STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175355	A. Building B. Wing	05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evergreen Community of Johnson County	11875 S Sunset Drive, Suite 100 Olathe, KS 66061

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45668 The facility identified a census of 70 residents. The sample included 19 residents with two residents reviewed for accommodation of needs related to assistive devices. Based on observation, record review, and interviews, the facility failed to provide Resident (R)47 with a wheelchair lap meal tray as care planned for his meals. The facility additionally failed to ensure R39's call light remained within reach while unsupervised in her room. This deficient practice placed both residents at risk for impaired quality of life and care. Findings Included: -The Medical Diagnosis section within R47's Electronic Medical Records (EMR) included diagnoses of senile degeneration of the brain, Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness), dysphagia (swallowing difficulty), memory deficit, left-sided hemiplegia (paralysis of one side of the body), left-sided hemiparesis (muscular weakness of one half of the body), and dementia (progressive mental disorder characterized by failing memory, confusion). R47's Quarterly Minimum Data Set (MDS) completed 04/09/24 noted a Brief Interview for Mental Status (BIMS) score of 12 indicating mild cognitive impairment. The MDS indicated he required partial assistance during meals. The MDS indicated he utilized a manual wheelchair for mobility. The MDS indicated he had upper and lower extremity impairments on one side of his body. The MDS indicated he displayed coughing and choking while swallowing meals or medications. The MDS indicated he received hospice services (end-of-life comfort care). R47's Functional Abilities Care Area Assessment (CAA) completed 01/14/24 indicated he required maximum assistance from staff for all his activities of daily living (ADLs) and care as needed. R47's Care Plan initiated on 11/01/21 indicated he was at risk for a decline in his ADLs, nutrition, and communication related to his Parkinson's disease and left-sided paralysis. The plan indicated he required staff assistance for dressing, bed mobility, bathing, personal hygiene, and toileting. The plan noted he could independently eat his food by himself (01/09/24). The plan indicated staff was to set up his wheelchair lap tray during meals and anytime he is drinking. The plan noted the lap tray was to be removed when he completed his meal or drink (01/31/24). (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/30/24 at 12:30 PM, R47 sat in the assisted dining room. R47 was assisted by staff as he ate his lunch. R47's lap tray lay on the floor next to the television area. At 01:11 PM R47 remained in his chair alone in the assisted dining area. R47's drink was positioned close to his left side on the table. R47's lap tray remained on the floor under the television. R47 struggled to grab his drink from the table and had to reposition his Broda chair (specialized wheelchair with the ability to tilt and recline) several times to get closer to the drink. On 05/01/24 at 09:51 AM R47 sat in his Broda chair in the assisted dining room. R47's drink was on the table to his left side. R47 attempted to reach the drink with his right arm several times but was unable to grab the covered cup. R47 moved his Broda chair with his right leg several times. R47's left leg pressed against the table metal bar. R47 grabbed his cup with his right hand. R47's lap tray remained on the floor under the television. On 05/01/24 at 9:56 AM Certified Nurse's Aide (CNA) P approached R47 and prepared to take him to his room. CNA P stated she was not sure why the lap tray was not being used. On 05/01/24 at 09:57 AM Licensed Nurse (LN) G stated staff were not using the lap tray due to it not fitting his new Broda chair. She stated hospice replaced his Broda chair, but the lap tray did not fit his wheelchair. She stated staff was expected to assist him during meals. On 05/01/24 at 12:41 PM Administrative Nurse D stated she was unaware staff were not using R47's lap tray. She stated she put it in place to prevent him from having to reach out further for his meals and to prevent any fall risks. She stated staff should have notified her of the concerns with the tray table not fitting so it could be replaced. The facility's Assistive Devices and Ambulatory Aids policy (undated) indicated the facility would ensure assistive eating devices would be provided to residents as care was planned and assessed. The facility failed to provide R47 with a wheelchair lap meal tray as care planned for his meals. This deficient practice placed the resident at risk for impaired quality of life and care. 49634 - R39's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of dementia (a progressive mental disorder characterized by failing memory), dysplasia oropharyngeal phase (difficulty initiating a swallow), combined systolic and diastolic heart failure (the heart cannot effectively contract with each heartbeat in diastolic heart failure your heart cannot relax between heartbeats), hypertension (HTN-elevated blood pressure), and anxiety (an emotion characterized by feelings of tension, worried thoughts, and physical changes). R39's Quarterly MDS dated [DATE] documented that a Brief Interview of Mental Status (BIMS) was not performed due to R39 being unable to. The MDS documented R39 was dependent on two staff for all toileting needs. The MDS documented R39 was dependent on two staff for positioning, transfers, and all activities of daily living (ADL). R39's Communication Care Area Assessment (CAA) dated 12/27/23 documented R39 had difficulty with communication at times. Staff were to allow time for communication, repeat things as needed, and anticipate R39's needs. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R39's Fall CAA dated 12/27/23 documented she had impaired mobility and weakness. R39 used psychotropic (mind-altering) drugs and was at risk of falling. R39's Care Plan dated 12/20/22 documented R39 was a fall risk and staff should avoid using pillows behind R39 when in bed. R39 should support a side-lying position, and her bed was to be in a low position. R39's fall mat should be in place when she was unattended. Staff were to recline R39 in her Broda chair (specialized wheelchair with the ability to tilt and recline) chair when not sitting at the table to eat or performing an activity. On 04/29/24 at 07:16 AM R39's push-button call light was pinned to the call light cord. The call light was out of reach of R39 as she sat in her Broda chair, reclined. On 05/01/24 at 09:17 AM R39's push-button call light was placed in the middle of the bed, out of reach of the resident, who sat in her Broda chair. On 05/01/24 at 09:20 AM Certified Nursing Aide (CNA) M stated all call lights should be within the resident's reach, and a call light should be placed on the resident's chest or lap. CNA M stated R39 was unable to push the button on the call light and staff were to check on her periodically. On 05/01/24 at 12:42 PM Administrative Nurse D stated she expected staff to place the call lights where residents could reach them. The facility's Call Light Monitoring policy dated 09/23 documented the facility is equipped with a call light system that includes a wireless paper system. When the system is activated by residents in their bedrooms, an alert is sent to the pagers carried by direct care staff, nursing staff, nursing administration staff, and the Administrator. When any call light is reset, the pagers reflect it has been cleared. The facility failed to ensure that R39's call light was within reach. This placed R39 at risk for impaired physical, mental, and psychosocial well-being.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49634 The facility identified a census of 70 residents. The sample included 19 residents with five residents reviewed for activities of daily living (ADLs). Based on observation, record review, and interviews, the facility failed to ensure Resident (R)39 received the required assistance with ADLs. This placed R39 at risk for complications including skin breakdown, discomfort, and impaired psychosocial well-being. Findings included: - R39's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of dementia (a progressive mental disorder characterized by failing memory), dysplasia oropharyngeal phase (difficulty initiating a swallow), combined systolic and diastolic heart failure (the heart cannot effectively contract with each heartbeat in diastolic heart failure your heart cannot relax between heartbeats), hypertension (HTN-elevated blood pressure), and anxiety (an emotion characterized by feelings of tension, worried thoughts, and physical changes). R39's Quarterly Minimum Data Set, dated dated dated [DATE] documented that a Brief Interview of Mental Status (BIMS) was not performed due to R39 being unable. The MDS documented R39 was dependent on two staff for all toileting needs. The MDS documented R39 was dependent on two staff for positioning, transfers, and all ADL. R39's Urinary Incontinence and Indwelling Catheter Care Assessment Area (CAA) dated 12/27/23 documented R39 had bladder incontinence, and she was at risk for skin breakdown and infection. Staff were to assist R39 with all toileting needs and incontinent care. R39's Pressure Injury CAA dated 12/27/23 documented R39 had impaired mobility, weakness, and incontinence. She was at risk for skin breakdown. She had a recent wound to her great toe with a treatment in place. Staff were to assist R39 with all mobility, positioning, and toileting care as needed. R39's Care Plan revised 10/12/23 directed staff to assist R39 in repositioning every two hours during the daytime and every four hours when sleeping/nighttime. The plan dated 10/26/23 documented R39 was incontinent of bowel and bladder. The plan directed two staff to check and change R39 between 3-4 AM, 8-9 AM, 11-12 PM, 2-3 PM, 4-5 PM, 7-8 PM 7-8 PM, 10-11 PM and as needed per R39's three-day bowel and bladder diary. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/30/24 at 08:14 AM, R39 sat in a Broda chair (specialized wheelchair with the ability to tilt and recline) in her room. There were two staff also present in the room. R39's chair was tilted, and the TV was on. The staff placed a call light and a pink stuffed animal in R39's lap and exited the room at 08:17 AM. Continued observation revealed at 09:20 R39 remained awake and in the same position and the stuffed animal fell to the floor. At 09:35 R39 closed her eyes. At 09:50 AM R39 had her eyes open and remained in the same position. Ongoing observation revealed at 10:23 AM R39 remained in the same position in her Broda chair. A staff member entered the room and then immediately exited. At 11:00 AM, two staff entered R39's room and the door remained open. Staff picked up R39's stuffed animal from the floor. At 11:02 AM one staff left the room. At 11:05 AM, R39 remained in the same position as the entire observation, A staff member stood at R39's side and visited with R39 from 11:05 AM through 11:12 AM. Ongoing observation revealed R39 remained in the chair in the same position until 11:36 AM when staff entered the room and propelled R39 in the chair to the dining area. On 04/30/24 at 11:37 AM R39 sat in her Broda chair in the dining room where she remained until 01:35 PM. On 04/30/24 at 01:35 PM, Certified Nursing Aide (CNA) N brought R39 back to her room from lunch. CNA N stated she would be back to change R39. CNA N stated she knew what time R39 should be checked and changed even though she was agency staff; she stated she picked up the care plan for each resident she cared for at the nurse's nook. She stated R39 should have her brief checked and changed every other hour. CNA N stated she was going to get help since R39 was a two-person Hoyer (total body mechanical lift) for changes. On 05/01/24 at 10:28 AM Licensed Nurse (LN) I stated each CNA was assigned to residents each morning by the nurse in charge. LN I stated the CNA assigned to a resident was to read the care plan and take care of the resident as assigned. LN I stated if the resident was to be toileted or repositioned at a certain time, that was the CNA's duty. LN I indicated the CNA could get help from another unit. On 05/01/24 at 12:42 PM Administrative Nurse D stated she expected the CNA staff to change all residents by the bowel and bladder program documented in the care plan. Administrative Nurse D said the only time she would not expect the resident to be checked and changed during the care-planned time is if the resident refused. She stated that residents had the right to refuse. The facility's Activities of Daily Living documented the facility provides each resident with care, treatment, and services according to the resident's individualized care plan. Based on the individual resident's comprehensive assessment, community staff will ensure that each resident's abilities in activities of daily living do not diminish unless the circumstances of the resident clinic condition demonstrate that the decline was unavoidable. The facility failed to ensure R39 was assisted with ADLs as directed in her plan of care. This placed R39 at risk for complications including skin breakdown, discomfort, and impaired psychosocial well-being.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49634 The facility identified a census of 70 residents. The sample included 19 residents, with one resident reviewed for activities. Based on observation, record review, and interviews, the facility failed to provide Resident (R)39 the opportunity to go to the activities she enjoys. This deficient practice placed R39 at risk for decreased psychosocial well-being. Findings included: - R39's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of dementia (a progressive mental disorder characterized by failing memory), dysplasia oropharyngeal phase (difficulty initiating a swallow), combined systolic and diastolic heart failure (the heart cannot effectively contract with each heartbeat in diastolic heart failure your heart cannot relax between heartbeats), hypertension (HTN-elevated blood pressure), and anxiety (an emotion characterized by feelings of tension, worried thoughts, and physical changes). R39's Significant Change Minimum Data Set (MDS) dated [DATE] lacked documented the interview for residents' preferences for customary routines and activities (section F) was not completed with R39, a representative, or per staff interview. R39's Quarterly MDS dated [DATE] documented that a Brief Interview of Mental Status (BIMS) was not performed due to R39 being unable to. The MDS documented R39 was dependent on two staff for all toileting needs. R39's Communication Care Area Assessment (CAA) dated 12/27/23 documented R39 had difficulty with communication at times. The CAA documented staff should R39 allow time for communication and repeat as needed; staff should anticipate R39's needs. R39's Care Plan documented R39 relied on staff to propel her in her Broda (a specialized wheelchair with the ability to tilt and recline). An intervention dated 06/29/21 directed staff to invite R39 to any church services as she enjoyed spiritual and religious activities. The plan, dated 12/08/22, documented R39 would engage in facility activities five times a week for social interaction and activities of leisure and interest, R39 enjoyed music. The plan documented an intervention dated 09/29/23 that documented that staff should invite R39 to all music-related activities. A review of the facility's Activity Calendar for 04/30/24 revealed Bible Study at 10:00 AM and live music in the Dug Out at 01:00 PM. On 04/30/24 at 09:50 AM R39 reclined in her Broda chair in her room. She was awake and looking at the TV. A continuous observation of R39 revealed staff did not offer or invite her to attend Bible Study. On 04/30/24 at 10:20 AM R39 reclined in her Broda chair next to her bed. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/30/24 at 10:21 AM one staff member entered R39's room. The staff member picked up R39's stuffed animal and placed it in her lap but did not offer to take the resident to the Bible Study which was in progress. On 04/30/24 at 11:36 AM staff took R39 out to lunch. R39 remained in the dining room until 01:35 PM when staff brought R39 back to her room. Staff did not offer or encourage R39 to attend the music activity that started at 01:00 PM. On 05/01/24 at 08:41 AM Certified Nurse Aide (CNA) O stated all CNAs knew what activities each resident liked to attend by their plan of care. CNA O stated she forgot to take R39 to the activities she enjoyed on 04/30/24 and stated the activity calendars were being changed and she did not see there were activities R39 would have enjoyed. On 05/01/24 at 10:00 AM Social Service X stated she oversaw the activities for R39's unit. Social Service X stated there were activity calendars posted everywhere. She stated there was one on the whiteboard in the dining area for all staff and residents to see daily. Social Service X stated there were also activity calendars in each resident's room. She stated the team for R39 was responsible for getting the resident to activities. She stated she saw R39 in the dining area so she did not take the resident to the live music playing in the Dug Out. The facility did not provide a policy for activities. The facility failed to ensure R39 was invited, encouraged, and assisted to go to activities she enjoyed. This deficient practice placed the resident at risk for decreased psychosocial well-being.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 45668 The facility identified a census of 70 residents. The sample included 19 with seven reviewed for accidents. Based on record review, interviews, and observations, the facility failed to utilize safe heat therapy practices for Resident (R) 64. This deficient practice resulted in a second degree (potentially painful burn which affects the first and second layer of the skin) burn on R64's right knee. The facility additionally failed to ensure a safe environment related to maintaining R22's wheelchair and bed fall-prevention alarm. This deficient practice placed R22 at risk for preventable accidents and injuries. Findings Included: - The Medical Diagnosis section within R64's Electronic Medical Records (EMR) included diagnoses of epilepsy (brain disorder characterized by repeated seizures), seizures (violent involuntary series of contractions of a group of muscles), osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain), muscle weakness, and Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure). R64's Quarterly Minimum Data Set (MDS) completed 04/15/24 noted a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. The MDS indicated he was independent with toileting, transfers, bathing, dressing, and personal hygiene. The MDS indicated he had no skin impairments or pressure ulcers (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). R64's Functional Abilities Care Area Assessment (CAA) completed 01/19/24 indicated he was independent with all of his activities of daily living (ADLs). The CAA indicated he had times of urinary incontinence and was at risk for skin breakdown. The CAA instructed staff to assist him as needed. R64's Care Plan initiated 02/11/23 indicated he was at risk for altered skin integrity. The plan instructed staff to complete weekly skin checks. The plan noted he received a second-degree burn on his right knee related to heat therapy (04/18/24). The plan indicated he would not have any heating packs applied to his right knee until his wound healed. A Facility Reported Incident (FRI) report 7318 dated 04/17/24 indicated Consultant GG worked with R64 in the therapy room. The report indicated R64 complained of knee pain and Consultant GG applied a moist heating pack to R64's right knee. The report indicated the heating pack did not have a protective cover and Consultant GG improvised using multiple layers of towels. The report indicated Consultant GG completed R64's therapy treatment, removed the towels, and noted R64 acquired a blister with clear fluid on the outside of his right knee from the heating packs. The burn measured 2.1 centimeters in length and one centimeter wide. Consultant GG reported the injury to nursing services, R64's medical practitioner, and R64's representative. The report's video review documented Consultant GG applied a gait belt around the towels on R64's right knee. Heat therapy services were immediately suspended by the facility until protective covers for the heating packs could be found or ordered. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 04/30/24 at 01:05 PM R64 sat in his recliner with his meal. R64 reported his burn no longer hurt but was still present. R64 pulled up his right pant leg to reveal his burn wound. R64's wound bed was clean with no signs of infection. The blister was no longer present. R64 denied pain or itching at the wound site. R64 stated the wound occurred when therapy did not use the right cover on their heating packs. He stated he did not realize the wound was occurring during his therapy treatment until the pack was removed. He stated he had never been burned or injured during therapy before or since this incident. He stated therapy was holding off on his treatments until his wound recovered. On 05/01/24 at 08:30 AM Consultant GG stated on 04/17/24 she provided therapy services for R64 when he complained of right knee pain, and she attempted to use a heating pack. She stated she searched throughout the facility for the appropriate safety covers for the heating packs but was unable to find them. Consultant GG stated she worked at the facility since 2020 and always had the covers for the packs but was unable to find them on that day. She stated she used multiple layers of terry cloths over the pack to provide a barrier and it was common practice to use two or more layers of towels on heating packs if the appropriate covers were not available. She stated she checked with R64 throughout his therapy to ensure he was okay and not in pain. She stated she checked his skin throughout his therapy service and once they completed his therapy she removed the pack and found the burn. She stated she immediately reported it to nursing staff. She stated she reported to Administrative Nurse D about not having the correct protective covers for the heating packs. On 05/01/24 at 12:41 PM Administrative Nurse D stated the facility had the correct covers and Consultant GG just needed to ask staff where the covers were. She stated the facility investigation indicated the burn may have come from Consultant GG applying an inappropriate barrier around the heating pack and the pressure from the gait belt during his physical therapy exercises. She stated the facility ordered extra safety covers and completed in-service training with both nursing and therapy staff related to burns, accidents, heating packs, and skin protection. She stated R64's therapy services would be held until his wound healed. The facility's Hydrocollator (thermostatically controlled water bath used to heat cloth pads) Pack Usage policy dated 01/2024 indicated hot moist pack treatments are to be used as a component of a patients plan of care for skilled therapy services. The policy indicated moist hot packs will be the appropriate size and pack cover for the area being treated. The policy noted staff would utilize the appropriate equipment and placement for heat therapy. The facility failed to utilize safe heat therapy practices during therapy for R64. These deficient practices resulted in a second degree burn on R64's right knee. - The Medical Diagnosis section within R22's Electronic Medical Records (EMR) included diagnoses of dementia (a progressive mental disorder characterized by failing memory, and confusion), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), cognitive-communication deficit, muscle weakness, and a need for assistance with personal cares. R22's Quarterly Minimum Data Set (MDS) completed 04/02/24 noted a Brief Interview for Mental Status (BIMS) score of four indicating severe cognitive impairment. The MDS indicated she required partial to moderate assistance with dressing, toileting, bathing, transfers, and personal hygiene. The MDS indicated she was occasionally incontinent of bowel and frequently incontinent of the bladder. The MDS indicated she had two non-injury falls since her admission. The MDS indicated she had no behavioral concerns or refusals of care. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R22's Dementia Care Area Assessment (CAA) completed 01/09/24 indicated she had a cognitive decline but was able to make her needs known. The CAA indicated intervention will be put in place to minimize her risks related to her cognitive impairment. R22's Fall CAA completed 01/09/24 indicated she had a history of falls related to her impaired mobility. The CAA indicated staff were to assist her with her activities of daily living (ADLs) and care as needed. R22's Care Plan initiated 11/01/21 indicated she was at risk for falls due to poor safety awareness and balance. The plan indicated she was able to ambulate independently in her wheelchair but required the assistance of one staff member for transfers (01/05/24). The care plan indicated R22 had a non-injury on 03/27/24 while she attempted to self-transfer from her bed. The plan indicated a pressure sensor pad was implemented for her bed and wheelchair (03/28/24). On 04/30/24 at 07:08 AM R22 was awake in her bed. She appeared confused and was attempting to transfer herself from her bed to her wheelchair. R22 attempted several times to reposition herself in her bed. The pressure sensor pad was underneath her. At 07:15 AM R22 lifted herself from her bed and moved to her wheelchair. R22 wheeled herself outside her room and down the hallway to the medication room. Staff did not come to the room to intervene in the self-transfer. On 04/30/24 at 07:38 AM an inspection and pressure test of R22's bed pressure sensor pad revealed the alarm did not relay to the relay box posted in the nurse's station in response to the pressure test. On 05/01/24 at 07:25 AM A test of R22's pressure sensor pad in her wheelchair revealed the alarm did not relay to the audible relay box posted in the nurse's station in response to the pressure test. Certified Nurses Aid (CNA) P acknowledged the pressure pad was not functioning and the relay box should have a loud audible alarm when R22 attempted to move from surface to surface. She stated the relay box should alarm for both R22's bed and chair alarms. She stated