STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175450	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Anew Healthcare Oxford	200 S Ohio St Oxford, KS 67119

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 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. 37026 The facility census totaled 31, with 16 included in the sample, and one resident reviewed for discharge requirements. Based on observation, interview, and record review the facility failed to ensure Resident (R)1 had a right to designate a representative of her choice who could exercise her rights as she delegated to the representative without fear of reprisal and/or honoring the resident's right to have her representative present during interactions with facility staff. Findings included: - Review of R1's Electronic Health Record (EHR) revealed the resident had the following diagnoses: paranoid schizophrenia (mental disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought), major depressive disorder (major mood disorder which causes persistent feelings pf sadness), need for assistance with personal care, post-traumatic stress disorder (PTSD- mental disorder characterized by an acute emotional response to a traumatic event or situation involving severe environmental stress), problems related to living in a residential institution, and suicidal ideations. Review of the 01/26/24 Annual Minimum Data Set [MDS] Assessment revealed the resident had a Brief Interview for Mental Status score of 15, which indicated intact cognition. The resident had a total mood severity score of zero, which indicated no depression. The resident reported never feeling lonely or isolated from those around her. The resident had no behaviors present during the observation period. Review of the 04/26/24 Quarterly MDS Assessment revealed the resident had no changes in BIMS or Mood Severity Scores but reported rarely feeling isolated from those around her. The resident used a walker and wheelchair for mobility. The resident's care plan lacked evidence the resident appointed a representative/guardian and/or her wishes related to the representative/guardian being present during interactions of her choice with staff. Review of the 05/19/24 at 05:13 PM Nurse Note revealed the resident reported R3 entered her room, took her belonging, stated R3 tried to lay in her bed, touched her, and was assisted out of her room at the time. The facility notified the resident's provider and family (representative/guardian). (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: 175450	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/13/2024

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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 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the 05/19/24 at 07:49 PM Nurse Note revealed staff assessed the resident's skin with no skin issues noted and the resident denied pain. The facility educated staff on the importance of staying one-on-one with R3. The note lacked any evidence the facility assessed R1's psychosocial wellbeing at the time and/or implemented interventions related to the resident's feeling about the incident with R3. Review of the 05/19/24 at 07:53 PM revealed later R1 reported the resident touched her in her private area while sleeping, but did not say anything till supper time. The note lacked any follow up or assessment of the resident's psychosocial wellbeing. The resident's care plan further lacked any direction to staff related to the incident, which occurred earlier in the day other than putting a stop sign on the resident's door to prevent unwanted entry. Review of the 05/19/24 at 11:04 PM Nurse Note revealed the resident declined a skin assessment at this time. The note lacked any interventions related to assessing the resident's psychosocial wellbeing. Review of the 05/20/24 at 09:10 AM Administrator Note revealed facility staff offered to send the resident to the emergency room for further treatment and stated she would make an appointment at her primary care provider. The Director of Nursing completed a skin assessment at this time with no new findings. Review of the Social Services Progress Note dated 05/21/24 at 11:39 AM revealed due to R1's allegations against R3 the Social Service Designee (SSD) reached out to the resident's mental health provider to schedule a zoom call for Thursday (05/23/24, five days after R1 reported being touched by R3). The SSD also reached out to Social Worker (SW) HH to see if she would see if it would be possible for her to see R1 twice a week for three weeks. SW HH did not know if time would allow for her visits but would let the facility know. The resident's care plan lacked any evidence the SSD, put any further interventions related to R1's psychosocial wellbeing in place during the time she was waiting to be seen by her mental health practitioner and/or social worker. Review of the 05/21/24 at 01:44 PM Social Service Progress Note revealed the SSD reached out, through email, to the resident's Guardian to get permission for the resident's mental health practitioner to do a Zoom call on Thursday, the facility would wait for the Guardian's response. Review of the 05/21/24 at 03:15 PM Nurse's Note revealed staff attempted to do a skin assessment on the resident twice. The resident voiced she had no skin problem and did not need a skin check. Review of the 05/23/24 at 10:02 AM Social Service Progress Note revealed the SSD set up a Zoom call for the resident with her mental health provider just to make sure she is stable after the incident that occurred earlier in the week. The SSD noted she reached out to the resident's Guardian on 05/21/24 to get permission to have R1 seen, but she never responded to email (the note lacked evidence the SSD spoke to the resident at the time). The SSD stated the Zoom appointment would stay open until noon incase R1's Guardian responded to the e-mail. The note lacked evidence the facility made any attempt since 05/21/24 to contact R1's Guardian or attempted any other means of communication since the original e-mail, two days prior. The facility further failed to document any attempts to ask the resident how she felt about talking to her mental health provider about the incident that occurred earlier in the week. (continued on next page)

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the 05/27/24 at 01:16 AM Nurse Note revealed the resident's Guardian called the facility to inquire about staff in the resident's room looking at her skin. She asked the staff to leave the resident's room at that time stating she had been traumatized enough. She then asked the staff if they took R1's clothes off to look at her skin or her private parts. The nurse assured the Guardian staff completed the resident's skin assessment earlier in the day and that no one had taken resident' clothes off to look at her private parts. The guardian stated to facility staff I don't want no one talking to her or going in her room unless they get permission from me first. The guardian asked staff to leave the resident alone and stated the staff present just did not listen. The guardian then asked staff again to be called before speaking to R1 and/or performing any cares on the resident. The EHR lacked evidence the facility followed up with R1 about her wishes regarding the guardian's request. Review of the 06/07/24 at 11:32 AM Social Service Progress Note revealed the SSD received a call from R1's Guardian stating the resident had some missing items. The SSD and Director of Nursing asked the resident about the missing items with the resident's Guardian on the phone. The resident's Guardian stated she was going to document the conversation as the facility asked the resident what was missing. The resident opened up a box with a lot of tea bags noting some of them were missing. The SSD asked the resident how she kept track of her teas and the resident reported one specific flavor was missing. The SSD pointed out inconsistencies in the resident's report. The writer stated the Guardian interrupted past allegations that the facility felt was resolved. The SSD called the conversation contradicting. The writer asked R1 if she felt safe and the resident's Guardian told the resident not to answer the question. The facility offered to replace the tea and left the room. Review of the 06/07/24 at 12:07 PM Social Service Progress Note revealed the resident's Guardian never responded to requests to give permission to do a Zoom call with the resident. The 06/07/24 at 11:32 AM (approximately 35 minutes earlier) Social Service Progress Note indicated the SSD spoke to the resident's Guardian on the phone and in the presence of the resident but failed to ask about the Zoom call for the resident. Review of the 06/16/24 at 04:00 AM Incident Note revealed R1 requested for the nurse to check on a rash located under her breast. A Certified Nurse Aide (CNA) accompanied the nurse to the resident's room, but the resident requested the aide (who is also female) to step outside. The CNA explained to the resident that they were informed by management to have two people in her room at all resident visit for safety concerns. The resident was on the phone at the time of the incident and the resident declined the nurse's cares stating she did not need her anymore and further stated her guardian would check on her, so the nurse and CNA left her room. EMS arrived at the facility at 03:35 AM stating the resident called them. EMS later left the facility without the resident when they reported the resident did not want to go to the hospital. Review of the resident's EHR and plan of care lacked any evidence/justification R1 required two staff present during her cares or follow up with the resident and/or guardian about the change in the resident's care. Review of the 06/19/24 at 01:34 PM Nurse Note revealed the writer went to the resident's room with another staff member to do a skin assessment and the resident refused. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Anew Healthcare Oxford		STREET ADDRESS, CITY, STATE, ZIP CODE 200 S Ohio St Oxford, KS 67119	

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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 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's EHR and plan of care lacked any evidence/justification R1 required two staff present during her cares or follow up with the resident and/or guardian about the change in the resident's care. Review of the 06/26/24 at 10:05 AM Plan of Care Note revealed the resident declined to attend the care plan meeting and her representatives attended via Zoom. One of the resident's representatives asked the facility about the process of discharging the resident and they were told they would have to transfer the resident to the receiving facility and let them know the discharge date once it was decided. The representatives stated they did not receive the thirty-day discharge notice the facility issued until 06/24/24. The Administrator informed the resident's guardian the facility sent it on 06/21/24. The representatives asked the facility about the appeal date and the Administrator stated she would send the appeals process through electronic mail. Review of the facility provided Discharge Letter for R1 dated 06/21/24 revealed the facility would discharge the resident thirty days from the date of the letter as necessary for the resident's welfare and noted the resident's needs could not be met in the home because the action and inaction of the resident's guardian. The letter stated the facility was unable to communicate with the resident without guardian present per guardians request. The letter further stated the resident's guardian is not available by phone 24/7. The letter stated the resident's guardian called the local police on facility administration and wanted to press harassment charges for an unknown reason to the facility and law enforcement. The resident's record lacked evidence the resident's guardian failed to communicate with the facility and/or the facility talked to the resident about her wishes regarding her guardian being present during all communication. Review of the 06/26/24 at 01:04 PM Late Entry Administrator Note revealed the facility resent a thirty-day discharge notice and a process to appeal the thirty-day notice. The facility would continue to monitor and support. The resident's care plan lacked any evidence the facility put in interventions related to the resident's involuntary discharge from the facility and/or her psychosocial wellbeing after being told she would have to relocate from her home of five, almost six, years. The resident's care plan continued to lack rationale or direction for the use of two staff when interacting with the resident and continued to lack trauma informed care related to R3 entering R1's room and touching her private parts. Review of 06/29/24 at 09:44 PM Nurse Note revealed the resident refused to allow two staff to monitor her during her shower and only allowed one staff member. Staff notified the administrator. The resident's record and care plan continued to lack a rationale for the use of two staff for cares of the resident, when the resident continued to voice concerns with two staff present for cares. Review of the facility provided Discharge Letter for R1 dated 07/12/24 revealed the facility would discharge the resident thirty days from the date of the letter as necessary for the resident's welfare and noted the resident's needs could not be met in the home because the action and inaction of the resident's guardian. The letter lacked any further documentation regarding the guardian as identified in the 06/21/24 letter. The resident's record lacked evidence the resident's guardian failed to communicate with the facility and/or the facility talked to the resident about her wishes regarding her guardian being present during all communication. (continued on next page)

