STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175351	A. Building B. Wing	04/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Advena Living of Clay Center	715 Liberty Clay Center, KS 67432

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49634 The facility had a census of 23 residents. The sample included 13 residents. Based on record review, and interview the facility failed to ensure R18's Admission Minimum Data Set (MDS- tool for implementing standardized assessment and for facilitating care management in nursing homes) had fully developed Care Area Assessments (CAA). Findings included: - R18's Electronic Medical Record (EMR) documented diagnoses of multiple sclerosis (a chronic autoimmune disease that effects the central nervous system (brain and spinal cord), diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), edema (swelling resulting from an excessive accumulation of fluid in the body tissues), hypokalemia (low level of potassium in the blood), chronic obstructive pulmonary disease (COPD - a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), muscle weakness, overactive bladder, retention of urine, anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), dementia (a progressive mental disorder characterized by failing memory and confusion), behavioral disturbance(a persistent and repetitive pattern of behavior that deviates significantly from societal norms, causing distress or impairing a person's function), hypertension (high blood pressure), major depressive disorder (major mood disorder that causes persistent feelings of sadness), and obesity (excessive body fat). A review of R18's Annual Minimum Data Set (MDS) dated [DATE] Functional Abilities (Self-Care Mobility) CAA lacked analysis or further development. A review of R18's Annual MDS dated [DATE] Urinary Incontinence and Indwelling Catheter CAA lacked analysis or further development. A review of R18's Annual MDS dated [DATE] Pain CAA lacked analysis or further development. A review of R18's Annual MDS dated [DATE] Pressure Ulcer/Injury CAA lacked analysis or further development. On 04/09/25 at 1:00 PM, Administrative Nurse D stated all CAA should include analysis of findings. She stated that documentation from the CAA did flow into the plan of care and the residents could have unidentified care needs. (continued on next page)

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility failed to provide a policy for MDS or CAAs development.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49634 The facility identified a census of 23 residents. The sample included 13 residents. Based on record review and interviews the facility failed to revise R19's care plan to address effective communication for R19. This deficient practice placed R19 at risk for isolation and impaired psychosocial well being. Findings included: - R19's Electronic Medical Record (EMR) under the Diagnosis tab documented diagnoses of anoxic brain damage (happens when the brain is deprived of oxygen for an extended amount of time), irritability/anger issues, development disorder of speech and language, and weakness. The Quarterly Minimum Data Set (MDS) dated [DATE], documented a Brief Interview of Mental Status (BIMS) score of 11, which indicated moderately impaired cognition. The MDS documented R19 required set and cleanup for eating and oral hygiene, was independent for toileting, and required set up and clean up for bathing. The Communication Care Assessment Area (CAA) dated 08/08/24 documented R19 had difficulty communicating at times. R19 stuttered and if staff did not understand the stuttering, R19 would get upset. R19's Care Plan revised 01/21/25 documented R19 had a behavior problem. R19's plan of care documented R19 had been known to grab at staff hair, hands, and their necks. Nursing staff were to administer R19's medications as ordered. R19's plan of care documented staff were to anticipate and meet R19's needs. R19's Care Plan lacked preferences or direction for effective staff communication when R19 stuttered and was not understood. R19's Communication with Physician Note dated 02/27/25 documented the resident had difficulty verbally communicating his wishes and would like speech therapy to assist with verbal communication. On 04/09/25 at 12:25 PM, Certified Nurses Aid (CNA) M stated all nursing staff have access to the care plans. CNA M stated how to communicate with R19 was in noted in the resident's care plan. CNA M stated if she was unsure of what R19 was trying to communicate she would ask her nurse. On 04/09/25 at 12:53 PM, Licensed Nurse (LN) G stated how to communicate with R19 should be care planned. LN G stated all nursing staff have access to the resident's care plans. On 04/09/25 at 01:00 PM Administrative Nurse D stated R19 did have trouble communicating, due to stuttering. She stated that R19's plan of care should address how staff should communicate with R19. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Care Plans, Comprehensive Person-Centered policy revised 10/21 documented A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs was developed and implemented for each resident. The comprehensive, person-centered care plan would include measurable objectives and timeframes; and describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.