the bed alarms were usually checked weekly, but she was not sure why the sensors were not working. On 05/01/24 at 07:30 AM the facility posted a direct care staff member in R22's room until her bed alarms could be replaced. On 05/01/24 at 07:45 AM Licensed Nurse (LN) G stated staff was expected to check to functionality of the pressure sensor pads each shift to ensure they were working. She stated R22 frequently transferred without asking for staff assistance and was a fall risk On 05/01/24 at 12:41 PM Administrative Nurse D stated staff were expected to check the alarms each shift to ensure their function. She stated the facility will be replacing R22's alarm due to it not operating consistently. She stated the facility ordered extra alarms to keep on hand in case other alarms malfunctioned. The facility's Fall Prevention and Management policy (undated) indicated the facility would identify residents at risk for falls and implement interventions to reduce to risks identified. The policy indicated staff were to ensure environmental conditions remained safe for residents at risk and equipment remained in working functional order. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The facility failed to ensure a safe environment related to maintaining R22's wheelchair and bed fall prevention alarm. This deficient practice placed R22 at risk for preventable falls and injuries.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41037 The facility identified a census of 70 residents. The sample included 19 residents with five residents reviewed for unnecessary medication. Based on observation, record review, and interviews, the facility failed to ensure a physician-documented rationale for extended use of an as-needed psychotropic (alters mood or thought) medication for Resident (R) 29, and R40. This deficient practice placed these residents at risk for unnecessary medication administration thus leading to possible harmful side effects. Findings included: - R29's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), delusion (untrue persistent belief or perception held by a person although evidence shows it was untrue), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). The Annual Minimum Data Set (MDS) dated [DATE] documented a staff interview that indicated severely impaired cognition. The Quarterly MDS dated [DATE] documented a staff interview which indicated severely impaired cognition. The MDS documented that R29 had received antipsychotics (a class of medications used to treat major mental conditions that cause a break from reality), antidepressants (a class of medications used to treat mood disorders), antianxiety (a class of medications that calm and relax people), and a diuretic (medication to promote the formation and excretion of urine) medication during the observation period. R29's Psychotropic Drug Use Care Area Assessment (CAA) dated 09/07/23 documented she received psychotropic medication which placed her at risk for adverse reactions. R29's Care Plan dated 12/28/22 documented that staff would provide comfort medication for pain, anxiety, and air hunger as ordered. R29's EMR under the Orders tab revealed the following physician orders: Lorazepam (antianxiety medication) oral concentrate 2 milligrams (mg) mg/milliliters (ml) give 0.25 ml by mouth three times a day for agitation, anxiety, and restlessness related to Alzheimer's disease for six months dated 03/17/24. Lorazepam oral concentrate 2 mg/ml give 0.25 ml every two hours as needed for mild to moderate anxiety or restlessness for six months and give 0.5 ml every two hours as needed for moderate to severe anxiety or restlessness for six months dated 03/17/24. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of R29's EMR lacked evidence of physician rationale for the extended duration for the as-needed lorazepam. The facility was unable to provide a physician-documented rationale for the extended duration for the as-needed lorazepam upon request. On 04/30/24 at 09:28 AM R29 sat reclined in her Broda chair (specialized wheelchair with the ability to tilt and recline) next to her bed asleep. On 05/01/24 at 09:49 AM, Licensed Nurse (LN) H stated the physician reviewed the monthly pharmacy reviews and made any changes. LN H stated the physician decided the duration for any medication. On 05/01/24 at 12:39 PM, Administrative Nurse D stated she was unable to locate any documented physician rationale for the extended duration for R29's as-needed lorazepam. The facility's undated Antipsychotic Drug policy documented based on a comprehensive assessment of each resident, the interdisciplinary team would ensure a resident who had not used antipsychotic drugs was not given an antipsychotic drug unless antipsychotic drug therapy was necessary to treat a specific condition as diagnosed and documented in the resident's clinical record. After other non-pharmacologic interventions or alternatives have been considered or used. Antipsychotic medication was prescribed at the lowest effective therapeutic dose for the shortest effective duration. The facility failed to ensure the physician documented a rationale for the extended duration of use of as-needed lorazepam for R29. This deficient practice placed R29 at risk for the potential of unnecessary medication administration thus leading to possible harmful side