STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175401	A. Building B. Wing	04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bonner Springs Nursing & Rehab Center	520 E Morse Street Bonner Springs, KS 66012

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32360 The facility had a census of 24 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to develop a comprehensive care plan with resident-centered interventions to prevent pressure ulcers for one resident, Resident (R) 33. This placed the resident at risk for unmet care needs and skin breakdown. Findings included: - The Electronic Medical Record (EMR) documented R33 has diagnoses of schizophrenia (a mental disorder characterized by gross distortion of reality, disturbance of language and communication, and fragmentation of thought), dementia (a progressive mental disorder characterized by failing memory and confusion), bipolar disorder (a major mental illness that causes people to have episodes of severe high and low moods), hypertension (high blood pressure), acquired absence of toes (a condition where one or more toes are lost as a result of trauma, infection, vascular disease, tumors or diabetes), and peripheral vascular disease (PVD - slow and progressive circulation disorder causing narrowing, blockage, or spasms in a blood vessel). The Admission Minimum Data Set (MDS), dated [DATE], documented R33 had severely impaired cognition. R33 required substantial assistance from staff for showers, lower body dressing, personal hygiene, transfers, and partial assistance for mobility. The MDS documented R33 was at risk for pressure ulcers, had no pressure relieving device for bed and chair, upper and lower functional impairment on both sides, and no turning or repositioning program. R33 had no skin breakdown. The Pressure Ulcer Care Area Assessment (CAA), dated 01/13/25, documented R33 was at risk for skin breakdown due to incontinent episodes and bed mobility, and directed staff to observe and report any skin changes. The Significant Change MDS, dated [DATE], documented R33 had severely impaired cognition. R33 was dependent upon staff for bed mobility, eating, oral hygiene, and lower body dressing. R33 was at risk for pressure ulcers, had pressure relieving devices for her bed and chair, and had no turning or repositioning program. R33 had an unhealed Stage 3 pressure ulcer and received pressure ulcer care. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Pressure Ulcer CAA, dated 04/08/25, documented R33 had a pressure ulcer due to a history of pressure ulcers, cognitive loss, incontinence, and pain. R33's skin would be assessed each week and the physician would be notified of any abnormal findings, The RD would monitor R33's food and fluid intake and implement dietary interventions as necessary. The caregivers would reposition R33 every two hours and as needed for comfort. The CAA further documented a care plan would be initiated to improve the actual pressure ulcer by decreasing size and condition, improving current status, and functional ability, and decreasing further pressure ulcer risk. R33's Care Plan lacked a care area with interventions for skin breakdown. The Braden Scale Assessment, (formal assessment for predicting pressure ulcer risk) dated 01/12/25, documented R33 had a very high risk for developing pressure ulcers. The Braden Scale Assessments, dated 01/22/25 and 04/10/25, documented R33 was a high risk for pressure ulcers. The Skin Only Evaluation, dated 03/26/25, documented R33's skin was intact. The Nurse's Note, dated 03/27/25 at 02:31 PM, documented R33 had a fluid-filled blister on her right heel. A low air-loss mattress (a specialized mattress designed to prevent skin breakdown and pressure ulcers by continuously circulating air through the mattress surface, creating a cool and dry environment). As on order, the wound clinic would evaluate and treat her heel. The note further documented the physician and guardian had been notified and R33 was to wear heel protectors while in bed. The Physician's Order, dated 03/27/25, directed staff to apply Skin prep (liquid skin protectant) daily, and may use a foam dressing for extra protection to be done daily at bedtime. The order further directed staff to check her low air loss mattress every shift to ensure it was functioning properly. The order was discontinued on 03/28/28. The Physician's Order, dated 03/28/25, directed staff to place heel protectors on R33's feet while in bed every shift. The Wound Clinic Assessment, dated 03/28/25, documented R33 had a blood/fluid-filled blister on her right heel that was still intact. The assessment documented the blister measured the area at 11.6 centimeters (cm), perimeter 12.9 cm, 4.6 cm long, and 3.7 cm wide, with a wound volume of 1.70 cm. Staff were ordered to cleanse the wound with wound cleanser, skin prep to stable eschar (dead skin), apply duoderm (wafer-type moisture-retentive wound dressing used for partial and full thickness wounds leaking fluids) at bedtime on Monday, Wednesday, Friday, and as needed. R33 had edema to her right and left leg and educated staff on the importance of offloading (removing or keeping pressure off) the area as much as possible. The Skin Only Evaluation, dated 04/02/25 documented R33 had intact skin. The Wound Clinic Assessment, dated 04/04/25, documented R33 had an open wound on her right heel. The assessment documented area measured 3 cm x 3.6 cm x 1.08 cm. The staff were ordered to continue the current treatment. Staff were education on the importance of offloading the area as much as possible. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Wound Clinic Assessment, dated 04/11/24, documented R33 had an open wound on her right heel. The assessment documented R33's wound measured 3.9 cm x 3 cm x 0.1 cm and to continue current treatment. Staff were provided with education to continue to elevate R33's legs due to edema and to continue with the pressure-relieving boots. The Skin Only Evaluation, dated 04/11/25, documented R33 had a pressure ulcer on her right heel that was a stage 3. The wound bed had epithelial tissue (new skin growing in a wound), no exudate (the fluid that leaks out of body vessels and tissue), and the undermining (the separation of skin and underlying tissues, creating a space or pocket around the wound edge) was mushy. The Skin Only Evaluation, dated 04/16/25, documented R33 had a pressure ulcer on her right heel that was a stage 3. The wound bed had epithelial tissue and no exudate was mushy. The evaluation documented protective boots were in place. On 04/14/25 at 02:05 PM AM, observation revealed R33 in bed, she had a low air-loss mattress on her bed. Licensed Nurse (LN) G and Certified Nurse Aide (CNA) N gowned, gloved, and masked. LN G placed a paper towel on the nightstand and laid the duoderm and skin prep on it. She asked R33 if she could change the dressing on her heel. R33 responded, Ok. LN G told R33 that this Surveyor needed to look at her heel and pulled down R33's blanket. R33 had regular socks on, and her heels pressed against the mattress, she did not have her protective boots on. R33 began to scream, NO, NO, NO loudly. LN G stated, Can we please look at your heel? R33 stated, NO! LN G stated, Do you want to hold your baby doll while we look at your heel? R33 screamed loudly. LN G pulled R33's blanket back up and stated, Her dressing is usually changed in the evening at bedtime. On 04/14/25 at 02:37 PM, Administrative Nurse E stated it was a team effort to provide interventions on the care plan but it was her responsibility to make sure the care plans were completed. Administrative Nurse E verified that there was not a pressure ulcer care plan in place. On 04/15/25 at 07:45 AM, observation revealed R33, in in the living room area, with regular socks and shoes on. On 04/15/25 at 09:25 AM, CNA N stated she did not know what had caused R33's pressure ulcer and was unable to tell me what interventions were put into place prior to and after she developed the pressure ulcer. On 04/15/25 at 9:30 AM, LN G stated R33 did not move her feet and were always planted with her heels on the mattress, and she developed the pressure ulcer. LN G further stated she has the pressure relieving mattress and was supposed to wear the protective boots at all times and verified R33 had not had them on while in bed. On 04/15/25 at 03:10 PM, Consultant GG stated she went to the facility monthly and had originally recommended Pro-Stat (to support the dietary management of a condition requiring increased protein intake in low volume) but since R33 did not have any skin issues, it was discontinued. Consultant GG stated she expected the facility to contact her for recommendations if a resident had a change in their skin condition. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/16/25 at 09:06 AM, Dietary BB stated she was unaware R33 had skin breakdown and verified R33 was not receiving any additional protein in her diet or any type of supplement for wound healing. On 04/16/25 at 09:45 AM, LN G stated R33 refused to have the dressing changed. On 04/16/25 at 01:00 PM, Administrative Nurse D stated that they should have interventions put into place to prevent her pressure ulcer. Administrative Nurse D stated that she would work with the RD for recommendations for healing of the pressure ulcer. The facility's Care Planning-Interdisciplinary Team policy, dated 08/11/21, documented the team was responsible for the development of an individualized comprehensive care plan for each resident. The care plan was developed within seven days of completion of the resident assessment.

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F 0686 Level of Harm - 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** 32360 The facility had a census of 34 residents. The sample included 12 residents, with three reviewed for 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). Based on observation, record review, and interview, the facility failed to act upon an identified risk for pressure ulcers and implement preventative interventions for Resident (R) 33, who had edema (swelling resulting from an excessive accumulation of fluid in the body tissues) in her leg and required staff assistance with activities of daily living (ADL). Subsequently, R33 developed a Stage 3 (full-thickness tissue loss) pressure ulcer on her right heel. The facility then failed to involve the Registered Dietitian (RD) for nutritional recommendations to promote wound healing, and also placed the resident at risk for delayed healing or worsened wounds. Findings included: - The Electronic Medical Record (EMR) documented R33 has diagnoses of schizophrenia (a mental disorder characterized by gross distortion of reality, disturbance of language and communication, and fragmentation of thought), dementia (a progressive mental disorder characterized by failing memory and confusion), bipolar disorder (a major mental illness that causes people to have episodes of severe high and low moods), hypertension (high blood pressure), acquired absence of toes (a condition where one or more toes are lost as a result of trauma, infection, vascular disease, tumors or diabetes), and peripheral vascular disease (PVD- slow and progressive circulation disorder causing narrowing, blockage, or spasms in a blood vessel). The Admission Minimum Data Set (MDS), dated [DATE], documented R33 had severely impaired cognition. R33 required substantial assistance from staff for showers, lower body dressing, personal hygiene, transfers, and partial assistance for mobility. The MDS documented R33 was at risk for pressure ulcers and had no pressure-relieving device for her bed and chair. She had functional impairment on both sides of her upper and lower extremities. The MDS recorded she was not on a turning or repositioning program and had no skin breakdown. The Pressure Ulcer Care Area Assessment (CAA), dated 01/13/25, documented R33 was at risk for skin breakdown due to incontinence episodes and bed mobility, and directed staff to observe and report any skin changes. The Significant Change MDS, dated [DATE], documented R33 had severely impaired cognition. R33 was dependent upon staff for bed mobility, eating, oral hygiene, and lower body dressing. The MDS documented R33 was at risk for pressure ulcers and had no pressure-relieving device for her bed and chair. She had functional impairment on both sides of her upper and lower extremities. R33 had an unhealed Stage 3 pressure ulcer and received pressure ulcer care. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The Pressure Ulcer CAA, dated 04/08/25, documented R33 had a pressure ulcer due to a history of pressure ulcers, cognitive loss, incontinence, and pain. R33's skin would be assessed each week, and the physician would be notified of any abnormal findings. The RD would monitor R33's food and fluid intake and implement dietary interventions as necessary. The caregivers would reposition R33 every two hours and as needed for comfort. The CAA further documented a care plan would be initiated to improve the actual pressure ulcer by decreasing size and condition, improving status, and functional ability, and decreasing further pressure ulcer risk. R33's Care Plan, dated 03/23/25, initiated on 01/09/25, documented R33 was assisted with all care and directed staff to assist her with activities, ensure her call light was within reach, and administer medication as ordered. The care plan lacked interventions to prevent skin breakdown. The Braden Scale Assessment (a formal assessment for predicting pressure ulcer risk) dated 01/12/25 documented R33 had a very high risk for developing pressure ulcers. The Braden Scale Assessments dated 01/22/25 and 04/10/25, documented R33 was at high risk for pressure ulcers. The Registered Dietitian Progress Note, dated 03/19/25, documented R33's weight had increased by four pounds and R33 often ate 100% at meals. R33 required meal assistance and had intact skin. The note documented staff were to refer to the RD as needed. The Skin Only Evaluation, dated 03/26/25, documented R33's skin was intact. The Nurse's Note, dated 03/27/25 at 02:31 PM, documented R33 had a fluid-filled blister on her right heel. The note documented that a low-air-loss mattress (a specialized medical mattress that maintains a constant airflow through tiny holes in the mattress surface to help with skin breakdown) was on order, and the wound clinic would evaluate and treat her heel. The note further documented that staff notified the physician and guardian, and R33 was to wear heel protectors while in bed. The Physician's Order, dated 03/27/25, directed staff to apply Skin-prep (liquid skin protectant) daily, and directed staff may place a foam dressing for extra protection to be done daily at bedtime. The order further directed staff to check R33's low-air-loss mattress every shift to ensure it was functioning properly. The order was discontinued on 03/28/28. The Wound Clinic Assessment, dated 03/28/25, documented R33 had a blood/fluid-filled blister on her right heel that was still intact. The assessment documented the blister measured the area at 11.6 centimeters (cm), with a perimeter of 12.9 cm, and was 4.6 cm long, 3.7 cm wide, with a wound volume of 1.70 cm. Staff were ordered to cleanse the wound with wound cleanser, apply Skin-prep to the stable eschar (dead skin), and apply Duoderm (wafer-type moisture-retentive wound dressing used for partial and full thickness wounds leaking fluids) at bedtime on Monday, Wednesday, Friday, and as needed. R33 had edema to her right and left legs, and staff received education on the importance of offloading (removing or keeping pressure off) the area as much as possible. The Physician's Order, dated 03/28/25, directed staff to place heel protectors on R33's feet while in bed every shift. The Skin Only Evaluation, dated 04/02/24, documented R33 had intact skin. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The Wound Clinic Assessment, dated 04/04/25, documented R33 had an open wound on her right heel. The assessment documented an area measured 3 cm (length) by 3.6 cm (width) by 1.08 cm (depth). The staff were ordered to continue the current treatment. Staff were educated on the importance of offloading the area as much as possible. The Wound Clinic Assessment, dated 04/11/24, documented R33 had an open wound on her right heel. The assessment documented R33's wound measured 3.9 cm (length) by 3 cm (width) by 0.1 cm (depth), and to continue the current treatment. Staff were provided with education on how to continue to elevate R33's legs due to edema and to continue with the pressure-relieving boots. The Skin Only Evaluation, dated 04/11/24, documented R33 had a Stage 3 pressure ulcer on her right heel. The wound bed had epithelial tissue (new skin growing in a wound), no exudate (the fluid that leaks out of body vessels and tissue), and the undermining (the separation of skin and underlying tissues, creating a space or pocket around the wound edge) was mushy. The Skin Only Evaluation, dated 04/16/24, documented R33 had a Stage 3 pressure ulcer on her right heel. The evaluation noted the wound bed had epithelial tissue, had no exudate, and was mushy. The evaluation documented that protective boots were placed on R33. The EMR for R33's lacked documentation the RD was notified after R33 developed skin breakdown and R33's clinical record lacked evidence of a RD evaluation or recommendation from 03/20/25 through 04/15/25. On 04/14/25 at 02:05 PM, observation revealed R33 laid in her bed, which had a low-air-loss mattress. Licensed Nurse (LN) G and Certified Nurse Aide (CNA) N donned gowns, gloves, and masks. LN G placed a paper towel on the nightstand and laid the Duoderm and Skin-prep on it. LN G asked R33 if she could change the dressing on her heel, and R33 consented. Continued observation revealed R33 wore regular socks and her heels were pressed against the mattress. R33 was not wearing her protective boots. On 04/15/25 at 07:45 AM, observation revealed R33 in the living room area and she did not have her protective boots on. On 04/14/25 at 02:37 PM, Administrative Nurse E stated it was a team effort to ensure interventions were on the care plan, but said it was her responsibility to make sure the care plans were completed. Administrative Nurse E verified there was not a pressure ulcer care plan in place for R33. On 04/15/25 at 09:25 AM, CNA N stated she did not know what caused R33's pressure ulcer. CNA N was unable to say what interventions were put in place before and after R33 developed the pressure ulcer. On 04/15/25 at 9:30 AM, LN G stated R33 did not move her feet, always had her heels directly on the mattress, and she had developed a pressure ulcer. LN G further stated R33 had the pressure-relieving mattress and was supposed to wear the protective boots at all times. LN G verified R33 had not had the protective boots on while in bed. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 04/15/25 at 03:10 PM, Consultant GG stated she went to the facility monthly and had originally recommended Pro-Stat (to support the dietary management of a condition requiring increased protein intake in low volume), but since R33 did not have any skin issues, it was discontinued. Consultant GG stated she expected the facility to contact her for recommendations if a resident had a change in their skin condition. On 04/16/25 at 09:06 AM, Dietary Staff BB stated she was unaware R33 had skin breakdown and verified R33 was not receiving any additional protein in her diet or any type of supplement for wound healing. On 04/16/25 at 01:00 PM, Administrative Nurse D stated they should have interventions put into place to prevent R33's pressure ulcer. Administrative Nurse D stated she would work with the RD for recommendations for healing the pressure ulcer. The facility's Pressure Injuries undated policy, documented that any area caused by unrelieved pressure resulting in damage of underlying tissue was a pressure ulcer. Pressure ulcers are usually located over bony prominences and are classified by stage to describe the degree of tissue damage. Assessment and documentation must appear in the medical record if the resident's pressure ulcer is unavoidable. Routine preventative care means proper positioning and repositioning, application of pressure reduction or relief devices, providing good skin care, and maintaining adequate nutrition and hydration.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41713 The facility identified a census of 34 residents. The sample included 12 residents, with five sample residents reviewed for unnecessary medications. Based on observation, record review, and interview, the facility failed to ensure that the physician responded to the recommendations made by the Consultant Pharmacist (CP) to ensure that Resident (R) 23's antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) medication Seroquel had an appropriate Centers for Medicare and Medicaid Services (CMS) indication for use. These deficient practices placed R23 at risk of unnecessary medication administration and related complications. Findings included: - R23's Electronic Medical Record (EMR) documented diagnoses of cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), hemiplegia (paralysis of one side of the body), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and symptoms involving emotional state (the feelings and mood an individual experiences, such as happiness, sadness, anger, fear, or anxiety). R23's Significant Change Minimum Data Set (MDS) dated [DATE] documented he had a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. R23 was independent with his functional abilities and used a walker to assist with ambulation. R23 received an antipsychotic on a routine basis. R23's Psychotropic Drug Use Care Area Assessment (CAA) dated 08/08/24 documented he received an antipsychotic and antianxiety (a class of medications that calm and relax people) medications to treat anxiety and mood impairment. A gradual dose reduction (GDR) had not been recommended by the physician since admission. R23's Care Plan revised on 07/25/24 directed staff to administer medications as ordered. Staff were to monitor and document side effects. Staff were directed to monitor his behaviors every shift. When R23 would become agitated, staff were directed to intervene before the agitation escalated. Staff were directed to guide the resident away from the source of distress. R23's Orders tab of the EMR documented an active order dated 09/13/24 for quetiapine (Seroquel an antipsychotic medication) 200 milligrams (mg) to be given by mouth at bedtime for mood management. A 04/24/24 Note to Attending Physician/Prescriber for R23 documented the CP's recommendation that R23 received the antipsychotic agent Seroquel but lacked an allowable diagnosis to support the use. If continued use of this medication for the indication currently listed in the chart was warranted, please provide a clinical rationale. The physician failed to respond to the CP recommendation. On 04/15/25 at 09:15 AM, R23 ambulated with his walker down the hall. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/16/25 at 12:50 PM, Administrative Nurse D stated administrative staff had noticed that in the past that the previous physician had not been addressing the CP recommendation as they should have been. Administrative Nurse D stated that she, along with other administrative staff were working with the physicians and pharmacy to ensure that the recommendations were being addressed promptly. The facility's Medication Regimen Reviews (MRR) policy, revised on October 2024 documented that the goal of the MRR was to promote positive outcomes while minimizing adverse consequences and potential risks associated with medication. The MRR involved a thorough review of the resident's medical record to prevent, identify, report, and resolve medication-related problems, medication errors, and other irregularities such as medications ordered in excessive doses or without clinical indication. Within 24 hours of the MRR, the Consultant Pharmacist provided a written report to the attending physicians for each resident identified as having a non-life-threatening medication irregularity. If the attending physician did not provide a timely or adequate response, or the CP identified that no action had been taken, he/she would contact the medical director or the administrator. The attending physician documented in the medical record that the irregularity had been reviewed and what action had been taken to address it. The CP provided the director of nursing services and the medical director with a written, signed, and dated copy of all medication regimen reports. Copies of MRR, including physician responses, were maintained as part of the permanent medical record.