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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** 45668 The facility identified a census of 23 residents. The sample included 13 residents with two reviewed for pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, because of pressure, or pressure in combination with shear and/or friction). Based on interviews, observations, and record reviews, the facility failed to ensure Resident (R) 6 and R18's low air-loss mattresses (specialized air mattresses used to reduce pressure on the body) were set to the appropriate settings. The facility further failed to ensure R18 had pressure relieving boots on when in bed. This deficient practice placed both residents at risk for complications related to skin breakdown and pressure ulcers. Findings Included: - The Medical Diagnosis section within R6's Electronic Medical Records (EMR) included diagnoses of general anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), obesity (severely overweight), schizoaffective disorder (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought), and post-traumatic stress disorder. R6's Admission Minimum Data Set (MDS) completed 02/05/25 noted a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. The MDS indicated she had lower extremity impairment and was totally dependent on staff assistance for bed mobility, toileting, and transfers. The MDS noted she weighed 298 pounds (lbs.) with no weight loss. The MDS noted she was at risk for pressure ulcers but had no unhealed wounds. The MDS noted she had a pressure-reducing device for her bed and was on a repositioning program. R6's Pressure Ulcer Care Area Assessment (CAA) completed 02/07/25 indicated she was at risk for skin breakdown due to her limited mobility. The CAA noted her risks for pressure ulcers would be addressed in her care plan. R6's Care Plan initiated on 02/05/25 indicated she had a self-care deficit related to her activities of daily living (ADL). The plan noted she was dependent on staff for assistance with bed mobility, transfers, toileting, dressing, bathing, and personal hygiene. The plan noted she was at risk for pressure-related injuries. The plan instructed staff to provide preventative skin care and complete routine skin assessments. The plan lacked information related to her low air-loss mattress. R6's EMR under Vitals revealed she weighed 305.8 lbs. on 03/19/25. A review of the manual of Low Air-Loss Mattress Manufacturers' Operation (Drive Model) indicated that the mattress system was intended to reduce the incidence of pressure ulcers while optimizing comfort. The manual indicated the mattress pump's pressure levels and firmness were preset based on the weight range and comfort settings. The manual indicated an optimal bed system assessment should be conducted on each patient by a qualified clinician or medical provider to ensure maximum safety. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/07/25 at 08:20 AM, R6 slept in her bed. R6's low air-loss mattress was set to 450 lbs. The mattress pump had fixed weight settings of less than (<) 250 lbs, 300 lbs, 350 lbs, 400 lbs, 450 lbs, 500 lbs, and 600 to 1000 lbs. On 04/08/25 at 10:45 AM, R6 reported staff did not adjust the weight setting on the mattress. R6 stated staff had not asked about the pump's weight settings. On 04/09/25 at 07:30 AM, R6 slept in bed, with the mattress pump still set to 450 lbs. On 04/09/25 at 11:20 PM, Certified Nurse Aide (CNA) M stated the mattress pumps were set up based on the resident's current weight and staff only looked at them if an alarm was going off. On 04/09/25 at 11:20 PM, Licensed Nurse (LN) G stated the company set up the mattresses and pump. She stated staff only monitored the pump alarms. She stated the pumps were set by the resident's weight. On 04/09/25 at 01:04 PM, Administrative Nurse D stated Breath (oxygen distributor; Durable Medical Equipment - DME company) placed the equipment and managed the air-loss mattress settings. Administrative Nurse D stated staff would only monitor the beds for alarms. The facility failed to provide a policy related to pressure ulcers as requested on 04/09/25. 49634 - R18's Electronic Medical Recorded (EMR) multiple sclerosis (a chronic autoimmune disease that effects the central nervous system (brain and spinal cord), diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), edema (swelling resulting from an excessive accumulation of fluid in the body tissues), hypokalemia (low level of potassium in the blood), chronic obstructive pulmonary disease (COPD - a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), muscle weakness, overactive bladder, retention of urine, anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), dementia (a progressive mental disorder characterized by failing memory and confusion), behavioral disturbance(a persistent and repetitive pattern of behavior that deviates significantly from societal norms, causing distress or impairing a person's function), hypertension (high blood pressure), major depressive disorder (major mood disorder that causes persistent feelings of sadness), and obesity (excessive body fat). R18's Annual Minimum Data Set (MDS) dated [DATE] documented R18 had a BIMS score of 15, which indicated intact cognition. The MDS documented R18 as at risk for pressure ulcers and noted the resident had a pressure-reducing device in the wheelchair and on the bed. The MDS documented R18 had a nutrition and hydration intervention to manage skin problems, and application of ointment to an area other than feet. R18's Care Plan dated 02/26/2024 documented R18 would have no complications related to diabetes. R18's plan of care directed staff would check R18's body for breaks in her skin. Nursing would inspect R18's feet for open areas, sores, pressure areas, blisters, edema, and redness. R18's care plan lacked direction for staff to monitor the resident's low air-loss mattress. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R18's Braden Scale for Prediction Pressure Sore Risk dated 04/02/25 documented a score of 18, indicating a risk for pressure ulcers. On 04/07/25 at 09:18 AM, R18 laid on the bed, R18's low air-loss mattress was set at yellow; and the pressure relieving boots were at the bottom of the bed. R18 did not have her boots on, and her heels laid directly on the mattress. On 04/08/25 at 08:50 AM, R18 laid on the bed, R18's low air-loss mattress was set at yellow, and the boots were at the bottom of the bed. R18 did not have her boots on, and her heels laid directly on the mattress. On 04/09/25 at 12:25 PM, Certified Nurse's Aide (CNA) M stated the CNAs were responsible for ensuring residents' heels were floated and boots were on the resident. CNA M stated there was a notebook at the nurses' station that documented anyone who needed any extra care, and the nurse would also let staff know if anyone's heels needed to be floated. CNA M stated all nursing staff had access to the care plans, the information would be documented in the care plan. CNA M stated she did not know if the nurses monitored the low air-loss mattresses. CNA M stated when she went into R18's rooms, she ensured the bed was working. On 04/09/25 at 12:53 PM, Licensed Nurse (LN) G stated residents who required boots or their heels floated would have an order and it would be placed on the Treatment Administrative Record for nurses to sign off on. She stated the air mattresses were placed by Breath (oxygen distributor; Durable Medical Equipment - DME company), the company comes in and sets the mattress to the resident's weight. LN G stated all nursing staff look at the mattress when we are in the residents' rooms, but she stated there was not a specific place to sign off on the mattress to ensure it was on the correct weight. LN G stated skin assessments are done weekly, and the Director of Nursing would be the one to let the nurse know if an assessment was missed. On 04/09/25 at 01:00 PM, Administrative Nurse D stated all nursing staff were responsible for ensuring a resident had their heels floated and boots were on the resident while they were in bed. She stated there was an alarm on the low air-loss mattresses to alert staff if the bed was not working. She stated Breath placed the mattress and set the mattresses to the correct weight. She stated they were not monitored by staff. Administrative Nurse D stated she was ultimately responsible if a skin assessment was not performed and should be done weekly as ordered. The facility failed to provide a policy to include pressure injuries.