effects. - R40's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), antianxiety (class of medications that calm and relax people), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and dementia (a progressive mental disorder characterized by failing memory, confusion). The Significant Change Minimum Data Set (MDS) dated [DATE] documented a staff interview that indicated moderately impaired cognition. The Quarterly MDS dated [DATE] documented a staff interview which indicated severely impaired cognition. The MDS documented that R40 received antianxiety (a class of medications that calm and relax people), antidepressant (a class of medications used to treat mood disorders), antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality), a diuretic (medication to promote the formation and excretion of urine), and opioid medication during the observation period. R40's Psychotropic Drug Use Care Area Assessment (CAA) dated 06/30/23 documented she received psychotropic medication which placed her at risk for adverse reactions. R40's Care Plan dated 05/31/23 documented staff would provide medication as ordered. The plan documented staff would monitor and notify her physician of any adverse reactions. R40's EMR under the Orders tab revealed the following physician orders: (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Lorazepam (antianxiety medication) intensol oral concentrate two milligrams (mg)/milliliters (ml). Give 0.5 ml by mouth every hour as needed for increased restlessness and/or anxiety for six months dated 01/24/24. A review of R40's EMR lacked evidence of a physician-documented rationale for the extended duration of R40's as-needed lorazepam. The facility was unable to provide a physician-documented rationale for the extended duration for the lorazepam upon request. On 04/29/24 at 09:12 AM R40 lay in bed with her eyes closed. The bed was lowered to the floor and there was a fall mat on the floor next to the bed. On 05/01/24 at 09:49 AM, Licensed Nurse (LN) H stated the physician reviewed the monthly pharmacy reviews and made any changes. LN H stated the physician decided the duration for any medication. On 05/01/24 at 12:39 PM, Administrative Nurse D stated she was unable to locate any documented physician rationale for the extended duration for R40's as-needed lorazepam. The facility's undated Antipsychotic Drug policy documented based on a comprehensive assessment of each resident, the interdisciplinary team would ensure a resident who had not used antipsychotic drugs was not given an antipsychotic drug unless antipsychotic drug therapy was necessary to treat a specific condition as diagnosed and documented in the resident's clinical record. After other non-pharmacologic interventions or alternatives have been considered or used. Antipsychotic medication was prescribed at the lowest effective therapeutic dose for the shortest effective duration. The facility failed to ensure the physician documented a rationale for the extended duration for as-needed lorazepam for R40. This deficient practice placed R40 at risk for the potential of unnecessary medication administration thus leading to possible harmful side effects.

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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 70 residents with one kitchen and two main dining rooms. Based on observation, record review, and interviews, the facility failed to follow sanitary dietary standards related to cleaning, food storage, equipment storage, and food preparation practices. These deficient practices placed the residents at risk related to food-borne illnesses and food safety concerns. Finding Included: - On 04/29/24 at 07:04 AM an initial walkthrough of the kitchen was completed. An inspection of a utensil storage rack next to the kitchen main entry revealed two Crock-pot lids and a water pitcher lid stored with the food/beverage side upward. An inspection of the kitchen's fryer station revealed old crumbs and food particles covering the outside of the fryer and the side of the baking oven next to it. An inspection of the kitchen's dry food storage revealed old pieces of food on the floor throughout the storage room. On 04/30/24 at 02:30 PM Dietary Staff CC completed hand hygiene and prepped the dinner puree meal. Dietary Staff CC prepared to make pureed tuna noodle casserole. Dietary Staff CC added three cups of pre-prepped tuna noodle casserole and one-half cup of chicken stock to the food processing machine. Dietary Staff CC started to food processor. Dietary Staff CC donned gloves without completing hand hygiene. Dietary Staff CC opened a drawer below the food processor, pulled out a four-ounce scoop (ice cream style scoop), and placed the scoop face down directly on the dirty food preparation area without a clean barrier. Dietary Staff CC stopped the food processor and prepared a tin food bin for the pureed meal. Dietary Staff CC utilized the scoop to transfer the pureed casserole into the food bin. An inspection of Connie's Place dining room refrigerator revealed six opened and unlabeled quart containers of ice cream and one opened bag of tater tots. An inspection of the walk-in freezer revealed an opened but undated bag of breaded chicken. On 05/01/24 at 10:10 AM Dietary Staff BB stated staff were expected to ensure clean hygienic food preparation and use clean utensils while serving or preparing meals. He stated staff were expected to store cooking utensils and plates with the food or eating surface downward. He stated staff cleaned the kitchen daily and checked stored food to ensure opened items were labeled and dated. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of the facility's Food Services and Nutrition policy (undated) indicated the facility would promote a system that identified proper service, cleaning, and food storage. The policy noted all surfaces within the dining room and kitchen were to be cleaned and sanitized per professional standards. The policy indicated food would be labeled/dated and stored in a manner that is safe and maintains nutritional value. The policy indicated staff were to ensure safe food handling practices to prevent cross-contamination and food-borne illness. The policy indicated staff should complete hand hygiene in between touching surfaces related to direct food preparation, handling, and serving. The policy noted all kitchen and dining equipment be stored in a manner that prevents soiling or contamination of clean items. The facility failed to follow sanitary dietary standards related to cleaning, food storage, equipment storage, and food preparation practices. These deficient practices placed the residents at risk related to food-borne illnesses and food safety concerns.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. 45668 The facility identified a census of 70 residents. The sample included 19 residents with one resident reviewed for hospice services. Based on observation, record review, and interviews, the facility failed to ensure collaboration between the nursing home and hospice services to identify hospice-supplied services, supplies, medication, and equipment for Resident (R)47. This deficient practice placed the resident at risk for delayed services and uncommunicated care needs. Findings Included: - The Medical Diagnosis section within R47's Electronic Medical Records (EMR) included diagnoses of senile degeneration of the brain, Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness), dysphagia (swallowing difficulty), memory deficit, left-sided hemiplegia (paralysis of one side of the body), left-sided hemiparesis (muscular weakness of one half of the body), and dementia (progressive mental disorder characterized by failing memory, confusion). R47's Quarterly Minimum Data Set (MDS) completed 04/09/24 noted a Brief Interview for Mental Status (BIMS) score of 12 indicating mild cognitive impairment. The MDS indicated he required partial assistance during meals. The MDS indicated he utilized a manual wheelchair for mobility. The MDS indicated he had upper and lower extremity impairments on one side of his body. The MDS indicated he displayed coughing and choking while swallowing meals or medications. The MDS indicated he received hospice services (end-of-life comfort care). R47's Functional Abilities Care Area Assessment (CAA) completed 01/14/24 indicated he required maximum assistance from staff for all his activities of daily living (ADLs) and care as needed. R47's Care Plan initiated 01/09/24 indicated he was on hospice services related to his medical diagnoses. The plan indicated he would be supported through the dying process. The plan noted he would remain comfortable through the next review period. The plan indicated the facility and selected hospice service provider would coordinate a care plan and invite hospice staff to care plan meetings. The plan lacked documentation related to the hospice equipment, medications, services, and scheduled visits from hospice staff. On 05/01/24 at 09:51 AM, R47 sat in his Broda chair (specialized wheelchair with the ability to tilt and recline) in the assisted dining room. R47's drink was on the table to his left side. R47 attempted to reach the drink with his right arm several times but was unable to grab the covered cup. R47 moved his Broda chair with his right leg several times. R47's left leg pressed against the table metal bar. R47 grabbed his cup with his right hand. R47's lap tray remained on the floor under the television. On 05/01/24 at 09:51 AM Licensed Nurse (LN) G stated staff was not using the lap tray due to it did not fit R47's new chair. She stated hospice replaced his Broda chair, but the lap tray did not fit his new chair. She stated staff was to assist R47 during meals. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/01/24 at 10:10 AM Certified Nurse's Aide (CNA) P stated the care plans did not include information related to equipment, medications, supplies, and staffing visits provided by hospice. She stated she was not sure if any of the care plans had hospice information other than the name of the hospice company. On 05/01/24 at 12:41 PM Administrative Nurse D stated the care plans should at least include the hospice contact information, staff visits, and services provided. The facility's Hospice Services policy revised indicated the facility will coordinate with the selected hospice agency to provide services necessary for effective end-of-life care. The facility failed to ensure collaboration between the nursing home and hospice services to identify hospice-supplied services, supplies, medication, and equipment for R47. This deficient practice placed R47 at risk for delayed services and uncommunicated care needs.