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32360 The facility had a census of 34 residents. The sample included 12 residents, with five reviewed for unnecessary medications. Based on observation, record review, and interview, the facility failed to hold blood pressure medications per the physician-ordered parameters for two residents, Resident (R) 8 and R21. This placed the resident at risk for physical decline and other related complications. Findings included: - The Electronic Medical Record (EMR) for R8 documented diagnoses of pain, traumatic brain injury (TBI - an injury to the brain caused by external forces), dementia (a progressive mental disorder characterized by failing memory and confusion), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin) type two, and hypertension (high blood pressure). R8's Quarterly Minimum Data Set (MDS), dated [DATE], documented R8 had severely impaired cognition. R8 was dependent upon staff for all activities of daily living (ADL) and did not ambulate. R8 received diuretic (a medication to promote the formation and excretion of urine), antidepressant (a class of medication used to treat mood disorders), and insulin (a hormone produced by the pancreas that regulates blood glucose levels) medication daily. R8's Care Plan 04/11/25, initiated on 01/22/24, directed staff to administer his blood pressure medication as ordered and monitor for potential side effects. The care plan directed staff to monitor the blood pressure according to the physician's instructions, accurately record blood pressure readings, and promptly notify the physician if readings fall outside the target range or if a significant change occurs. The Physician's Order, dated 03/18/23, directed staff to administer losartan (high blood pressure medication), 100 milligrams (mg), one tablet, by mouth, daily, for hypertension. Hold the medication if the systolic blood pressure (SBP - the top number, the force your heart exerts on the walls of your arteries) was less than 110 millimeters of mercury (mmHg) or if the heart rate was less than 65 beats per minute (bpm). The Physician's Order, dated 08/22/24, directed staff to administer amlodipine (high blood pressure medication), 10 mg, one tablet, by mouth, daily for hypertension. Hold the medication if the SBP was less than 110 or his heart rate was less than 60 bmp. The Physician's Order, dated 03/04/25, directed staff to administer Coreg (high blood pressure medication), 3.125 mg, one tablet, by mouth, twice per day, for hypertension. Hold for SBP less than 110 or heart rate less than 60 bpm. R8's Medication Administration Record (MAR) for March and April 2025 documented the following days R8 received the losartan when his heart rate was under the ordered parameters: 03/14/25 - 58 bpm (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	03/21/25 - 56 bpm 03/22/25 - 57 bpm 04/10/25 - 58 bpm 04/15/25 - 55 bpm R8's MAR for March and April 2025 documented the following days R8 received the amlodipine when his heart rate was under the ordered parameters: 03/11/25 - 53 bpm 03/14/25 - 58 bpm 03/21/25 - 56 bpm 03/22/25 - 57 bpm 04/10/25 - 58 bpm 04/13/25 - 54 bpm 04/15/25 - 55 bpm R8's MAR for March and April 2025 documented the following days R8 received the Coreg when his heart rate was under the ordered parameters: 03/11/25 - 57 bpm 03/13/25 - 55 bpm 03/14/25 - 58 bpm 03/21/25 - 56 bpm 03/22/25 - 57 bpm 04/15/25 - 55 bpm On 04/15/25 at 09:20 AM, observation revealed Certified Medication Aide (CMA) R took R8's blood pressure and heart rate. CMA R administered all of R8's medication and stated he was to hold the blood pressure medications if the SBP was less than 110. R8's heart rate was 55 and CMA R had not realized he should have held the blood pressure medication due to R8's low heart rate. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/16/25 at 10:16 AM, Licensed Nurse (LN) G stated the CMAs were supposed to tell her when a resident's vital signs were out of the physician-ordered parameter because some orders directed that the physician was to be notified. LN G stated she would follow up with R8 and the physician regarding the low heart rate. On 04/16/25 at 01:00 PM, Administrative Nurse D stated she expected staff to follow the physician's orders and hold the medication when the vital signs were out of parameters. The facility's Medication Therapy policy, dated 10/24, documented each resident's medication regimen should include only those medications necessary to treat existing conditions and address significant risks. Medication use shall be consistent with an individual's condition, prognosis, values, wishes, and responses to such treatment. All medication orders would be supported by appropriate care processes and practices. - The Electronic Medical Record (EMR) for R21 documented diagnoses of heart failure (CHF - a condition with low heart output and the body becomes congested with fluid), anxiety (a mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin) and pain. The Significant Change MDS, dated [DATE], documented R21 had intact cognition. R21 required substantial assistance from staff for showers, lower body dressing, mobility, and personal hygiene. R21 received antianxiety (a class of medications that calm and relax people), antidepressant (a class of medication used to treat mood disorders), diuretic (a medication to promote the formation and secretion of urine), pain, and anticoagulant (a class of medications used to prevent the blood from clotting) daily. R21's Care Plan dated 03/23/25, initiated on 09/23/23, directed staff to administer medications as ordered and to monitor for side effects and effectiveness. The Physician's Order, dated 12/04/24, directed staff to administer, metoprolol tartrate (a medication used for high blood pressure), 25 milligrams (mg), one tablet, by mouth twice a day, for hypertension. Hold the medication if the systolic blood pressure (SBP - the top number, the force your heart exerts on the walls of your arteries less than 110 millimeters of mercury (mmHg) or if the pulse is less than 65 beats per minute (bpm). R21's Medication administration Record (MAR) for March 2025 documented the following days R21 received the metoprolol when the SBP was under the ordered parameters: 03/16/25 - 102/63 mmHg 03/17/25 - 108/64 mmHg 03/21/25 - 105/61 mmHg 03/23/25 - 107/75 mmHg 03/26/25 - 98/56 mmHg (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R21's Medication Administration Record (MAR) for April 2025 documented the following days R21 received the metoprolol when the SBP was under the ordered parameters: 04/02/25 - 99/56 mmHg AM dose 04/02/25 - 95/60 mmHg PM dose 04/03/25 - 92/61 mmHg PM dose 04/04/25 - 106/78 mmHg AM dose 04/11/25 - 102/64 mmHg AM dose On 04/15/25 at 12:15 PM, observation revealed R21 in bed, 02 on, and waiting for lunch. On 04/16/25 at 10:16 AM, Licensed Nurse (LN) G stated the CMAs were supposed to tell her when a resident's vital signs were out of the physician-ordered parameter because some orders directed that the physician was to be notified. On 04/16/25 at 01:00 PM, Administrative Nurse D stated she expected staff to follow the physician's orders and hold the medication when the vital signs were out of parameters. The facility's Medication Therapy policy, dated 10/24, documented each resident's medication regimen should include only those medications necessary to treat existing conditions and address significant risks. Medication use shall be consistent with an individual's condition, prognosis, values, wishes, and responses to such treatment. All medication orders would be supported by appropriate care processes and practices.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32360 The facility had a census of 34 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility to prevent medication administration errors for Resident (R) 8 whose heart rate was out of physician-ordered parameters and he received four blood pressure medications. This placed the resident at risk for physical decline and other related complications. Findings included: - The Electronic Medical Record (EMR) for R8 documented diagnoses of pain, traumatic brain injury (TBI - an injury to the brain caused by external forces), dementia (a progressive mental disorder characterized by failing memory and confusion), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin) type two, and hypertension (high blood pressure). R8's Quarterly Minimum Data Set (MDS), dated [DATE], documented R8 had severely impaired cognition. R8 was dependent on staff for all activities of daily living (ADL) and did not ambulate. R8 received diuretic (a medication to promote the formation and excretion of urine), antidepressant (a class of medication used to treat mood disorders), and insulin (a hormone produced by the pancreas that regulates blood glucose levels) medication daily. R8's Care Plan dated 04/11/25, initiated on 01/22/24, directed staff to administer his blood pressure medication as ordered and monitor for potential side effects. The care plan directed staff to monitor the blood pressure according to the physician's instructions, accurately record blood pressure readings, and promptly notify the physician if readings fall outside the target range or if a significant change occurs. The Physician's Order, dated 03/18/23, directed staff to administer losartan (high blood pressure medication), 100 milligrams (mg), one tablet, by mouth, daily, for hypertension. Hold the medication if the systolic blood pressure (SBP - the top number, the force your heart exerts on the walls of your arteries) was less than 110 millimeters of mercury (mmHg) or if the heart rate was less than 65 beats per minute (bpm). The Physician's Order, dated 08/22/24, directed staff to administer amlodipine (high blood pressure medication), 10 mg, one tablet, by mouth, daily for hypertension. Hold the medication if the SBP was less than 110 or his heart rate was less than 60 bmp. The Physician's Order, dated 03/04/25, directed staff to administer Coreg (high blood pressure medication), 3.125 mg, one tablet, by mouth, twice per day, for hypertension. Hold for SBP less than 110 or heart rate less than 60 bpm. On 04/15/25 at 09:20 AM, observation revealed Certified Medication Aide (CMA) R took R8's blood pressure and heart rate. CMA R administered all of R8's medication and stated he was to hold the blood pressure medications if the SBP was less than 110. R8's heart rate was 55 and CMA R had not realized he should have held the blood pressure medication due to R8's low heart rate. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/16/25 at 10:16 AM, Licensed Nurse (LN) G stated the CMAs were supposed to tell her when a resident's vital signs were out of the physician-ordered parameter because some orders directed that the physician was to be notified. LN G stated she would follow up with R8 and the physician regarding the low heart rate. On 04/16/25 at 01:00 PM, Administrative Nurse D stated she expected staff to follow the physician's orders and hold the medication when the vital signs were out of parameters. Administrative Nurse D stated she would write up a medication error and the physician would be notified. A policy for medication errors was not provided by the facility.