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation of the resident on 07/31/24 at 04:09 PM during an interview at the same time revealed the resident sat on her bed with her telephone propped on the bed next to her and her Guardian on the line. The resident appeared clean and well groomed. She originally presented with combed hair, was well dressed, and had an overall pleasant affect and offered the surveyors a place to sit in her room. Once the resident began talking about her feelings related to past events, which occurred at the facility her mood became more somber and timid, and her body language began to change. The resident began to have furrowed brows, became teary eyed at times, and her voice fluctuated with frustration/defeat over how the facility handled the incidents with R3. Over the course of the conversation the resident reported she felt she had to diminish her presence for fear of retribution and the surveyor noted the resident's shoulders started to fold toward each other and her hands folded into her lap as she made her size smaller throughout the course of the conversation without realizing it. R1 mentioned there were two staff whom she considered close to her before but were treating me bad because they wanted to be in [Administrative Staff A's] good graces, and that was upsetting. When R1 stated this her eyes welled with tears, and she then looked down toward the floor and was silent. (continued on next page)

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F 0551

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

An interview with R1 and her representative at 04:09 PM on 07/31/24 revealed one day she was not feeling great due to her back pain. She was sleeping and felt a hit in her private parts and described R3 was in her room again. R1 stated R3 would come into the room at times when she was changing her bra and panties. R1 stated at one time R3 was in her room playing in water in her bathroom, she pulled her call light, and when staff responded they could not handle him or get him out. R1 reported at one point staff had to pick R3 up and put him in his chair to get him out of her room. R1 stated she was not going to say anything originally but was upset and wanted the facility to know about it, and it was embarrassing. R1 felt staff were vindictive toward her since the incident occurred and she reported it. She further reported staff told her R3 just climbed in most resident's beds and that he had the mentality of a five-year-old. The resident's representative said she asked the facility what do you mean, he touched my [relationship to the resident] and the facility responded that R3's arm slipped and probably hit the top of R1's thigh. R1 stated she had multiple missing items and felt R3 was responsible for taking the items out of her room. R1 reported after the incident with R3 many staff, at various times asked to do skin checks on the resident (private area) and insisted that she should be seen the hospital. The resident told the nurses and administrative staff she did not need to go to the hospital. She said she was sleeping with covers on at the time of the contact and was sure there was no injury such as bruising or scratching. R1 reported just because there were not bruises or scratches does not mean R3 did not attempt to get into bed with her and did not hit her private areas. (The resident re-enacted how she was laying in her bed at the time of the contact). R1 stated she knew if she went to the hospital with no bruises or scratches it was going to make her look bad. After the incident with R3, R1 stated the facility took all rights away from her. She could no longer have one staff performing cares and even housekeeping staff were required to have two people in the room and she could no longer leave the room if housekeeping was in the room. Two staff now had to watch her shower and it was very upsetting to her. R1 reported she bathed herself in her sink at times because she did not want so many staff watching her shower. R1 reported the floor of the bathroom became slippery when bathing herself and further reported being fearful of a fall as her balance and stamina were not always the best. R1 reported if the facility had been supervising R3, she would not have had to go through this and felt like the facility treated her like she did something wrong. She reported being at the facility for the last five years with no concerns and now she has been issued a discharge notice from the facility. R1 stated she called her Guardian when staff were in the room for her protection and was glad the Guardian was involved in her care. The Guardian expressed she told staff to leave the resident alone unless they called her because of the frequent requests to do skin checks after the incident with R3. The resident reported the facility has further filed an Adult Protective Services report against her Guardian for speaking up for her. The resident voiced fears a new facility might persecute her based on what this facility told them about her.

During a phone interview on 08/05/24 at 12:44 PM with Law Enforcement Officer (LEO) GG he reported R1 had an iPad stolen at one time and the facility did replace it, but never did prove who took it from her room. LEO GG reported R3 was not appropriately placed at the facility and noted the facility could not meet his needs. Regarding the battery incident between R1 and R3 he stated staff talked about R3's rights, but LEO GG then stated, what about [R1's] rights?. LEO GG further stated the facility treated R1 like she was the one at fault for the encounter. LEO GG stated the police department was called many times over the last year, they respond to calls at the facility approximately two to three times a week, and approximately only two were not legitimate out of all of the calls for the year.

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with CNA N on 08/05/24 at 11:38 PM revealed she knew what cares to provide residents by looking at their plans of care. CNA N reported she gave the resident showers, did not have two people present every time and the resident did fine. CNA N reported she has had no concerns with the resident or guardian since she started working at the facility. The incident with R3 happened before she started but heard that is why R3 required one-on-one supervision. CNA N reported the resident had no behaviors, delusions, hallucinations, and remembered things they talked about during showers from week to week. CNA N reported having no trauma informed care training and being unaware of any interventions related to trauma for R1. During an interview on 08/06/24 at 12:24 AM with CNA II revealed she heard the resident had called the cops but was not there for the calls. CNA II reported the resident isolates herself. CNA II reported staff were not allowed to go in the resident's room and could only talk to her through the door. She reported she did not try to go in the resident's room too much but did pick up her trash and give her water. CNA II stated she heard the resident's Guardian would incite behaviors from the resident, but she was not there for it and thought it might just be hearsay. CNA II reported having no trauma informed care training and being unaware of any interventions related to trauma for R1. During an interview on 08/06/24 at 03:42 AM with Administrative Staff C revealed the resident kept to herself and did not want staff in her room. Administrative Staff C reported the resident's outlook at the facility had changed over the last year and she had a different outlook, behavior wise. She reported the resident did not seem to be happy at the facility and she tried hard to fix the problem and accommodate resident needs. Administrative Staff C reported she heard the resident's story about R3 changed three times, but the Director of Nursing and Administrator were handling that situation. She reported R1 as more secluded since the incident with R3. Staff offered skin assessments, but R1 refused. Administrative Staff C said R1 was very different than when she started a few years ago and noted the resident has not called 911 recently. During an interview at 04:43 AM on 08/06/24 with Administrative Staff B revealed R3 used to walk around until after the incident with R1. Administrative Staff B reported the resident originally reported R3 tried to get into bed with her but then told her Guardian that R3 touched her private parts. Administrative Staff B reported the resident refused to have skin checks of her private parts. She stated the resident and Guardian wanted to file charges against R3 and since she was not happy corporate said they could help R1 find another facility. R1 reported being happy at the facility until R3 came and Administrative Staff B stated R3 was still a human too. When asked about how the facility handled R1's psychosocial wellbeing and/or history of trauma Administrative Staff B reported they offered for her to go to the ER, but she refused. Administrative Staff B confirmed the facility had not addressed R1's psychosocial impact from the incident with R3, had not addressed potential past trauma's R1 may have had, and not viewed the incident with R3 as traumatic to R1. During an electronic mail interview with R1's Guardian dated 08/07/24 at 10:52 AM revealed the facility had not assessed R1 for any past trauma that she was aware of. R1's Guardian stated the facility listed information that was not correct concerning R1's history in the care plan and noted they did not reach out to her or the resident's other family members for further information. R1's Guardian stated she did not believe that R1 received any visits from SSD L, when R1 was assaulted by a male resident that was uninvited to her room. The Guardian stated she asked the facility to call her when they talked to the resident about the incident with R3 because a major trust factor has been broken. (continued on next page)