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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. 45668 The facility reported a census of 23 residents. The sample included 13 residents with one reviewed for accidents. Based on interviews, observations, and record review, the facility failed to ensure a safe care environment related to Resident (R) 16's call light placement. This placed R16 at risk for preventable accidents and injuries. Findings Included: - The Medical Diagnosis section within R16's Electronic Medical Records (EMR) included diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), need for personal care, muscle weakness, and repeated falls. R16's Quarterly Minimum Data Set (MDS) completed 02/13/25 noted a Brief Interview for Mental Status (BIMS) score of zero indicating severe cognitive impairment. The MDS noted she required substantial to maximal assistance for dressing, personal hygiene, bathing, transfers, and toileting. The MDS noted no behaviors. The MDS noted she had two non-injury falls and was at risk for further falls. R16's Falls Care Area Assessment (CAA) completed 05/23/24 Indicated she was at risk for falls related to her impaired gait and balance. The CAA instructed staff to anticipate her needs, provide toileting, and engage in activities. R16's Care Plan initiated 07/13/23 indicated she had a self-care deficit related to her medical diagnoses. The plan noted she was dependent on staff for bathing, transfers, bed mobility, dressing, and personal hygiene. The plan noted she was a high fall risk. The plan instructed staff to provide frequent checks, offer toileting, provide activities, and asses her for pain. The plan noted she had a non-injury fall while attempting to self-transfer from her bed on 07/13/23 and required a soft-touch call light. The plan instructed staff to ensure her call light remained within reach at all times. On 04/08/25 at 01:20 PM, R16 slept in her bed. R16's fall mat was placed on the floor to the right of her. R16's call light was on the floor underneath her bed. The cord of the light ran down the back of the foot of her bed to the floor. On 04/08/25 at 01:45 PM, R16's call light remained on the floor as she slept in her bed. On 04/08/25 at 03:01 PM, R16's call light remained on the floor as she slept. On 04/09/25 at 11:35 AM, Certified Nurse's Aide (CNA) M stated all resident's call lights were to be placed within reach of the residents. She stated R16 had a soft touch light and should have been placed in a visible spot for her to recognize. On 04/09/25 at 01:02 PM, Administrative Nurse D stated R16's light should be placed next to her in bed for easy access and use. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Facility's Falls and Fall Risk policy revised 10/2021 indicated the facility was to ensure a safe care environment was provided for all residents. The policy noted residents would be assessed and provided the appropriate assistive devices.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49634 The facility identified a census of 23 residents. The sample included 13 residents with one resident reviewed for respiratory care. Based on observation, record review, and interviews, the facility failed to ensure Resident (R) 18's continuous positive airway pressure (CPAP - ventilation device that blows a gentle stream of air into the nose to keep the airway open during sleep), was stored in a sanitary container when not in use. This defiant practice placed R18 at increased risk for respiratory complications. Findings included: - R18's Electronic Medical Record (EMR) multiple sclerosis (a chronic autoimmune disease that effects the central nervous system (brain and spinal cord), diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), edema (swelling resulting from an excessive accumulation of fluid in the body tissues), hypokalemia (low level of potassium in the blood), chronic obstructive pulmonary disease (COPD - a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), muscle weakness, overactive bladder, retention of urine, anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), dementia (a progressive mental disorder characterized by failing memory and confusion), behavioral disturbance(a persistent and repetitive pattern of behavior that deviates significantly from societal norms, causing distress or impairing a person's function), hypertension (high blood pressure), major depressive disorder (major mood disorder that causes persistent feelings of sadness), and obesity (excessive body fat). The Annual Minimum Data Set (MDS) dated [DATE] documented R18 BIMS score of 15, which indicated intact cognition. The MDS documented R18 required setup and cleanup for eating and oral hygiene and was dependent on staff for toileting. The MDS documented R18 required supervision or touching for bathing, and substantial to maximum assistance for dressing. The MDS lacked indication of R18's CPAP. R18's Functional Abilities (Self-Care Mobility Care Area Assessment (CAA) dated 02/21/25 lacked analysis. R18's Care Plan dated 11/27/24 documented R18 had impaired cognitive function and dementia or impaired thought processes. R18's plan of care documented staff would administer medications as ordered and monitored/documented any side effects and the effectiveness. R18's plan of care lacked direction for staff to clean and store R18's CPAP mask. R18's physician's orders under the Orders tab revealed the following orders: Staff were to clean CPAP supplies weekly with vinegar and water every day shift every Saturday dated 02/17/24. The facility would ensure the resident's CPAP would be worn at night, at bedtime related to COPD dated 02/14/24. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/07/25 at 09:12 AM, R18 laid on her bed resting, with the CPAP on the bed and stuffed between the side rail and her low air-loss mattress (specialized air mattresses used to reduce pressure on the body). R18 stated she took her mask off herself. R18 stated she did not have a bag for the mask, and staff did not tell her that she needed to ensure the mask was stored in a sanitary manner. On 04/09/25 at 12:25 PM, Certified Nurse's Aide (CNA) M stated all respiratory equipment was to be stored in a plastic bag. On 04/09/25 at 12:53 PM, Licensed Nurse (LN) G stated all respiratory equipment was stored in a plastic bag. She stated new bags were placed in the resident's room. On 04/09/25 at 03:25 PM, Administrative Nurse D stated all respiratory equipment not in use should be placed in a plastic bag. She stated CPAP masks and oxygen tubing should not be left in the bed or hung over wheelchairs. The facility failed to provide a policy related to the storage of respiratory equipment.