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32360 The facility had a census of 34 residents. The sample included two residents, with two reviewed for Hospice (specialized care that mainly aims to provide comfort and dignity to the patients, by providing physical comfort and emotional, social, and spiritual support for people nearing the end of life) services. Based on observation, record review, and interview, the facility failed to ensure a communication process between the hospice provider and the facility for Resident (R)26 and R16, which included a plan of care and a description of the services provided which included visit frequency, medications, and medical equipment. This placed the residents at risk of not receiving needed care. Findings included: - The Electronic Medical Record (EMR) for R26 documented diagnoses of epilepsy (brain disorder characterized by repeated seizures), bipolar disorder (a major mental illness that causes people to have episodes of severe high and lows), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), hypertension (high blood pressure), atrial fibrillation (rapid heart rate), and morbid obesity (a disorder that involves having too much body fat which increases the risk of health problems). R26's Significant Change Minimum Data Set (MDS), dated [DATE], documentR26 had intact cognition. R26 was dependent upon staff for transfers, toileting, showers, dressing, and personal hygiene. The MDS documented R26 received hospice services. R26's Care Plan, dated 02/04/25, directed staff to document in social service notes the advanced directive review and maintain advanced directives in his file. The care plan directed staff to ensure R26's wishes were honored regarding any advanced directive or end-of-life care. The care plan documented R26 was enrolled in hospice. The care plan lacked a contact number for hospice, and what supplies, equipment, and medications hospice would provide. The care plan lacked when hospice staff would be in the building and what care they would provide. The Physician Order, dated 01/10/25, directed staff to admit R26 to hospice services. On 04/15/25 at 02:20 PM, observation revealed R26 in bed, eyes closed. On 04/16/25 at 12:6 PM, Administrative Nurse E stated she had been trying to catch up on all of the care plans and get them updated. Administrative Nurse E stated she was aware the care plan was not complete with the required information. On 04/16/25 at 01:00 PM, Administrative Nurse D stated the care plan would be updated with information related to his hospice services. The facility's Hospice Program policy, dated 10/21, documented coordinated care plans for residents receiving hospice services including the most recent hospice plan of care as well as the care and services provided by our facility to maintain the resident's highest practicable physical, mental, and psychosocial well-being. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	41713 - R17's Electronic Medical Record (EMR) documented diagnoses of hypertension (HTN - elevated blood pressure), trigeminal neuralgia (a condition that causes intense pain like an electric shock on one side of the face), and major depressive disorder (a serious mental illness that involves persistent feelings of sadness and loss of interest in activities). R17's Significant Change Minimum Data Set (MDS) dated [DATE] documented she had a Brief Interview for Mental Status (BIMS) score of 13, which indicated an intact cognition. R17 required set-up assistance with eating and was dependent on staff for toileting, bathing, and dressing. R17 was on hospice services. R17's Functional Abilities Care Area Assessment (CAA) dated 03/21/24 documented she had a decline in her overall functioning. R17 required extensive to total assist with care, mobility, and transfers. R17 was alert and oriented at times and able to make her needs known. R17 required a wheelchair for mobility. R17 signed for hospice services due to breast cancer (tumor). R17's Care Plan revised on 03/30/25 directed staff that she was on hospice services. Staff was directed to honor R17's advance directives and end-of-life care. Staff were directed to provide life-sustaining treatment decisions per resident. R17's hospice care plan lacked staff direction for the services the hospice would provide (durable medical equipment, supplies, etc.). The care plan lacked staff directions on the services the facility would continue to provide. The care plan lacked a communication process, including how the communication would be documented between the facility and the hospice provider, to ensure that the needs of the resident are addressed and met. Provision that the LTC facility immediately notified the hospice about the following: a significant change in the resident's physical, mental, social, or emotional status; clinical complications that suggest a need to alter the plan of care; a need to transfer the resident from the facility for any condition; and the resident's death. The care plan lacked staff direction on when the hospice provider team members would visit the facility and the frequency of the visits. R17's Orders tab of the EMR documented a physician's order dated 02/17/25 to admit to hospice. On 04/15/25 at 11:47 AM, R17 was wheeled by staff to the dining room in her Broda chair (specialized wheelchair with the ability to tilt and recline). On 04/16/25 at 12:50 PM, Administrative Nurse D stated that R17's care plan should include how to contact the hospice provider and what supplies and equipment were provided by hospice. Administrative Nurse D stated the care plan should also direct staff on when to notify the hospice service and how often the hospice staff would visit the facility. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Hospice Program policy dated October 2021 documented it was the responsibility of the facility to meet the resident's personal care and nursing needs in coordination with the hospice representative and ensure that the level of care provided was appropriately based on the resident's needs including 24-hour room and board care, administering prescribed therapies, notifying the hospice about significant change in the resident's status, clinical complications that suggest a need to alter the plan of care, a need to transfer the resident from the facility for any condition, and the resident's death. Coordinated care plans for residents receiving hospice services would include the most recent hospice plan of care as well as the care and services provided by the facility (including the responsible provider and discipline assigned to specific tasks) to maintain the resident's highest practicable physical, mental, and psychosocial well-being.