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility failed to ensure R1 had a right to designate a representative of her choice who could exercise her rights as she delegated to the representative without fear of reprisal and/or honoring the resident's right to have her representative present during interactions with facility staff.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. 37026 The facility census totaled 31, with 16 included in the sample, and one resident reviewed for discharge requirements. Based on observation, interview, and record review the facility failed to ensure Resident (R)1 had a right to make choices about her life in the facility that were significant to her, which included the right to have only one staff present during cares as requested by the R1 when the facility failed to provide a valid rationale to the resident for the use of two staff for cares and interactions with the resident. Findings included: - Review of R1's Electronic Health Record (EHR) revealed the resident had the following diagnoses: paranoid schizophrenia (mental disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought), major depressive disorder (major mood disorder which causes persistent feelings pf sadness), need for assistance with personal care, post-traumatic stress disorder (PTSD- mental disorder characterized by an acute emotional response to a traumatic event or situation involving severe environmental stress), problems related to living in a residential institution, and suicidal ideations. Review of the 01/26/24 Annual Minimum Data Set [MDS] Assessment revealed the resident had a Brief Interview for Mental Status score of 15, which indicated intact cognition. The resident had a total mood severity score of zero, which indicated no depression. The resident reported never feeling lonely or isolated from those around her. The resident had no behaviors present during the observation period. Review of the 04/26/24 Quarterly MDS Assessment revealed the resident had no changes in BIMS or Mood Severity Scores but reported rarely feeling isolated from those around her. The resident used a walker and wheelchair for mobility. The resident's care plan lacked evidence or rationale as to why the facility initiated two staff for cares and interactions with R1. Review of the 05/19/24 at 05:13 PM Nurse Note revealed the resident reported R3 entered her room, took her belonging, stated R3 tried to lay in her bed, touched her, and was assisted out of her room at the time. The facility notified the resident's provider and family. Review of the 05/19/24 at 07:49 PM Nurse Note revealed staff assessed the resident's skin with no skin issues noted and the resident denied pain. The facility educated staff on the importance of staying one-on-one with R3. The note lacked any evidence the facility assessed R1's psychosocial wellbeing at the time and/or implemented interventions related to the resident's feeling about the incident with R3. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the 05/19/24 at 07:53 PM Nurse Note revealed later R1 reported the resident touched her in her private area while sleeping, but did not say anything till supper time. The note lacked any follow up or assessment of the resident's psychosocial wellbeing. The resident's care plan further lacked any direction to staff related to the incident, which occurred earlier in the day other than putting a stop sign on the resident's door to prevent unwanted entry. Review of the 05/19/24 at 11:04 PM Nurse Note revealed the resident declined a skin assessment at this time. The note lacked any interventions related to assessing the resident's psychosocial wellbeing. Review of the 05/20/24 at 09:10 AM Administrator Note revealed facility staff offered to send the resident to the emergency room for further treatment and stated she would make an appointment at her primary care provider. The Director of Nursing completed a skin assessment at this time with no new findings. Review of the 05/21/24 at 03:15 PM Nurse's Note revealed staff attempted to do a skin assessment on the resident twice. The resident voiced she had no skin problem and did not need a skin check. Review of the 05/23/24 at 10:02 AM Social Service Progress Note revealed the SSD set up a Zoom call for the resident with her mental health provider just to make sure she is stable after the incident that occurred earlier in the week. The SSD noted she reached out to the resident's Guardian on 05/21/24 to get permission to have R1 seen, but she never responded to email (the note lacked evidence the SSD spoke to the resident at the time). The SSD stated the Zoom appointment would stay open until noon incase R1's Guardian responded to the e-mail. The note lacked evidence the facility made any attempt since 05/21/24 to contact R1's Guardian or attempted any other means of communication since the original e-mail, two days prior. The facility further failed to document any attempts to ask the resident how she felt about talking to her mental health provider about the incident that occurred earlier in the week. Review of the 05/27/24 at 01:16 AM Nurse Note revealed the resident's Guardian called the facility to inquire about staff in the resident's room looking at her skin. She asked the staff to leave the resident's room at that time stating she had been traumatized enough. She then asked the staff if they took R1's clothes off to look at her skin or her private parts. The nurse assured the Guardian staff completed the resident's skin assessment earlier in the day and that no one had taken resident' clothes off to look at her private parts. The guardian stated to facility staff I don't want no one talking to her or going in her room unless they get permission from me first. The guardian asked staff to leave the resident alone and stated the staff present just did not listen. The guardian then asked staff again to be called before speaking to R1 and/or performing any cares on the resident. The EHR lacked evidence the facility followed up with R1 about her wishes regarding the guardian's request. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Anew Healthcare Oxford		STREET ADDRESS, CITY, STATE, ZIP CODE: 200 S Ohio St Oxford, KS 67119	

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the 06/07/24 at 11:32 AM Social Service Progress Note revealed the SSD received a call from R1's Guardian stating the resident had some missing items. The SSD and Director of Nursing asked the resident about the missing items with the resident's Guardian on the phone. The resident's Guardian stated she was going to document the conversation as the facility asked the resident what was missing. The resident opened up a box with a lot of tea bags noting some of them were missing. The SSD asked the resident how she kept track of her teas and the resident reported one specific flavor was missing. The SSD pointed out inconsistencies in the resident's report. The writer stated the Guardian interrupted past allegations that the facility felt was resolved. The SSD called the conversation contradicting. The writer asked R1 if she felt safe and the resident's Guardian told the resident not to answer the question. The facility offered to replace the tea and left the room. The facility further failed to follow up on the resident's concerns of someone being in her room uninvited, unsupervised. Review of the 06/16/24 at 04:00 AM Incident Note revealed R1 requested for the nurse to check on a rash located under her breast. A Certified Nurse Aide (CNA) accompanied the nurse to the resident's room, but the resident requested the aide (who is also female) to step outside. The CNA explained to the resident that they were informed by management to have two people in her room at all resident visit for safety concerns. The resident was on the phone at the time of the incident and the resident declined the nurse's cares stating she did not need her anymore and further stated her guardian would check on her, so the nurse and CNA left her room. EMS arrived at the facility at 03:35 AM stating the resident called them. EMS later left the facility without the resident when they reported the resident did not want to go to the hospital. Review of the resident's EHR and plan of care lacked any evidence/justification R1 required two staff present during her cares or follow up with the resident and/or guardian about the change in the resident's care. Review of the 06/19/24 at 01:34 PM Nurse Note revealed the writer went to the resident's room with another staff member to do a skin assessment and the resident refused. Review of the resident's EHR and plan of care lacked any evidence/justification R1 required two staff present during her cares or follow up with the resident and/or guardian about the change in the resident's care. Review of 06/29/24 at 09:44 PM Nurse Note revealed the resident refused to allow two staff to monitor her during her shower and only allowed one staff member. Staff notified the administrator. The resident's record and care plan continued to lack a rationale for the use of two staff for cares of the resident, when the resident continued to voice concerns with two staff present for cares. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation of the resident on 07/31/24 at 04:09 PM during an interview at the same time revealed the resident sat on her bed with her telephone propped on the bed next to her and her Guardian on the line. The resident appeared clean and well groomed. She originally presented with combed hair, was well dressed, and had an overall pleasant affect and offered the surveyors a place to sit in her room. Once the resident began talking about her feelings related to past events, which occurred at the facility her mood became more somber and timid, and her body language began to change. The resident began to have furrowed brows, became teary eyed at times, and her voice fluctuated with frustration/defeat over how the facility handled the incidents with R3. Over the course of the conversation the resident reported she felt she had to diminish her presence for fear of retribution and the surveyor noted the resident's shoulders started to fold toward each other and her hands folded into her lap as she made her size smaller throughout the course of the conversation without realizing it. R1 mentioned there were two staff whom she considered close to her before but were treating me bad because they wanted to be in [Administrative Staff A's] good graces, and that was upsetting. When R1 stated this her eyes welled with tears, and she then looked down toward the floor and was silent. An interview with R1 and her representative at 04:09 PM on 07/31/24 revealed one day she was not feeling great due to her back pain. She was sleeping and felt a hit in her private parts and described R3 was in her room again. R1 stated R3 would come into the room at times when she was changing her bra and panties. R1 stated at one time R3 was in her room playing in water in her bathroom, she pulled her call light, and when staff responded they could not handle him or get him out. R1 reported at one point staff had to pick R3 up and put him in his chair to get him out of her room. R1 stated she was not going to say anything originally but was upset and wanted the facility to know about it, and it was embarrassing. R1 felt staff were vindictive toward her since the incident occurred and she reported it. She further reported staff told her R3 just climbed in most resident's beds and that he had the mentality of a five-year-old. The resident's representative said she asked the facility what do you mean, he touched my [relationship to the resident] and the facility responded that R3's arm slipped and probably hit the top of R1's thigh. R1 stated she had multiple missing items and felt R3 was responsible for taking the items out of her room. R1 reported after the incident with R3 many staff, at various times asked to do skin checks on the resident (private area) and insisted that she should be seen the hospital. The resident told the nurses and administrative staff she did not need to go to the hospital. She said she was sleeping with covers on at the time of the contact and was sure there was no injury such as bruising or scratching. R1 reported just because there were not bruises or scratches does not mean R3 did not attempt to get into bed with her and did not hit her private areas. (The resident re-enacted how she was laying in her bed at the time of the contact). R1 stated she knew if she went to the hospital with no bruises or scratches it was going to make her look bad. After the incident with R3, R1 stated the facility took all rights away from her. She could no longer have one staff performing cares and even housekeeping staff were required to have two people in the room and she could no longer leave the room if housekeeping was in the room. Two staff now had to watch her shower and it was very upsetting to her. R1 reported she bathed herself in her sink at times because she did not want so many staff watching her shower. R1 reported the floor of the bathroom became slippery when bathing herself and further reported being fearful of a fall as her balance and stamina were not always the best. R1 reported if the facility had been supervising R3, she would not have had to go through this and felt like the facility treated her like she did something wrong. She reported being at the facility for the last five years with no concerns and now she has been issued a discharge notice from the facility. R1 stated she called her Guardian when staff were in the room for her protection and was glad the Guardian was involved in her care. The Guardian expressed she told staff to leave the resident alone unless they called her because of the frequent requests to do skin checks after the incident with R3. (continued on next page)

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F 0561

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

During a phone interview on 08/05/24 at 12:44 PM with Law Enforcement Officer (LEO) GG he reported R3 was not appropriately placed at the facility and noted the facility could not meet his needs. Regarding the battery incident between R1 and R3 he stated staff talked about R3's rights, but LEO GG then stated, what about [R1's] rights?. LEO GG further stated the facility treated R1 like she was the one at fault for the encounter.