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45668 The facility identified a census of 23 residents. The sample included 13 residents with one reviewed for trauma-informed care. Based on observation, record review, and interviews, the facility failed to identify, implement, and utilize trauma-based care strategies related to Resident (R) 6's reported history of post-traumatic stress disorder (PTSD - a mental disorder characterized by an acute emotional response to a traumatic event or situation involving severe environmental stress). This deficient practice placed R6 at risk for decreased psychosocial well-being and increased behaviors. Findings Included: - The Medical Diagnosis section within R6's Electronic Medical Records (EMR) included diagnoses of general anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), obesity (severely overweight), schizoaffective disorder (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought), and post-traumatic stress disorder. R6's Admission Minimum Data Set (MDS) completed 02/05/25 noted a Brief Interview for Mental Status (BIMS) score of 13 indicating intact cognition. The MDS indicated she had lower extremity impairment and used a wheelchair for mobility. The MDS noted she was totally dependent on staff assistance for dressing, bathing, bed mobility, personal hygiene, toileting, and transfers. The MDS noted she was incontinent of bladder and bladder. The MDS noted she had PTSD. The MDS noted she weighed 298 pounds (lbs.) with no weight loss. The MDS noted she was at risk for pressure ulcers but had no unhealed wounds. The MDS noted she had a pressure-reducing device for her bed and was on a repositioning program. R6's Psychosocial Wellbeing Care Area Assessment (CAA) completed 02/07/25 indicated she was depressed about her admission into a nursing home and recent time in jail. The CAA noted she felt lonely. The CAA noted her psychosocial well-being will be addressed in her care plan. R6's Care Plan initiated on 02/05/25 indicated she had a self-care deficit related to her activities of daily living (ADL). The plan noted she was dependent on staff for assistance with bed mobility, transfers, toileting, dressing, bathing, and personal hygiene. The plan noted she required a full-body mechanical lift (Hoyer - total body mechanical lift). The plan noted she had a mood problem. The plan indicated she was to be offered behavioral health consults as needed. The plan noted caregivers were to be educated on the expectations of treatments, side effects, and potential adverse effects of her medication. The plan noted she had an alteration of neurological status. The plan instructed staff to discuss with R6 concerns, fears, or issues related to her diagnoses or treatments. The plan lacked information related to R6's potential effects related to her history of trauma or PTSD. R6's EMR under Assessments revealed a Patient Health Questionnaire (PHQ) evaluation completed on 01/30/25. The assessment indicated she reported little interest or pleasure in doing things. The assessment indicated R6 felt down, depressed, or hopeless. The assessment indicated R6 felt tired or had little energy. The assessment indicated R6 felt bad about herself or had feelings of being a failure. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R6's EMR under Assessments revealed an undated PTSD / Trauma Assessment Tool scanned into the EMR on 02/24/25. The assessment indicated she reported having nightmares. The assessment noted she tried hard not to think about or went out of her way to avoid situations. The assessment indicated R6 felt easily startled, on guard, and watchful. The Assessment indicated she felt numb or detached from people's activities or in her surroundings. A review of R6's EMR was completed on 04/08/25. The review revealed no other PTSD or Trauma-related assessment from 01/02/25 to 04/08/25 in R6's medical record. R6'S EMR under Progress Notes revealed a Care Plan Note completed 03/12/25. The note revealed R6 reported to staff that she wanted to live at her house and her anxiety was at its worst. On 04/07/25 at 10:33 AM, R6 lay in her bed. R6 was shaking and reported she had high levels of anxiety. She stated her nightmares were improving but were still present. She stated she believed her tremors were from her anxiety. She stated she had PTSD from childhood abuse and anxiety from her recent court-related issues. She stated she had talked to the facility about her past trauma-related concerns and was supposed to have a mental health evaluation. She stated she had ongoing fears from her childhood trauma and legal issues. She stated she was forced to move to the care facility and felt it fed into her anxiety. R6 reported she felt like the facility had addressed her trauma concerns. On 04/09/25 at 09:01 AM, Social Services X provided a PTSD - Trauma assessment dated [DATE]. The assessment indicated no reported concerns or triggers for R6. On 04/09/25 at 12:35 PM, Social Service X stated R6 completed the form scanned in on 02/25/35 but reported no other traumatic issues for the form completed on 01/30/25. She stated R6 had anxiety related to her court-related problems but reported no childhood abuse. On 04/09/25 at 12:20 PM, Certified Nurse Aide (CNA) M stated R6 often displayed anxiety and withdrew from activities. She stated R6 often had worries related to her recent court problems. She stated staff should spend time talking with R6 and help calm her fears. CNA M stated she was not aware of PTSD or trauma care interventions for R6. On 04/09/25 at 01:04 PM, Administrative Nurse D stated she was not aware of trauma or PTSD-related concerns for R6. She stated all residents were screened upon admission and it should be care planned. She stated she was unaware of R6's history of childhood abuse or nightmares related to her trauma. The facility's Trauma Informed Care policy revised 10/20/21 indicated the facility was to screen all residents and provide trauma-related services to residents at risk for PTSD and trauma. The policy noted all residents were to receive a comprehensive screening to identify past trauma or adverse experiences and provide interventions to prevent potential triggers and unnecessary stimuli.