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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. 32360 The facility had a census of 34 residents. The sample included 12 residents. Based on record review and interview, the facility failed to submit complete and accurate staffing information through Payroll-Based Journaling (PBJ) as required. This deficient practice placed the residents at risk for inadequate nurse staff. Findings included: - The PBJ report provided by the Centers for Medicare & Medicaid Services (CMS) for Medicare & Medicaid Services (CMS) for Fiscal Year (FY) 2024 Quarter (Q) 2 indicated no licensed nurse coverage on nine dates. The PBJ for FY 2024 Q4 recorded no licensed nurse coverage on six dates. The PBJ for FY 2025 Q1 recorded no licensed nurse coverage on eleven dates. Review of the facility licensed nurse payroll data for the dates listed above revealed a licensed nurse was on duty for 24 hours a day, seven days a week. On 04/15/24 at 10:00 AM, Administrative Staff B stated she did the scheduling for the nursing staff but did not submit the information for the PBJ report. Administrative Staff B stated she always scheduled a nurse from 6:00 AM- 06:00 PM and then a nurse from 06:00 PM- 06:00 AM. She had the availability of agency staff and there has always been a nurse scheduled for each of the 12-hour shifts. On 04/15/25 at 04:45 PM, Administrative Nurse A stated the corporate team submitted the PBJ. Administrative Staff A stated there was always a nurse in the building. The facility's Report Direct-Care Staffing Information (Payroll-Based Journal) policy, dated 10/21 documented staffing and census information would be reported electronically to CMS through the Payroll-Based Journal system in compliance with 6106 of the Affordable Care Act. Direct care staffing information included staff hired directly by the facility, those hired through an agency, and contract employees. The facility failed to submit complete and accurate staffing information through PBJ as required. This deficient practice placed the residents at risk for inadequate nurse staff.

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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 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 32360 The facility had a census of 34 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to maintain a Quality Assessment and Assurance Committee (QA&A) that met quarterly and had the required membership in attendance. The facility failed to maintain a QA&A Committee that met quarterly and had the required membership in attendance. Findings included: - The facility provided QA&A committee attendance roster for 09/11/24 only. On 04/16/25 at 01:23 PM, Administrative Staff A provided the signature sheet for the meeting held on 09/11/24. Administrative Staff A stated that they had also had a QA&A meeting on 04/20/25 but did not have the attendance sheet available. Administrative Staff A stated they are meeting monthly, and the Medical Director would attend the meetings quarterly. Administrative Staff A stated they had started working through the areas that were lacking direction and were working hard to get the facility in good standing as they had gone through a lot of administrative staff. The facility's Quality Assurance and Performance Improvement (QAPI) Program policy, dated 10/21, documented the committee meets monthly to review reports, evaluate data, monitor QAPI-related activities, and make adjustments to the plan. The QAPI committee oversees the implementation of the QAPI Plan, which is the written component describing the specifics of the QAPI program, how the facility would conduct its QAPI functions, and the activities of the QAPI committee.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. 41713 The facility identified a census of 34 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to implement the core elements of antibiotic stewardship to ensure an effective infection prevention and control program, including antibiotic stewardship for the residents of the facility. Findings included: - Review of the facility Infection Control Surveillance Log for tracking and trending infections from January 2024 through March 2025, lacked evidence of organism identifications, duration of antibiotic prescribed, and the infections treated for February 2024, April 2024, May 2024, September 2024, November 2024, and December 2024. On 04/16/25 at 12:50 PM, Administrative Nurse D stated when she took over the infection control program, she was made aware that the previous infection preventionist had not been completing the monthly antibiotic stewardship surveillance logs. The interdisciplinary team has a Performance Improvement Project (PIP) in place for the infection control program. The Antibiotic Stewardship policy dated October 2021 documented that antibiotics would be prescribed and administered to residents and the guidance of the facility's antibiotic stewardship program. The purpose of the program was to monitor the use of antibiotics in the residents. The Surveillance for Infections policy dated October 2021 documented the purpose of the surveillance of infections was to identify both individual cases and trends of epidemiologically (in a manner relating to the branch of medical science concerned with the occurrence, transmission, and control of epidemic diseases) significant organisms and health-associated infections, to guide appropriate interventions, and to prevent future infections. Infections would be included in routine surveillance, including those with evidence of transmissibility (the ease with which a disease or other agent can be transmitted from one individual to another) in a healthcare environment; the available processes and procedures that prevent or reduce the spread of infection; clinically significant morbidity or mortality associated with infection; and pathogens (a living organism that can cause disease in another organism) associated with serious outbreaks.