During an interview with CNA N on 08/05/24 at 11:38 PM revealed she knew what cares to provide residents by looking at their plans of care. CNA N reported she gave the resident showers, did not have two people present every time and the resident did fine. CNA N reported she has had no concerns with the resident or guardian since she started working at the facility.

During an interview on 08/06/24 at 12:24 AM with CNA II revealed the resident isolates herself. CNA II reported staff were not allowed to go in the resident's room and could only talk to her through the door. She reported she did not try to go in the resident's room too much but did pick up her trash and give her water. CNA II stated she heard the resident's Guardian would incite behaviors from the resident, but she was not there for it and thought it might just be hearsay.

During an interview on 08/06/24 at 03:42 AM with Administrative Staff C revealed the resident kept to herself and did not want staff in her room. Administrative Staff C reported the resident's outlook at the facility had changed over the last year and she had a different outlook, behavior wise. She reported the resident did not seem to be happy at the facility and she tried hard to fix the problem and accommodate resident needs. She reported R1 as more secluded since the incident with R3. Staff offered skin assessments, but R1 refused. Administrative Staff C said R1 was very different than when she started a few years ago.

During an interview at 04:43 AM on 08/06/24 with Administrative Staff B revealed R3 used to walk around until after the incident with R1. Administrative Staff B reported the resident originally reported R3 tried to get into bed with her but then told her Guardian that R3 touched her private parts. Administrative Staff B reported the resident refused to have skin checks of her private parts. She stated the resident and Guardian wanted to file charges against R3 and since she was not happy corporate said they could help R1 find another facility. R1 reported being happy at the facility until R3 came and Administrative Staff B stated R3 was still a human too. When asked about how the facility handled R1's psychosocial wellbeing and/or history of trauma Administrative Staff B reported they offered for her to go to the ER, but she refused. Administrative Staff B confirmed the facility had not addressed R1's psychosocial impact from the incident with R3, had not addressed potential past trauma's R1 may have had, and not viewed the incident with R3 as traumatic to R1.

During an electronic mail interview with R1's Guardian dated 08/07/24 at 10:52 AM revealed the facility had not assessed R1 for any past trauma that she was aware of. R1's Guardian stated the facility listed information that was not correct concerning R1's history in the care plan and noted they did not reach out to her or the resident's other family members for further information. R1's Guardian stated she did not believe that R1 received any visits from SSD L, when R1 was assaulted by a male resident that was uninvited to her room. The Guardian stated she asked the facility to call her when they talked to the resident about the incident with R3 because a major trust factor has been broken.

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	175450	A. Building B. Wing	08/13/2024

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility failed to ensure Resident (R)1 had a right to make choices about her life in the facility that were significant to her, which included the right to have only one staff present during cares as requested by R1 when the facility failed to provide a valid rationale to the resident for the use of two staff for cares and interactions with the resident.

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F 0570 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Assure the security of all personal funds of residents deposited with the facility. 35717 The facility reported a census of 31 residents. Based on observation, interview, and record review, the facility lacked evidence of a current Surety Bond, to ensure the security of resident funds, as required. This had the potential to affect all residents with personal funds accounts. Findings included: - During the onsite complaint investigation personal funds were reviewed. The facility provided a copy of the Surety Bond (Resident Funds Deposit Bond) for the amount of $20,000.00 and noted the bond was effective beginning 03/01/2022 and shall terminate one year from such date unless continued by certificate or until cancelled by the Surety . None of the three pages provided contained evidence the bond was still ongoing and active. Interview with Social Services Designee (SSD) L on 08/09/24 at 01:29 PM revealed the current copy of security bond (Surety Bond) was the correct copy. The undated policy provided by the facility, regarding Transactions Involving Resident Funds (with a 2023 copyright by The Compliance Store, LLC) revealed all resident funds that were entrusted to the facility for a resident would be covered by a surety bond, to include any refundable fees. The facility failed to provide evidence/documentation of an active and current surety bond to ensure the security of resident funds, as required. This had the potential to affect all residents with personal funds accounts.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 35717 The facility reported a census of 31 residents. Based on observation, interview, and record review the facility failed to support the resident's rights to voice any grievance without discrimination, reprisal, or the fear of discrimination and reprisal. The facility further failed to ensure residents knew how to file a grievance, failed to provide information on how to file a grievance anonymously, failed to ensure grievance forms were available to residents, failed to include a summary statement of the resident's grievance or steps taken to investigate the grievance, and failed to ensure all grievances were documented on the grievance log. This deficient practice had the potential to affect all residents in the facility. Findings included: - Upon initial tour of the facility on entrance, 07/31/24 after 08:50 AM revealed no signs indicating where the grievance forms were or to whom to report a grievance. Walking by Social Services Designee (SSD) L and Administrative Offices no highly visible designated sign to indicate where forms were located or where to submit them or how to obtain one or an area to file anonymously. At the entrance to administrative Staff Hallway was a metal square locked box with an open slot at the top, but it was for submitting payments to the facility. Observations of the bulletin boards and entrance area revealed no posting of how to file a grievance, who to contact for a grievance, or the location of grievance forms. On 08/01/24 after entrance revealed in one of the two resident hallways, just outside of Social Service (SS) L's office was a clear wall file holder, which contained a manilla folder that had a small tab on it indicating grievances. Inside the folder were grievance forms. Review of the Grievance Log form provided by the facility revealed the following columns with named areas: Grievance Number Date Received Name of Resident Room Number Department of Grievance Name of Person Filing Report Relationship Date of Incident (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Name of Person Investigating Incident Disposition of Grievance Date of Written Decision The form lacked an area to record the summary/nature of the grievance. Review of the facility provided grievance forms revealed four grievances documented for June 2024: Grievance 1: On 06/01/24 Resident (R)9, had a Nursing grievance, date of incident of 05/31/24, resolved, 06/03/24. (Did not specify what the resident grievance was or how it was resolved). Grievance 2, 3, and 4: On 06/28/24, Resident Council had a Dietary, Housekeeping, and Maintenance, with incident date 06/28/24, and they were all resolved on 07/01/24. (Did not specify what the resident grievance was or how it was resolved). Review of the facility provided grievance forms revealed three grievances documented for July 2024: Grievance 1: On 07/04/24, R10 had an Activities concern from 07/04/24, resolved, 07/05/24. Grievance 2: On 07/12/24, R9 had a Nursing grievance from 07/13/24 (one day after the grievance was received), resolved 07/15/24. Grievance 3: On 07/15/24, R9 had a Nursing grievance from 07/13/24, resolved 07/16/24. (Did not specify what the resident grievance was or how it was resolved). (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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An Interview with R1 and her representative at 04:09 PM on 07/31/24 revealed one day she was not feeling great due to her back pain. She was sleeping and felt a hit in her private parts and described R3 was in her room again. R1 stated R3 would come into the room at times when she was changing her bra and panties. R1 stated at one time R3 was in her room playing in water in her bathroom, she pulled her call light, and when staff responded they could not handle him or get him out. R1 reported at one point staff had to pick R3 up and put him in his chair to get him out of her room. R1 stated she was not going to say anything originally but was upset and wanted the facility to know about it, and it was embarrassing. R1 felt staff were vindictive toward her since the incident occurred and she reported it. She further reported staff told her R3 just climbed in most resident's beds and that he had the mentality of a five-year-old. The resident's representative said she asked the facility what do you mean, he touched my [relationship to the resident] and the facility responded that R3's arm slipped and probably hit the top of R1's thigh. R1 stated she had multiple missing items and felt R3 was responsible for taking the items out of her room. R1 reported after the incident with R3 many staff asked to do skin checks on the resident and insisted that she was sent to the hospital. The resident told the nurses and administrative staff she did not need to go to the hospital. She was sleeping with covers on at the time of the contact and was sure there was no injury such as bruising or scratching. R1 reported just because there were not bruises or scratches does not mean R3 did not attempt to get into bed with her and did not hit her private areas. R1 stated she knew if she went to the hospital with no bruises or scratches it was going to make her look bad. After the incident with R3, R1 stated the facility took all rights away from her. She could no longer have one staff performing cares and even housekeeping staff were required to have two people in the room. Two staff now had to watch her shower and it was very upsetting to her. R1 reported she bathed herself in her sink because she did not want so many staff watching her shower. R1 reported if the facility had been supervising R3, she would not have had to go through this. She reported being at the facility for the last five years with no concerns and now she has been issued a discharge notice from the facility. The facility has further filed an Adult Protective Services report for her Guardian speaking up for her. The resident voiced fears a new facility might persecute based on what this facility told them about her. During the same interview R1 voiced she did voice to the facility she was missing some tea bags. She stated the facility asked her how she knew she was missing tea bags and she said because all of one flavor were missing. The facility provided grievance forms for June 2024 and July 2024 did not include any grievance entry regarding R1. Interview with Certified Nurse Aide (CNA) N on 08/05/24 at 11:38 PM revealed she did not know how the residents filed a grievance. CNA N said when a resident voiced a grievance, she passed it along to the other aide and let the resident know as well. Interview with CNA II on 08/06/24 at 12:25 AM said if a resident voiced a grievance to her, she handled it calmly and reported the grievance to the LN. CNA II stated she believed there was a grievance form and thought it was at the nurse's station. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview with Social Services Designee (SSD) L on 08/09/24 at 01:29 PM revealed the grievance forms were located outside of her office and she was responsible for replacing the forms, and noted the forms were outside of her office and accessible 24 hours. SSD L noted the staff, family, or herself would fill out the grievance form for residents who could not. When asked how she decided which grievances were listed on the grievance forms, SSD L responded that all grievances are listed. When asked how visitor and resident know where to find the forms, SSD L responded that they are educated at admission and staff can direct them to my office. We also go over where the grievances are in resident council. When asked how can someone discern what the grievance was regarding on the grievance form, SSD L said she would have to read it. SSD L further noted the staff received training regarding grievances at orientation and at monthly all staff meetings. The facility failed to support the resident's rights to voice any grievance without discrimination, reprisal, or the fear of discrimination and reprisal. The facility further failed to ensure residents knew how to file a grievance, failed to provide information on how to file a grievance anonymously, failed to ensure grievance forms were available to residents, failed to include a summary statement of the resident's grievance or steps taken to investigate the grievance, and failed to ensure all grievances were documented on the grievance log.

