy, dated [DATE], stated the facility would ensure all medication on the premises would be stored according to the manufacturer's recommendations. The medication rooms would be routinely inspected by the consultant pharmacist for discontinued and outdated drugs and those medications would be destroyed in accordance with policy. The facility failed to date insulin pens when opened and/or add a discard date for four residents and failed to remove or dispose of expired stock medications, placing the residents at risk of receiving expired or ineffective medications.

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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 74 residents. The sample included 18 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 one kitchen. This placed the residents who received their meals from the facility's kitchen at risk for foodborne illness. Findings included: - On 11/05/24 at 08:15 AM, observation in the kitchen's walk-in freezer revealed the following: Fourteen uncovered, unlabeled, and undated styrofoam bowls of chocolate ice cream on a tray. A three-gallon container of chocolate ice cream with the lid opened and lifted approximately one-half inch. An uncovered, unlabeled, opened, and unsealed plastic bag of shredded carrots. An unlabeled, undated opened, and unsealed plastic bag of breaded fish. On 11/06/24 at 11:00 AM, observation in the kitchen revealed the following: The flour and sugar containers had numerous different-sized blackish-gray areas around the outside and the lids had a greasy gray substance with white particles. Fourteen fluorescent light fixtures, approximately 18 inches by 3 feet, had bugs and debris inside the cover. On 11/05/24 at 08:17 AM, the Dietary Manager (DM) BB verified the above findings in the kitchen's walk-in freezer and stated the bowls of ice cream were old. DM BB said staff should label, date, and make sure the items were in a sealed container before placing them in the freezer. On 11/06/24 at 02:46 PM, DM BB verified the findings in the facility kitchen. DM BB stated he was unsure if maintenance cleaned the ceiling lights but said he would find out. The Kitchen Cleaning Rotation Sheet, had items listed for dietary to clean daily, weekly, monthly, and annually. The facility's Food Storage (Dry, Refrigerated, and Frozen) Policy, undated, documented all food items would be labeled. The label must include the name of the food and the date by which it should be consumed or discarded. The policy documented that leftover contents of cans and prepared food would be stored in covered, labeled, and dated containers in refrigerators and/ or freezers. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility failed to store, prepare, distribute, and serve food by professional standards for food service safety for all residents who received their meals from the facility's kitchen. This placed 73 residents at risk for foodborne illness.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 27168 The facility had a census of 74 residents. The sample included 18 residents. Based on observation, record review, and interview the facility failed to adhere to infection control for Enhanced Barrier Precautions (EBP -an infection control intervention designated to reduce transmission of resistant organisms that employs targeted gown and gloves used during high contact resident care activities) for Resident (R)26, who had a peripherally inserted central catheter (PICC-a thin, flexible tube that is inserted into a vein in the upper arm and threaded into a large vein above the heart)line in her right upper arm, and R130 who had a urinary catheter (a flexible tube inserted through a narrow opening into a body cavity, particularly the bladder, for removing fluid). This placed the residents at increased risk for infection. Findings included: - On 11/05/24 at 03:45 PM observation revealed License Nurse (LN) K entered the room of R26, who was on EBP. Observation revealed a sign posted on the cabinet of the resident's room giving instructions on personal protection equipment (PPE-gown and gloves). The PPE equipment and supplies were located in a cabinet in the resident's room. Continued observation revealed LN K entered the resident's room and donned only gloves. LN K cleansed the resident's PICC port to administer the antibiotic. LN K stated the medication had to run for 2.5 hours then she would return and disconnect it at that time. On 11/06/24 at 08:30 AM, observation revealed R130 lying in bed with her eyes closed. Observation revealed a urinary catheter collection bag in a privacy bag hung on the side of the bed to dependent drainage. There was no EBP signage or gowns observed in the room or closet. On 11/06/24 at 02:46 PM, Certified Medication Aide (CMA) R washed her hands and applied gloves but did not don a gown. She used an alcohol wipe on R130's catheter port before and after emptying the bag, then removed her gloves and washed her hands. On 11/07/24 at 07:58 AM, observation revealed R130 lying in bed with the urinary catheter bag on the bare floor by her bed. Certified Nurse Aide (CNA) O verified the catheter bag should not be touching the floor. At that time, without wearing gloves or gown, CNA O moved the catheter bag and touched the tubing on R130's thigh to see if it was kinked. CNA O also verified there were no EBP signs in the room or closet. On 11/07/24 at 08:40 AM, Administrative Nurse F verified there was no EBP signage in R130's room. Administrative Nurse F verified staff should have initiated EBP for the resident with a catheter upon admission. On 11/05/24 at 4:30 PM interview with LN K verified that R26's cabinet door had an Enhanced Barrier Isolation sign with the initials EBP posted on the door frame and instructions for wearing appropriate PPE. LN K verified she should wear the appropriate PPE, a gown, and gloves when providing care for the resident. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/06/24 at 08:00 AM interview with Administrative Nurse D verified the staff should wear PPE when providing care for R26. Administrative Nurse D said the facility would do some education with the staff in regard to EBP and wearing PPE for resident care. On 11/07/24 at 08:40 AM, Administrative Nurse F verified there was no EBP signage in R130's room. Administrative Nurse F verified staff should have initiated EBP for the resident with a catheter upon admission. On 11/07/24 at 08:47 AM, Administrative Nurse D verified staff should have worn a gown and gloves while touching the catheter bag and tubing. The facility's Enhanced Barrier Precautions policy, dated 08/03/2024, documented the facility would fully implement EBP for the prevention of transmission of multidrug-resistant organisms. EBP refers to the use of gowns and gloves for use during high-contact resident care activities for residents known to be colonized or infected with MDRO as well as those at increased risk of MDRO acquisition such as residents with wounds or indwelling medical devices. EBP should be used for the duration of the affected resident's stay in the facility or until the wound heals or indwelling medical devices are removed. The facility failed to ensure staff used EBP as required R26 and R130. This placed the resident at increased risk for infection.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 32358 The facility had a census of 74 residents. The sample included 18 residents. Based on observation, record review, and interview the facility failed to provide a sanitary environment in one of three dining rooms. This placed the residents who ate in the main dining room at risk for impaired health and well-being. Findings included: - On 11/5/24 at 8:20 AM, observation in the main dining room revealed the wall to the right of the kitchen entrance door had numerous different-sized reddish-brown dried liquid-stained areas, approximately eight feet long and three feet high. On 11/06/24 at 08:40 AM, Administrative Nurse D verified the above observation and stated housekeeping and dietary were both responsible for cleaning the main dining room wall. Administrative Nurse D stated dietary staff had recently moved the serving table to the kitchen and the area was where it used to be. The Environmental Services Checklist: Daily Cleaning of Patient Rooms, documented daily cleaning tasks for the environmental services to provide daily. The facility failed to provide a sanitary environment in the main dining room when staff failed to clean the wall by the entrance door to the kitchen. This placed the residents who ate in the main dining room at risk for impaired health and well-being.