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45668 The facility identified a census of 23 residents. The sample included 13 residents with two reviewed for bed rails. Based on observation, record review, and interviews, the facility failed to ensure that Residents (R) 6 and R18 had safety assessments for the use of side rails that acknowledged the risks of their low air-loss mattress. This deficient practice placed both residents at risk for uninformed decisions and impaired safety related to the risks associated with the use of side rails. Findings Included: - The Medical Diagnosis section within R6's Electronic Medical Records (EMR) included diagnoses of general anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), obesity (severely overweight), schizoaffective disorder (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought), and post-traumatic stress disorder. R6's Admission Minimum Data Set (MDS) completed 02/05/25 noted a Brief Interview for Mental Status (BIMS) score of 13 indicating intact cognition. The MDS indicated she had lower extremity impairment and used a wheelchair for mobility. The MDS noted she was totally dependent on staff assistance for dressing, bathing, bed mobility, personal hygiene, toileting, and transfers. The MDS noted she weighed 298 pounds (lbs.) with no weight loss. The MDS noted she was at risk for pressure ulcers but had no unhealed wounds. The MDS noted she had a pressure-reducing device for her bed and was on a repositioning program. R6's Pressure Ulcer Care Area Assessment (CAA) completed 02/07/25 indicated she was at risk for skin breakdown due to her limited mobility. The CAA noted her risks for pressure ulcers will be addressed in her care plan. R6's Functional Abilities Care CAA completed 02/07/25 indicated she was dependent on staff for transfers, bed mobility, bathing, toileting, dressing, and personal hygiene. The CAA noted her risks for functional abilities decline will be addressed in her care plan. R6's Care Plan initiated on 02/05/25 indicated she had a self-care deficit related to her activities of daily living (ADL). The plan noted she was dependent on staff for assistance with bed mobility, transfers, toileting, dressing, bathing, and personal hygiene. The plan noted she required a full-body mechanical lift (Hoyer - total body mechanical lift. The plan noted she was at risk for pressure-related injuries. The plan instructed staff to provide preventative skin care and complete routine skin assessments. The plan instructed staff to keep her skin clean and moisturized. The plan lacked information related to her low air-loss mattress. R6's EMR under Assessments revealed an Admission Assessment completed on 01/23/25. The Section K of the assessment indicated she did not use any type of bed rails. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of R6's EMR on 04/09/25 revealed no documentation showing the identified risks related to the use of her low air-loss mattress in conjunction with her bed's side rails. On 04/07/25 at 08:20 AM, R6 slept in her bed. R6's low air-loss mattress was set to 450lbs. The mattress pump had fixed weight settings of less than (<) 250lbs, 300lbs, 350lbs, 400lbs, 450lbs, 500lbs, and 600 to 1000lbs. R6's bed had bilateral assist rails at the head of the bed. On 04/09/25 at 11:20 PM, Certified Nurse Aide (CNA) M stated the mattress pumps were set up based on the resident's current weight and staff only looked at them if an alarm was going off. On 04/09/25 at 11:20 PM, Licensed Nurse (LN) G stated staff were expected to check the pump and side rails for safety each shift. On 04/09/25 at 01:04 PM, Administrative Nurse D stated nursing staff were expected to check for gaps in the side rails but was not sure if the side rail assessments covered the risks of the low-air-loss mattresses. The facility Bed Rail policy revised on 10/21 documented that the resident's sleeping environment would be assessed by the interdisciplinary team, considering the resident's safety, medical conditions, comfort, and freedom of movement, as well as input from the resident and family regarding previous sleeping habits and bed environment. The facility would try to prevent deaths/injuries from the beds and related equipment (including the frame, mattress, side rails, headboard, footboard, and bed accessories), the facility shall promote the following approaches: Inspection by the maintenance staff of all beds and related equipment as part of our regular bed safety program to identify risks and problems including potential entrapment risks. Review that gaps within the bed system are within the dimensions established (Note: the review shall consider situations that could be caused by the resident's weight, movement, or bed position.). Ensure that when bed system components are worn and need to be replaced, components meet the manufacturer's specifications: Ensure that bedside rails are properly installed using the manufacturer's instructions. 49634 - R18's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of multiple sclerosis (a chronic autoimmune disease that effects the central nervous system (brain and spinal cord), diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), edema (swelling resulting from an excessive accumulation of fluid in the body tissues), hypokalemia (low level of potassium in the blood), chronic obstructive pulmonary disease (COPD - a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), muscle weakness, overactive bladder, retention of urine, anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), dementia (a progressive mental disorder characterized by failing memory and confusion), behavioral disturbance (a persistent and repetitive pattern of behavior that deviates significantly from societal norms, causing distress or impairing a person's function), hypertension (high blood pressure), major depressive disorder (major mood disorder that causes persistent feelings of sadness), and obesity (excessive body fat). (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R18's Annual Minimum Data Set (MDS) dated [DATE] documented R18's BIMS score of 15 intact cognition. The MDS documented R18 required setup and cleanup for eating and oral hygiene and was dependent on staff for toileting. The MDS documented R18 required supervision or touching for bathing, and substantial to maximum assistance for dressing. The MDS documented bed rails were not used. The Functional Abilities (Self-Care Mobility) Care Assessment Area (CAA) dated 02/21/25 lacked analysis. R18's Care Plan revised on 02/27/24 documented activities of daily living (ADL) deficit related to dementia, and musculoskeletal impairment. The plan of care documented R18 was able to reposition herself with the assistance of bed rails. R18's plan of care dated 05/08/24 documented R18 was dependent on one or two staff for repositioning and turning in bed. The plan of care documented R18 used half-bed rails on both sides to maximize independence with turning and repositioning in bed. A review of R18's EMR under the Assessment tab dated 02/14/24 revealed a Side Rail/Transfer Bar Assessment. The side rail assessment did not include an assessment to include a low air loss mattress. R24's EMR lacked evidence of risk versus benefits and education was provided to R18 or her representative regarding the risks associated with the use of side rails. On 04/07/25 at 09:36 AM, R18 laid in her bed, on her back. R18's side rails on both sides of the bed were up. On 04/07/25 at 09:05 AM, R24 laid in her bed on her back. R18's side rails on both sides of the bed were up. On 04/09/25 at 12:53 PM, Licensed Nurse (LN) G stated R18 liked the side rails she stated she felt safe and would not roll out of the bed. LN G stated she was unsure if the gaps were