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35717 The facility reported a census of 31 residents, with 16 residents sampled. Based on observation, interview, and record review, the facility failed to the prevent the neglect of quadriplegic, dependent Resident (R) 4, when facility nursing staff did not adequately monitor or follow up on the decreased urinary output and decline R4 experienced on [DATE], just one day after she completed antibiotic treatment for a Urinary Tract Infection (UTI). On [DATE] at around 01:15 AM, staff found the resident unresponsive, cyanotic, with wet lung sounds, and with no urinary output. The staff did not apply oxygen and did not ensure a staff member stayed with R4 during the critical incident. License Nurse (LN) S left the room and called the physician, discussed the situation, received an order to call 911, then she called 911, printed and filled out papers, then went to the bathroom. When emergency responders arrived, they found no staff in the hallway and found the resident was alone in her room and with no oxygen applied, even though the staff noted R4 displayed obvious signs of airway distress. R4 required emergency medical services (EMS) response and treatment to include obtaining her oxygen saturation level of 77%, a systolic blood pressure of 44 millimeters of mercury (mmHg) and could not obtain her diastolic pressure. R4 required supplemental oxygen and EMS took R4 to the local hospital for treatment. The Emergency Department (ED) staff documented R4 appeared in poor health, appeared toxic, in severe distress, with flat jugular veins, cyanotic nail beds, lethargic, confused, only made sounds of moan/groans, and appeared poorly groomed, disheveled, malodorous. The ED placed a urinary catheter and noted 10 milliliters (ml) of dark orange/red urine with obvious pus and R4 required placement of an intraosseous to her right lower tibia (shinbone). The hospital admitted R4 with acute respiratory failure, pneumonia (inflammation of the lungs), sepsis (life threatening systemic reaction that develops due to infections which cause inflammation throughout the entire body), and comfort care with an onset date of [DATE]. Hospital staff noticed 25 ml of a creamy white/green substance in R4's urinary catheter tube and R4 died at 09:08 AM on [DATE]. The failure of facility staff to adequately follow up on R4's decreased urinary output, decreased oxygen saturation level, and declines in the resident's status, placed R4 in immediate jeopardy. Findings included: - The EHR revealed Resident (R)4 was [AGE] years old and admitted to the facility on [DATE]. The signed [DATE] Medication Review Report in the Electronic Health Record (EHR) revealed R4 had diagnoses which included the following: dysphagia (swallowing difficulty), anemia (inadequate number of healthy red blood cells to carry adequate oxygen to body tissues), generalized anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), chronic pain due to trauma, chronic pain syndrome, hypertension (high blood pressure), hydronephrosis (swelling of kidneys due to build up of urine, when it cannot drain), chronic kidney disease stage 1 (mild kidney damage with normal kidney function), history of traumatic brain injury, personal history of urinary (tract) infection, hypocalcemia (abnormally low level of calcium in the blood), quadriplegia (inability to move the arms, legs and trunk of the body below the level of an associated injury to the spinal cord), muscle weakness, type 2 diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), dysphagia following other cerebrovascular disease. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175450	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Anew Healthcare Oxford	200 S Ohio St Oxford, KS 67119

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F 0600

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

The [DATE] Annual Minimum Data Set (MDS) revealed R4 had a Brief Interview for Mental Status score of 9, indicating moderate cognitive impairment. The MDS noted R4 did not reject care but did have a worsening of verbal behavioral symptoms directed towards others which occurred one to three days of the seven-day observation period. R4 had impairment to both sides of her upper and lower extremity regarding functional limitation in range of motion and used a wheelchair for mobility. R4 required supervision or touching assistance with eating and was dependent on staff for oral hygiene, toileting, shower/bathing, dressing and personal hygiene, and was dependent on staff for mobility. R4 was always incontinent of bladder and occasionally incontinent of bowel. R4 weighed 264 pounds. R4 received daily injections of insulin and received antianxiety and hypoglycemic medications. The resident was not on oxygen therapy. The MDS noted R4's primary medical condition was quadriplegia. The MDS further indicated R4 had cerebrovascular accident (CVA/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), renal (pertaining to kidneys) insufficiency, renal failure, and End Stage Renal Disease (ESRD, a terminal disease of the kidneys) indicated.

The [DATE] Urinary Incontinence/Indwelling Catheter Care Area Assessment revealed the resident was always incontinent, but the CAA was not completed.

The [DATE] Quarterly MDS revealed she had a BIMS score of nine and no change in behavioral symptoms since the prior assessment. The resident continued to have functional range of motion impairment to both sides of her upper and lower extremity, used a wheelchair for mobility, required substantial/maximal assistance with eating, and was dependent on staff for her self-care and mobility. The MDS noted she was frequently incontinent of urine and bowel. R4 had no swallowing disorder noted and weighed 262 pounds. R4 received antianxiety and antidepressant medications. The resident did not receive oxygen or any special treatments, procedures, and programs.

The [DATE] Care Plan included the following staff interventions/tasks regarding R4:

[DATE] - Sometimes R4's response was not to actual pain, but an anticipation of pain, as R4 has been known to say that hurts ow or even curse at staff before they touch her.

[DATE], revised [DATE] - Staff would remind R4 she needed to swallow an extra time after every ,d+[DATE] bites to make sure she removed any residual food from her mouth, to help with choking and aspiration risks. R4 required assistance with feeding, should sit upright for all meals and for 30 minutes afterward, and should take all meals in the dining hall for safety. The resident used a lidded cup with a built-in straw to protect from spilling and maintain her independence.

[DATE], revised [DATE] - R4 had an ADL self-care performance deficit related to her diagnoses of CVA and quadriplegia and staff were to report any changes to the nurse. R4 required total assistance of two staff for transfers and use of a mechanical lift.

[DATE], revised [DATE] - R4 was totally dependent on two staff for toilet use.

[DATE], revised [DATE] - R4 had bowel incontinence r/t [related to] and did not finish the care plan focus. The following staff intervention to provide peri-care after each incontinent episode. A [DATE], revised [DATE], intervention included to check and change every two hours and PRN (as needed).

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A [DATE] Care Plan focus noted R4 had a urinary tract infection and included the staff interventions to check and change R4 every two hours for incontinence; wash, rinse, and dry soiled areas; give antibiotic therapy as ordered; Monitor/document for side effects and effectiveness and administer Macrobid (antibiotic) Oral Capsule 100 MG, give 1 capsule by mouth two times a day for UTI for 10 days. The staff were to obtain and monitor lab/diagnostic work as ordered and report the results to the physician and follow up as indicated. A [DATE] Care Plan focus noted R4 had a tooth infection and included staff to administer 1 tablet of Bactrim (antibiotic) DS Oral Tablet ,d+[DATE] MG, by mouth two times a day for R4's tooth infection for seven days. The [DATE] at 05:47 PM Health Status Note included R4 remained in bed the entire first shift. She was not feeling well, however, was not able to verbally convey what was not feeling well. She consumed 480 cubic centimeters (cc) of health shakes today at breakfast and lunch meals but otherwise was not eating today. Her vital signs remained within normal limits and staff placed her in the Provider Book for a full assessment. The [DATE] at 08:42 AM Nurse Note included R4 was not feeling well for the past couple of days. She remained without a fever; however, she declined getting up again this morning and on Wednesday. She was up in her chair yesterday (Thursday) morning; however, she did not eat, she only took fluids at breakfast and lunch. Labs were ordered yesterday, to be drawn today, and a urinalysis (UA) with culture and sensitivity (C&S) if indicated. This morning R4 began coughing and her chest was congested and had some Ronchi as evidenced by a rumbling (sound) upon expiration to her right (R) upper and mid lobe, and her R lower lobe was difficult to auscultate anteriorly. She was not able to cough hard enough to expectorate her phlegm at the time. The left (L) upper lobe presented with rales. R4 had no fever, but her face was very flushed. Her temperature measured 98.4 degrees Fahrenheit by noncontact thermometer to her forehead, pulse measured 102 beats per minute (bpm), Respirations were 19, blood pressure was ,d+[DATE] millimeters of mercury (mmHg). The staff made notifications and received an order for a chest X-ray and obtained a UA per straight catheterization with assistance of three staff. The [DATE] at 11:59 AM Nurse Note revealed R4's chest x-ray revealed no acute pulmonary or pleural abnormality is identified and noted the resident continued coughing with some mucous that she could not spit up. The [DATE] at 03:18 AM Order Note revealed the Macrobid Oral Capsule 100 MG, 1 capsule by mouth, two times a day for UTI for ten days, noted This dose fails a general dose range check based on drug inputs and/or the patient information provided. This drug's dose should be adjusted based on renal function. Manual screening is required. A secondary Order Note from [DATE] at 03:18 AM revealed a mild drug interaction: The antimicrobial effectiveness of Macrobid Oral Capsule 100 mg may be decreased by Milk of Magnesia Oral Suspension 400 mg per 5 ml. A Nurse Note dated [DATE] at 12:40 PM noted an order for Amoxicillin (antibiotic) 500 mg three times a day for 10 days and Ibuprofen 600 mg twice a day for 7 days. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A [DATE] at 12:46 PM Order Note included the system has identified a possible drug allergy for the following order: Amoxicillin Oral Tablet 500 MG (Amoxicillin), give 1 tablet by mouth three times a day for tooth infection. Another [DATE] at 01:42 PM Order Note included a moderate severity drug interaction between Bactrim DS Oral Tablet ,d+[DATE] mg (sulfamethoxazole-trimethoprim) and Losartan Potassium tablet 50 MG and noted the coadministration of angiotensin II receptor antagonist and trimethoprim may increase the risk for hyperkalemia (higher than normal potassium levels in the blood) especially in the elderly. A [DATE] at 09:23 AM Nurse Note included the speech therapist changed R4's diet to puree diet due to her change in condition. The [DATE] at 10:19 PM Nurse Note documented the resident refused her shower today and stated she did not want one due to not getting up today and said, another day. The [DATE] at 08:21 AM Nurse Note documented the resident was up for breakfast this morning in good spirits, eating pureed diet and tolerating well, with no emesis (vomiting). The [DATE] at 10:37 PM Nurse Note documented the resident had an elevated temperature at 07:00 PM of 100.2 (degrees F) and received her scheduled ibuprofen prior, no complaints made by resident, alert in bed, with no nausea or vomiting noted. Temperature noted at 97.3 (degrees F). Review of an Alert Note dated [DATE] at 05:15 AM revealed Licensed Nurse (LN) S documented the following regarding R4: Resident at 0115 [01:15 AM] presented with lethargy unable to arouse, sternum rub attempted without success, all lung lobes crackles throughout O2 sat unable to obtain, R 28 BP ,d+[DATE] T 98 P 88 BS 167. Resident eyes fluttering very minimal urine output. LN contacted the physician, who contacted the LN writer and gave the order to send R4 to the ER. The LN contacted EMS, local law enforcement, and EMS arrived and transported the resident to the local hospital at 01:45 AM. The LN documented she sent the notification to Administrative Staff A, Administrative Nurse B, and Administrative Nurse C. Per a witness statement (which did not have a back page to identify name, date, or notarization) revealed a CNA documented the following regarding R4 on [DATE]: They got R4 up for breakfast, chatted with her and she acknowledge the CNA's presence. She was not feeling well but she wanted up for breakfast. She only ate a couple of bites of oatmeal but did eat her gelatin. The CNA statement noted they came around a few times to offer her water, which she took a few sips of. She refused lunch, and I got her more water. She did not look like she felt good any time I passed, so I informed the nurse that she didn't look very good. For dinner she stayed in bed and we gave her a chocolate shake and water. At dinner she was lightly wet so we changed her, but not much was on her. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Per the signed and notarized witness statement dated [DATE], Certified Nurse Aide (CNA) R documented she started her shift on [DATE] at 06:00 PM and noted R4 did want to get up for breakfast, however, did not want to eat much. CNA R documented she provided R4 with some gelatin and a health shake, and R4 laid back down. CNA R and another CNA changed R4 and made sure she was dry and comfortable. CNA R documented they reported to LN G that R4 wasn't feeling well and really didn't want to get up for lunch! CNA R said we were told she was being treated for a UTI and to push fluids. She did drink water and shakes for us through out our shift at 6pm the night shift came in, we did rounds with them . we adjusted her in bed. We reported how she had been feeling. She was responding to us well at that time. Per the signed and notarized witness statement dated [DATE], CNA N documented on [DATE] at about 01:00 AM she and CNA P were starting rounds, beginning with R4. Upon entering the room R4 still seemed to not feel well as passed down from first shift staff. CNA P laid the bed flat to change R4's brief. CNA N documented that CNA P verbalized R4 barely had any output and how that was not normal. CNA N documented that after elevating the head of the bed, CNA N and CNA P both noticed a flushed look on R4's face, pale lips, wheezing in her lungs that sounded like phlegm, and her eyes were fluttering. CNA N documented that CNA P did a sternum rub on R4's chest and R4 did not respond, and CNA P went to the LN to inform her of R4's condition, while CNA N stayed in R4's room. CNA N documented the LN S arrived and took vitals and could not get an O2 reading on R4. CNA N documented the LN then decided to send R4 to the hospital and the nurse made the call, then waited in R4's room until EMS arrived, while CNA N and CNA P continued our rounds as the Nurse gave EMS & Cops info. The other aide went back to [R4's] room to relay her info as well while I finished with other resident. As I finished with other resident [R4] was wheeled out. Per the signed and notarized witness statement dated [DATE], CNA P documented on [DATE] she saw R4 about 11:40 PM and she seemed to be normal. She opened her eyes and was awake. Just seemed tired. CNA P noted R4 was dry and had been dry all night. On [DATE] CNA P noted she started her next rounds around 01:00 AM and she and CNA N went to R4's room to change her first. CNA P noted she and CNA N cleaned R4's room and her wheelchair, then went to change R4, and noted she looked find just seemed tired. CNA P noted when she laid R4's bed flat, so they could roll her to change her, she noticed R4 had very little pee in her brief. CNA P documented that as they set R4 back up, she noticed that her breathing was heavy in her stomach and sounded like phlegm possibly in her throat or lungs when she would breath (sic). Her lips were turning purple. Her eyes were rolling back in her head and wasn't responding to the sternal rub. CNA P documented she immediately went and told LN S, who gathered equipment and responded, obtained R4's blood sugar and vitals, listened to her lungs, but could not get R4's O2 saturation. CNA P documented the LN then went back to the nurse's station while CNA N stayed in the room with R4. The nurse then called the cops, and the physician and CNA P went back down to the room to tell CNA N R4 was being sent out. CNA P documented that she and CNA N then continued their rounds and went to the next room. CNA P further documented Not too long after going to our next room I went back down to the nurses station where I seen the nurse [LN S] and a female cop meet in the hallway right outside the nurse's station. The nurse [LN S] gave the cop paper work on [R4]. They then went down to [R4's] room. I then met the cop and [LN S] down in [R4's] room a few min. later. I gave the cop a run down of what happened when I was with [R4]. I then left the room and was walking down the hallways and seen a male EMT at the nurses station. I told the EMT that the cop and nurse [LN S] were in [R4's] room and where [R4's] room was. I then got back to doing my rounds. A little bit later I seen the EMT(s) wheeling [R4] out and the nurse [LN S] walking with them. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Per the [DATE] signed and notarized Witness Statement by Licensed Nurse (LN) S revealed at 01:15 AM that morning Certified Nurse Aide (CNA) P came to the nurse's room and stated to her that R4 was not acting like herself and she'd tried sternum rub and [R4] would not wake up. LN S documented she then grabbed the stethoscope, blood pressure cuff, thermometer, glucometer, oxygen saturation (O2) monitor, and went to R4's room with the CNA. She documented she went to R4s room, turned the overhead light on and noted the resident was her WNL [Within Normal Limits] pale skin color no sweating noted eyes mostly closed fluttering. LN S noted she could hear liquid in R4's lungs and attempted but could not obtain R4's O2 saturation reading, attempting on two of R4's left fingers (the statement lacked evidence LN S provided oxygen to R4 at this time). LN S documented Labor breathing noted and said R4's vital signs measured as follows: blood pressure was ,d+[DATE] millimeters of mercury (mmHg), respirations were 28 (BPM - breaths per minute) (normal range for an adult female at rest is ,d+[DATE] BPM), pulse was 88 (beats per minute), and temperature was 98.0 (degrees Fahrenheit). LN S noted she then went to get glucometer strips and left the CNAs in R4's room and came right back to obtain R4's blood sugar, noted as167. LN S documented she used the stethoscope and could hear crackles throughout all lung lobes. LN S further documented that before she attempted to get an O2 sat, she tried sternum rub, shaking resident arms and hollering to her without response (the witness statement continued to lack evidence O2 was provided to R4). LN S documented that during report (coming onto her shift) she had received no information from any staff, prior to 01:15 AM, that anything was going on with R4. LN S documented she had not noticed any issues with R4 during her before bed treatment, when she gave her roommate her breathing treatment (11:30 PM), or removed the roommate's breathing treatment mask at 12:09 AM. LN S noted she went to call the physician at 01:13 AM according to her phone log (and she noted the facility clock showed it was at 01:20 AM) and LN S said she waited three minutes and received a call back from a physician. LN S stated she explained the situation and asked if she could send R4 to the ER, the physician and LN S had a discussion over R4's status, vitals, lung sounds, and breathing, and the physician gave the order to send R4 to the ER. LN S then said, while she was still at the nurse's station after she hung up with the physician, she then called 911, filled out all paperwork, and printed all papers, then ran to the restroom. LN S documented that when she came out of the restroom, she saw a law enforcement officer in the hallway and ran down to them with the printed papers. LN S documented she and the law enforcement officer then went to R4's room and found R4 alone in her room with no staff present. LN S documented that shortly after another responder appeared, they retrieved R4's vital signs, and after reading the resident's O2 saturation level, LN S then asked the responder do you want me to get O2? and the responder stated, yeah that probably be a good idea. LN S then left the room to get O2 tubing then headed to get an O2 tank as EMS arrived so she led EMS to R4's room. EMS assessed and transferred R4 to the gurney and left with R4 at approximately 01:45 AM. LN S documented she then texted the notification to Administrative Staff A, Administrative Nurse B, and Administrative Nurse C. Review of the [DATE] Emergency Department (ED) Nursing Documentation for R4 revealed the following: Physical Assessment as Appears in poor health, Appears toxic, Tense, Severe distress. Skin: Pale, Mottled Respiratory: Left Lung Sounds: Rales/Crackles, Right Lung Sounds: Rales/Crackles Cardiovascular: Edema: 3+ pitting: BLE Neurologic: Level of Consciousness: lethargic, confused; Verbal Response: only sounds/moan/groans (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Psychiatric: Appearance: Poorly groomed, Disheveled, Malodorous The Patient Progress Notes from the local hospital dated [DATE] at 02:18 AM revealed R4's blood pressure was ,d+[DATE] mmHg, and her pulse was 112 beats per minute. At 02:31 AM R4's blood pressure was , d+[DATE] mmHg, and her pulse was 113 beats per minute. The [DATE] ED Nursing Note regarding R4 on [DATE] included: At 03:38 AM the LN placed a urinary catheter which returned approximately 10 ML Dark Orange/Red urine with obvious pus. At 05:17 AM, due to unsuccessful attempts to place a central line, the ED placed an intraosseous (IO, process of injecting medication/fluids/blood products directly into the bone marrow) to R4's right proximal tibia. Review of the labs collected by the local hospital on [DATE] at 02:39 AM revealed the resident had a platelet count of 67 (Low=130 and High=400). R4 had critically high Lactic Acid lab results which measured 3.7 millimoles per liter (mmol/L) (Low=0.70 and High=2.00). Review of the ED Provider Documentation Report for R4 from [DATE] revealed the following: Chief Complaint and Reason for Visit: Acute Respiratory Failure, pneumonia, sepsis, comfort care. Final Impression: Sepsis, left lower lobe pneumonia, pulmonary edema. Quadriplegic. Current Condition: Critical Per the Unites States Centers for Disease Control and Prevention website, dated [DATE], revealed Sepsis is listed as the body's extreme response to an infection. It is a life-threatening medical emergency. The website further stressed the importance of early recognition and timely treatment of sepsis, reassessment of antibiotic needs and prevention of infections. Review of the chest X-Ray Report on [DATE] at 03:06 AM revealed R4 had airspace infiltrate and atelectasis in the left lower lobe of her lung, with no heart failure present. The report noted the left lower lobe infiltrate and atelectasis was mostly new compared to the last exam on [DATE] (12 days prior). Review of the local hospital Patient Progress Notes dated [DATE] at 09:07 AM revealed the urinary catheter tubing contained a creamy white/green substance. At 09:08 AM, progress note revealed it was 25 ml of white/green urine. The hospital record review revealed R4 died at the hospital on [DATE] at 09:08 AM, approximately 8 hours after staff found her unresponsive. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with CNA N on [DATE] at 11:38 PM revealed the nurse's usually do the vital signs and stated she had only taken vitals once. Regarding the [DATE] incident with R4, CNA N stated that R4 did not respond to sternal rub, and she stayed in the room with R4 while CNA P told the nurse. Then, when the LN came back to the room, CNA N and CNA P continued their rounds with residents. CNA N stated by the time they finished the next room, they saw R4 going out with EMS. When asked about R4's earlier in her shift, CNA N stated R4 was actually a very heavy wetter but stated when she checked on R4 she was dry, then she was barely wet like a quarter sized spot in her brief when they changed her at approximately 01:00AM on [DATE]. CNA N confirmed she did not change R4's brief upon arrival on her shift and did not change her brief earlier in her shift because she was dry. CNA N stated she had received report that R4 was a little worse today and not active or talkative. Interview with CNA II on [DATE] at 12:25 AM revealed she received training about a week ago over R4, not outwardly about R4, but just about a lack of oxygen and to put oxygen on the resident if their O2 was down and to ensure things were done properly. CNA II stated she worked with R4 two days prior to the incident and said R4 seemed okay, but you never know. CNA II said CNAs are hands on and they know about changes in residents and to report any change to the nurse. CNA II stated she does take vitals and if a resident displayed abnormal breathing or too high or low of blood pressure, she would report that to the nurse. CNA II stated the CNAs report the color of urine, such as urine color of concern like red or orange, brown/black, orange or anything cloudy, need reported or if the urine is chunky, as she had seen chunky urine. CAN II stated if a resident had a UTI the nurses let the CNA staff know and the CNAs encourage fluids and keep the residents cleaned up. CNA II stated the electronic charting for CNAs only allowed for a checkmark on whether a resident was continent or incontinent. During an interview with Administrative Nurse C on [DATE] at 03:43 AM revealed she knew R4 was being treated for a UTI and tooth infection and stated they were monitoring signs and symptoms. Administrative Nurse C said she thought R4 was getting better, was up for a meal and she was doing okay, so when she found out about the outcome to R4, she was shocked. Administrative Nurse C was told they transferred R4 out to the ED. Administrative Nurse C stated she expected staff to report to a licensed nurse if a resident was not voiding within so many hours and further stated to be honest R4 was always wet no matter what, but sometimes she did not drink as much as other times. Administrative Nurse C expected staff to report any change in condition. Administrative Nurse C stated the CNAs task charting included checkmarks to indicate if a resident voided or not but verified it did not allow for an amount or urine description. Administrative Nurse C said they were pushing fluids for R4, would encourage fluids, expected staff to report if a resident had no output and for staff to follow up. When asked about the lack of output for R4 and EMS transport, Administrative Nurse C stated she was probably dehydrated and not doing too hot, but if a resident was not voiding the staff should have reported that and then said, poor communications. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with Administrative Nurse B on [DATE] at 04:45 AM, revealed R4 was able to get up that morning and barely ate breakfast, but that night Administrative Nurse B received a text stating that R4 was at the hospital with an O2 saturation level of 77%, and the nurse did not call to notify her. Administrative Nurse B said when she came in that morning ([DATE]) she did not even know what happened, had the police not called and told the facility that the vital signs the nurse obtained did not align with what EMS reported or else she would not know that. Administrative Nurse B said if the staff could not get the O2 saturation level on a resident, she expected the staff to put oxygen therapy on, but then said the LN failed to administer O2 to R4. Administrative Nurse B stated she heard that the nurses were not in the room with R4 the whole time and further said she expected the staff to stay in the room with residents in distress. Administrative Nurse B stated she did call the nurse in as the police officer said he was going to press charges. The nurse stated she needed to go to the bathroom real bad, she confirmed she could not get the resident's O2 saturation level, she said she did not put oxygen on the resident, and then confirmed she asked the officer if she should put the oxygen on R4. Administrative Nurse B stated some CNAs had training, and others were not supposed to do sternal rubs on residents. During a telephone interview with Law Enforcement Officer (LEO) GG on [DATE] at 12:44 PM revealed LEO's have responded to lots of calls to the facility over the past almost two years and estimated that number to be over 300 calls. LEO GG noted he was just in the facility recently to address a resident (R4) with difficulty breathing and with wet lungs that you could hear without a stethoscope. LEO GG said the nurse did not remain in R4's room, she left the room and when one of his officers arrived the resident was in her room alone. LEO GG stated he responded to the call as an EMT and said when he arrived CNA P was walking down the hall towards him and he yelled which room? and CNA P continued to walk down the hallway in no hurry, probably about 1 to 3 minutes to wait, and then stated the room, and it was the room she had just come out of. LEO GG stated that was very frustrating as time counts in emergency response situations. LEO GG stated that is a problem and R4 needed positive pressure ventilation to get the water out of her lungs and he could not believe she did not have oxygen on her. LEO GG said after he arrived to the resident's room and they got an oxygen saturation level on her of 77% the LN then asked if she should put oxygen on R4 and he said yes, that is probably a good idea and further stated she should have put that on first thing that is why they do the ABC's, A is Airway. LEO GG said in a very exacerbated tone, to have a nurse look at me and say, 'do you want me to get oxygen?' and to look at R4 I am thinking why are you not bagging her or something? To have the nurse just say she had to pee, I just can't believe it. LEO GG further stated the LN gave him a blood pressure number for R4 that was impossible to be accurate (,d+[DATE]), considering that when they arrived to get the blood pressure, they could not even get a diastolic number and her systolic was in the 60's. LEO GG said it was accurate to say that R4 looked disheveled and was malodorous. LEO GG said if the residents were able to be ambulatory and able to do things, they look good, if they are not and not able to do anything and be vocal, then they were not getting the care. LEO GG said day shift and night shift are not the same and stated night shift were never in the resident's rooms and every time LEO GG went into the facility at night, they were not providing cares. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Anew Healthcare Oxford	200 S Ohio St Oxford, KS 67119