measured for an air-loss mattress or who would be responsible for measuring to ensure the bed rails were safe with the low air-loss mattress. On 04/09/25 at 12:53 PM, Administrative Nurse D stated bed rail assessments were done on admission. She stated R18 requested bed rails on her bed for her safety. Administrative D stated the bed rails were not measured for safety after the low air loss mattress was placed. The facility's Bed Rail policy revised on 10/21 documented that the resident's sleeping environment would be assessed by the interdisciplinary team, considering the resident's safety, medical conditions, comfort, and freedom of movement, as well as input from the resident and family regarding previous sleeping habits and bed environment. The facility would try to prevent deaths/injuries from the beds and related equipment (including the frame, mattress, side rails, headboard, footboard, and bed accessories), the facility shall promote the following approaches: Inspection by the maintenance staff of all beds and related equipment as part of our regular bed safety program to identify risks and problems including potential entrapment risks. Review that gaps within the bed system are within the dimensions established (Note: the review shall consider situations that could be caused by the resident's weight, movement, or bed position), ensure that when bed system components are worn and need to be replaced, components meet the manufacturer's specifications, and ensure that bedside rails are properly installed using the manufacturer's instructions.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 45668 The facility identified a census of 23 residents. The sample included 13 residents. Based on record review and interviews, the facility lacked a census on its posted staffing reports. Findings included: - On 04/07/25 at 07:14 AM, an inspection of the facility revealed no posted staffing documentation posted in the facility. On 04/07/25 at 09:20 AM, no posted staffing was posted next to the facility's dry-erase board. On 04/08/25 at 08:30 AM a posted staffing report was posted next to the lobby's dry-erase board. The report did not include the daily census. On 04/09/25 at 09:10 AM a posted staffing report was posted next to the lobby's dry-erase board. The report did not include the daily census. On 04/09/25 at 12:24 PM, Administrative Nurse D stated the charge nurse was responsible for creating and posting the staffing in the lobby. She stated the census was only put on the dry-erase board and not included on the census report. A review of the facility's Staffing policy revised 08/2021 dated indicated that staffing hours must be maintained for facility records for a minimum of 18 months. The policy indicated the records must be made available upon request.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. 45668 The facility identified a census of 23 residents. The sample included 13 residents with three reviewed for behavioral services. Based on observation, record review, and interviews, the facility failed to identify, implement, and monitor Resident (R) 21's behavioral care needs. This deficient practice placed R21 at risk for continued behavioral episodes and unmet care needs. Findings included: - The Medical Diagnosis section within R21's Electronic Medical Records (EMR) included diagnoses of post-traumatic stress disorder (PTSD - a mental disorder characterized by an acute emotional response to a traumatic event or situation involving severe environmental stress), intracranial brain injury, mild cognitive impairment, and an accidental gunshot wound to the head. R21's Admission Minimum Data Set (MDS) completed 02/06/25 noted a Brief Interview for Mental Status (BIMS) score of four indicating severe cognitive impairment. The MDS indicated a care plan was implemented to address her behaviors. The MDS noted he was independent with his activities of daily living (ADL). The MDS noted he had no behaviors. The MDS noted he took antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality), antianxiety (a class of medications that calm and relax people), and antidepressant (a class of medications used to treat mood disorders) medications. R21's Psychotropic Medication Area Assessment (CAA) completed 02/07/25 indicated he used psychotropic medication daily. The CAA instructed staff to monitor his medication use for sedation. The CAA noted his care plan addressed his medication use. R21's Cognitive Impairment CAA completed 02/07/25 indicated he had a traumatic brain injury that resulted in cognitive impairment. The CAA noted he had difficulty with understanding others and making himself understood. The CAA noted confusion, forgetfulness, and disorientation. The CAA noted his care plan addressed his cognitive impairment. R21's CAA triggered for behaviors. R21's Care Plan initiated on 01/24/25 indicated he had a self-care deficit related to his medical diagnoses. The plan noted he was independent with bathing, toileting, transfers, bed mobility, and ambulation. The plan noted he had severe cognitive impairment. The plan instructed staff to keep his routines consistent, ask yes/no questions, and present one question at a time. The plan noted he took psychotropic medications. The plan instructed staff to monitor and report adverse reactions to his medications. The plan encouraged staff to discuss the ongoing need for his psychotropic medication with his medical provider and family. The plan lacked interventions related to his wandering, behaviors, and allowing female residents to enter his room. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R21's EMR under Progress Notes revealed a Behavior Note on 02/16/25 at 04:47 AM indicating he had extreme behaviors. The note revealed he removed his clothing from his wardrobe and walked down the hall. The note revealed he yelled vulgarities down the hallway and returned to his room. The note indicated staff continued to monitor for dangerous behaviors. R21's EMR under Progress Notes revealed a Behavior Note on 02/16/25 at 01:00 PM. The note revealed R21 wandered down the hall opening other resident's doors. R21's EMR under Progress Notes revealed a Behavior Note on 02/16/25 at 09:21 PM. The note indicated he continued to have extreme behaviors. The note revealed he displayed wandering, combativeness, yelling profanity, and throwing items. The note revealed that R21's behaviors disturbed other residents and caused complaints. R21's EMR under Progress Notes revealed a Behavior Note on 02/17/25 at 09:38 AM. The note revealed R21 urinated in the 100 hall. The note revealed that R21 moved his belongings into three other residents' rooms. R21's EMR under Progress Notes revealed a Behavior Note on 02/22/25 at 03:01 PM noted R21 wandered the hallways opening doors. R21's EMR under Progress Notes revealed a Behavior Note on 02/23/25 at 12:13 PM noted that R21 wandered the hallways opening other residents' doors. The note indicated R21 became visibly upset when redirected. The note revealed that R21 began yelling profanity at staff. On 04/07/25 at 09:10 AM, R23 wandered down the 100 hallway towards the back activity room area. R23 entered R21's room as he sat in his recliner. R23 began looking through R21's personal items. R21 asked her to stop and leave. R23 left the room and returned to the hallway. R23 returned back into R21's room and stood looking around. R23 then exited the room and walked back toward the dining area. No staff were present to monitor R23's wandering. On 04/09/25 at 11:23 AM, Certified Nurse Aide (CNA) M stated R21 normally was calm and cooperative but had exhibited aggressive behaviors towards staff. She stated he had wandering behaviors and verbal aggression but had not displayed it recently. She stated that R21 had displayed concerns with R23 entering his room and touching his stuff. She stated staff were expected to keep R23 out of his room to prevent upsetting him. On 04/09/25 at 11:36 AM, Licensed Nurse (LN) G stated R21 had not had behaviors recently. She stated he usually was calm. He did not like R23 going into his room and touching his stuff. She stated interventions should be implemented for residents who displayed aggression, wandering or other potential behaviors. On 04/09/25 at 12:23 PM, Administrative Nurse D stated behavioral interventions should be care planned for all residents with a history of behaviors to assist with calming them down. She stated that R21 was not happy with R23 continually entering his room and going through his things. She stated the facility is trying to keep her out of his room. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Behavioral Assessment, Interventions, and Monitoring policy revised 08/2021 indicates the facility will complete comprehensive assessment and provide behavioral services to residents in need of services to allow the resident to maintain or achieve the highest practicable level of functioning. The facility failed to identify, implement, and monitor R21's behavioral care needs. This deficient practice placed R21 at risk for continued behavioral episodes and unmet care needs.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. 45668 The facility identified a census of 23 residents. The sample included 13 residents with one reviewed for dementia (a progressive mental disorder characterized by failing memory, and confusion) care. Based on interviews, record review, and observations, the facility failed to provide dementia-related behavioral services for Resident (R) 23 to promote her highest practicable level of well-being resulting in numerous non-injury falls. This deficient practice placed R23 at risk for decreased quality of life, isolation, and impaired dignity. Findings Included: - The Medical Diagnosis section within R23's Electronic Medical Records (EMR) included diagnoses of acute encephalopathy (damage or injury to the brain resulting in memory loss, confusion, cognitive impairment, and/or disorientation), abnormal behaviors, and acute kidney injury. R23's Admission Minimum Data Set (MDS) completed 03/27/25 noted a Brief Interview for Mental Status (BIMS) score of nine indicating moderate cognitive impairment. The MDS indicated she was independent with dressing, toileting, bed mobility, transfers, and ambulation. The MDS noted she had hallucinations (untrue persistent belief or perception held by a person although evidence shows it was untrue sensing things while awake that appear to be real, the mind created) and delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue). The MDS noted she exhibited wandering behaviors. The MDs indicated she had no falls since her admission. R23's Behaviors Area Assessment (CAA) completed 04/01/25 indicated that she wandered daily and was easily redirectable. The MDS indicated a care plan was implemented to address her behaviors. R23's Care Plan initiated she was at risk for a self-care performance deficit related to her cognitive impairment. The plan noted she independently completed her dressing, bed mobility, toileting, transfers, and ambulation. The plan noted she required supervision with bathing. The plan noted she was an elopement risk due to her wandering. The plan instructed staff to offer pleasant diversion and identify the reason for wandering. R23's EMR under Progress Notes revealed a Behavior Note on 04/07/25. The note indicated that R23 was found by staff in R21's room. The note revealed that R23 attempted to change her clothes in his room. R23's EMR under Progress Notes revealed a Behavior Note on 04/08/25. The note indicated that R23 continued to go into R21's (severely cognitively impaired male resident) room and attempt to remove her clothing. The note revealed staff redirected her back to her room. The note revealed that R23 made multiple attempts to go back into R21's room. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/07/25 at 09:10 AM, R23 wandered down the 100 hallway towards the back activity room area. R23 entered R21's room as he sat in his recliner. R23 began looking through R21's personal items. R21 asked her to stop and leave. R23 left the room and returned to the hallway. R23 returned back into R21's room and stood looking around. R23 then exited the room and walked back toward the dining area. No staff were present to monitor R23's wandering. On 04/07/25 at 03:30 PM, R21 stated R23 frequently went into his room and messed with his things. He stated she tried to change in his room and lay on his bed. He stated he felt sorry for her but had told staff numerous times that she shouldn't be in his room. On 04/08/25 at 03:24 PM, R23 walked down the 100 hall and attempted to remove her shirt. R23 entered R21's room and closed the door. R23 reopened the door after a few seconds and exited the room. On 04/09/25 at 11:23 AM, Certified Nurse Aide (CNA) M stated the facility had tried many different activities and tasks to keep R23 engaged and prevent wandering. She stated R23 liked R21 and would repeatedly wander into his room. She stated staff were to redirect her back to her own room. On 04/09/25 at 12:43 PM, Administrative Nurse D stated that R23 was difficult to manage because she would not engage in one-to-one activities and was constantly wandering. She stated R21 disliked that R23 would constantly enter his room. She stated the facility tried many different interventions with no success. She stated R23 was only allowed to go into rooms that other residents invited her into and should not be left alone in male residents' rooms. The facility's Care of Dementia policy revised 11/2018 indicated the facility was to provide each resident with individualized care interventions and use the last restrictive approaches to care. The policy noted each resident was evaluated and provided interventions to address each resident's needs.

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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. 45668 The facility identified a census of 23 residents. The facility had one kitchen. Based on observation, record review, and interviews, the facility failed to follow sanitary dietary standards related to food preparation. This deficient practice placed the residents at risk for food-borne illness. Findings included: - On 04/07/25 at 07:00 AM an inspection of the facility's kitchen revealed sausages cooking on the stove top. An inspection of the food preparation area revealed Dietary Staff EE prepared food without wearing a hairnet. Dietary Staff EE then exited the cooking area, put a hairnet on, and returned to the cooking area. On 04/09/25 at 11:23 AM, Dietary Staff BB stated all staff were required to immediately put hairnets on when in the kitchen's food preparation and service areas. The facility's Food Preparation and Service revised 10/2021 stated the facility was to ensure food service employees handle food in a manner that complied with safe handling practices. The policy indicated staff were required to follow safe sanitary practices, including the use of hairnets and hand hygiene.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. 45668 The facility identified a census of 23 residents. The sample included 13 residents. Based on observations, interviews, and record reviews, the facility failed to conduct a thorough facility-wide assessment to determine the resources necessary to care for residents competently during both day-to-day operations and emergencies. This failure affected all 13 residents who resided in the facility. Findings Included: - On 04/07/25 Administrative Nurse D provided a Facility Assessment updated 11/13/24. A review of the assessment revealed the following: The assessment failed to identify the specific staffing levels needed for each unit and to identify the number of Registered Nurses (RN), Licensed Nurses (LPN/LVN), Certified Medication Aides (CMA), and Certified Nurse Aides (CNA) needed for each unit, patient acuity, and census. The assessment lacked staffing levels required for each shift to include evenings and weekends. On 04/09/25 at 12:45 PM, Administrative Staff A stated the facility updated the facility assessment quarterly and followed the recent changes related to Centers for Medicaid and Medicare Services (CMS) regulatory updates. He stated the staffing information may be in a separate report and the facility would provide it. On 04/09/25 at 03:36 PM, Administrative Staff A provided a Neighborhood Staffing Assessment and Analysis report showing the required staffing levels. The creation date on the report was 04/09/25. The facility's Facility Assessment Quick Reference Guide dated 07/2024 indicated the facility assessment was to be individualized to the community needs and developed utilizing evidence-based, data-driven methods.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175351	A. Building B. Wing	04/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Advena Living of Clay Center	715 Liberty Clay Center, KS 67432

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 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 45668 The facility reported a census of 23 residents. Based on record review and interviews, the facility failed to submit accurate staffing information to the federal regulatory agency through Payroll Based Journaling (PBJ -Staffing Data Report), when the facility failed to submit accurate licensed nurse coverage and weekend staffing hours. This placed the residents at risk for unidentified and ongoing inadequate staffing. Findings included: - The PBJ provided by CMS for Fiscal Year (FY) 2024 of the second quarter (01/01/24 through 03/30/24) indicated the facility triggered for low weekend staff. The report also indicated the facility failed to provide licensed nurse coverage 24 hours per day. The PBJ provided by CMS for Fiscal Year (FY) 2025 of the first quarter (10/01/24 through 12/31/24) indicated the facility was triggered for low weekend staff. The report also indicated the facility failed to provide licensed nurse coverage 24 hours per day. A review of the facility's working schedule, time sheets and clock in and out information, and posted staffing hours was completed for the identified days missing the required licensed nurse coverage: 01/01/24, 02/11/24, 02/23/24, 03/10/24, 03/17/24, 10/31/24, 12/01/24, 12/21/24, 12/22/24, 12/22/24, 12/29/24, 12/30/24, and 12/31/24. The review revealed no missed coverage or gaps. A review of the facility's working schedule, time sheets and clock in and out, and posted staffing hours was completed for missed weekend coverages between 01/01/24 to 03/31/24 and 10/01/24 to 12/31/24. The review revealed no missed coverage or gaps. On 04/09/24 at 12:21 PM, Administrative Nurse D stated the facility had no missed licensed nurse shits and utilized agency staff to fill in gaps on the schedules. She stated some of the shifts may not have been accurately reported during the PBJ submission hours to reflect agency and shift fill-ins. The facility's Payroll Based Journaling policy revised 06/2024 indicated the facility will provide complete and accurate payroll data that can be validated and auditable. The facility failed to ensure accurate staffing hour information was submitted to the federal regulatory agency through PBJ when the facility failed to submit accurate data related to weekend staffing and licensed nursing coverage. This placed the residents at risk for unidentified and ongoing inadequate staffing.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175351	A. Building B. Wing	04/09/2025

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 49634 The facility identified a census of 23 residents. Based on record review, observations, and interviews, the facility failed to ensure R18's continuous positive airway pressure (CPAP - ventilation device that blows a gentle stream of air into the nose to keep the airway open during sleep) and R4's nasal cannula were stored in a sanitary manner and further failed to ensure laundry employee's had person protective equipment (PPE) in the soiled laundry area, to sort soiled laundry. This defiant practice placed residents at risk for infections. Findings included: - On 04/07/25 at 09:12 AM, R18's CPAP lay on her bed stuffed between the side rail and her low air loss mattress. On 04/07/25 at 09:22 AM, R4's nasal cannula tubing was laid over the back of her wheelchair, R4's nasal cannula tubing was not stored in a sanitary manner. On 04/08/25 at 08:22 AM, a tour of the laundry room revealed cleaning rags were left in the washer overnight, and the soiled laundry and sorting room did not have PPE for staff to wear to sort dirty laundry. 04/08/24 at 08:25 AM, Housekeeping Supervisor U stated the soiled laundry did not have PPE in the soiled sorting area for staff to put on before sorting dirty laundry. On 04/09/25 at 12:25 PM, Certified Nurse's Aide (CNA) M stated respiratory equipment not in use should have a bag. On 04/09/25 at 12:53 PM, Licensed Nurse (LN) G stated all respiratory equipment not in use should be in a bag, and bags were changed weekly. On 04/09/25 at 01:00 PM, Administrative Nurse D stated all respiratory equipment not in use should be in a bag. She stated it was all nursing responsibility to ensure the respiratory equipment not in use was in a bag. The Monitoring Compliance with Infection Control dated 10/21 documented that routine monitoring and surveillance of the workplace are conducted to determine compliance with infection prevention, and control policies and practices. The infection preventionist or designee monitors the compliance and effectiveness of our infection prevention and control policies and practices. Monitoring includes regular surveillance of adherence to hand hygiene practices availability of hand hygiene supplies, and the availability of personal protective equipment and its appropriate use.