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with LEO LL on [DATE] at 04:09 PM revealed she was the responding officer to the [DATE] incident regarding R4. LEO LL stated she had a healthcare background (prior CNA/EMT) and stated she did not agree with how the facility staff handled the incident involving R4, in any way. She stated in any kind of healthcare, if the person is struggling to breathe, you get oxygen on them and it did not even matter what their O2 saturation is, you put oxygen on a person when they are struggling like R4. LEO LL stated when she arrived at the facility the dispatch had told her the room number, but when LEO LL walked in there were not staff in the commons area, no staff in the nurse's station, no staff in the hallway. When LEO LL walked by the room number given to her by dispatch, she thought it was the wrong number since no staff were in the room and the lights were mostly off, so she walked back to the nurse's station and ran into LN S. LEO LL said LN S stated Oh

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from separation (from other residents, his/her room, or confinement to his/her room). **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35717 The facility reported a census of 31 residents, with 16 residents sampled. Based on observation, interview, and record review, the facility failed to ensure facility staff assessed for the preferences of Resident (R) 5, to prevent the potential involuntary seclusion of R5. Facility staff did not know why they continued to place R5 into the same spot of the facility each day, taking all meals in this same spot removed from the dining area and other residents, and spending much of R5's day in this same spot, without staff offering to include him in the main dining or into another area. The facility further failed to ensure they did not involuntarily seclude R5 to his room at night, when surveyors entered the facility (at approximately 11:17 PM) and found R5's wheelchair, his only mode of transportation, to be in the hallway outside of R5's room, with his room door closed. These failures, using reasonable person concept, involuntarily secluded R5 to his room. Findings included: - The Electronic Health Record (EHR) included the following diagnoses for R5: schizophrenia (mental disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought), dementia (progressive mental disorder characterized by failing memory, confusion) unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, major depressive disorder (major mood disorder which causes persistent feelings of sadness), pseudobulbar affect (condition with episodes of sudden uncontrollable and inappropriate laughing or crying), drug induced subacute dyskinesia, extrapyramidal and movement disorder (abnormal condition characterized by involuntary repetitive movements of the muscles of the face, limbs and trunk), insomnia (inability to sleep), ataxia (impaired ability to coordinate movement) following unspecified cerebrovascular disease, abnormal weight loss, unspecified intracranial (within the skull) injury without loss of consciousness, sequela (condition which is the consequence of a previous disease or injury), adverse effect of unspecified antipsychotics and neuroleptics, subsequent encounter, and personal history of traumatic brain injury (TBI-an injury to the brain caused by external forces). The 03/01/24 Annual Minimum Data Set (MDS) Assessment included R5 had adequate hearing, clear speech, made himself understood and understood others, had adequate vision, and R5 never needed someone to help him read instruction, pamphlets or other written material from his doctor or pharmacy. The MDS documented R5 had a Brief Interview for Mental Status (BIMS) score of 6, indicating severe cognitive impairment. R5 had no impairment to functional range of motion and used a wheelchair for mobility. The MDS documented R5 had occasional incontinence. R5 did not receive a mechanically altered or therapeutic diet. The MDS documented R5 had obvious or likely cavity or broken natural teeth, inflamed or bleeding gums or loose natural teeth. R5 did not have restraints or alarms used. The MDS documented R5 received antidepressant and antipsychotic medications. The MDS indicated the resident gave no response or was non-responsive to the interview for daily preferences and activity preferences; noting the interview could not be completed by resident or family/significant other. The staff indicated that R5 preferred choosing clothes to wear, caring for personal belongings, receiving tub bath, snacks between meals, staying up past 08:00 PM, family or significant other involvement in care discussions, use of phone in private, place to lock personal belongings, listening to music, and participating in favorite activities. (continued on next page)

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 05/31/24 Quarterly MDS Assessment included R5 had clear speech and was usually understood with difficulty communicating some words or finishing thoughts but was able if prompted or given time. R5 usually understands others, misses some part/intent of message but comprehends most conversation. The resident had adequate vision and R5 never needed someone to help him read instruction, pamphlets or other written material from his doctor or pharmacy. R5 had a BIMS score of 9, indicating moderate cognitive impairment. The MDS documented R5 had no delirium present and documented a Mood Severity Score of 00, indicating no depression. The MDS included the D0700 question How often do you feel lonely or isolated from those around you? and scored R5 as 1, indicating rarely. The MDS indicated R5 had no psychosis, behavioral symptoms, no wandering, no rejection of care, Review of the Care Plan for R5 revealed numerous areas of focus to include addressing his incontinence related to his immobility, his ADL self-care performance deficits related to his immobility, his impaired cognitive function/dementia or impaired though processes, and his communication problem related to his history of CVA, dementia, and schizophrenia. The Care Plan did not address R5's preference to sit by the front door, eat by the front doors in his wheelchair and use of a bed side table staff provided, and/or spending most of his time near the front doors, seated in his wheelchair, in front of the activity calendar wall area; nor, did the Care Plan account for keeping the resident's wheelchair in the hallway at night, outside of his room. Review of the Nurse Note in the EHR from 07/01/24 through 08/01/24 lacked evidence the facility assessed or addressed R5's continued positioning by the front entrance doors, in front of the Activity calendar wall area. Review of the IDT Meeting Notes dated 07/12/24 at 10:38 AM revealed Resident care plan has been reviewed and updated as needed. Resident notified of plan of care. Review of the IDT Meeting Noes dated 07/19/24 at 09:30 AM revealed Resident care plan has been reviewed and updated as needed. Resident notified of plan of care. Observation upon entrance to the facility on [DATE] at 08:55 AM revealed R5 sat in his high back wheelchair and hunched himself forward with movement evident and almost appeared active in nature. The resident did not speak. The resident did not move his wheelchair on his own, and continued to sit in his wheelchair, moving his head left or right and had poor coordination in his movement. It was hard to discern if he understood what was going on around him, as he did not hold his attention long on anything. Observation on 07/31/24 at 12:16 PM revealed residents at the dining room tables eating, and R5 remained in his high back wheelchair positioned in front of the activities calendar and could not see the dining room from his vantage point. From where the resident was positioned, the dining room was about 15 feet in front of him, but to his right, extending approximately 25 to 30 feet. R5 remained near the front doors with a bedside table in front of him, awaiting his meal. (continued on next page)

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observations on 08/01/24 at 12:15 PM, as the surveyor walked through the dining room to assess the use of Styrofoam cups for the dining room residents revealed R5 seated in his high back wheelchair in the area by the front door facing the commons television area, but was too far away to hear or actively watch the program, while residents were in the dining room, just around the bed of the room. Observed several dietary and CNA staff walking around, including one CNA who carried a clipboard as she walked around the dining room area and documenting while the residents ate. The CNA returned to the nurses' station. There were 5 facility staff present during meals, talking to residents while they ate. R5 sat by himself near the entrance doors with a bedside table in front of him. He was not checked on, specifically by staff passing by who looked his way, but did not attempt to engage him or visit with him. At 12:20 PM Administrative Staff A walked by R5 and looked over at him but did not engage him. Therapy staff walked over, stood by him, but did not engage the resident until 12:22 PM when Administrative Staff A then checked on the resident, while the surveyor sat in the only chair nearby. Observation on immediate facility tour after entering on 08/05/24 at 11:17 PM revealed R5's wheelchair was outside of his room in the hallway and his door was closed fully. After the surveyors walked through the hallways for a brief tour, observation revealed Administrative Nurse C moved R5's wheelchair back into his room. Attempted to interview R5 on 07/31/24 and 08/01/24, but unable to establish if the resident understood the questions, as he only made a small, slightly drawn out 'nyaw' sound, while moving his head (without a discernable meaning, as it did not indicate 'yes' or 'no') when asked a yes or no question. The surveyor asked a follow-up question and R5 did not respond in any discernable way to decide if he understood to main idea of the question. The surveyor paused to wait and then smiled and thanked him for his time as the resident continued to look around and displayed uncoordinated, jerky movements. His face looked unkept, unshaven, and hair did not look styled/combed and he had visible food debris around his mouth. During an interview with Law Enforcement Officer (LEO) GG on 08/05/24 at 12:44 PM revealed he and his officers were in the facility multiple times a week, estimated at probably 3-4 times a week, and estimated in the last two years the facility has operated his police department has received well over 300 calls. LEO GG stated night shift does not provide the cares and he stated that every time he had been to the facility over the past 2 years, R5 was sitting there. LEO GG stated he had never seen R5 anywhere else in the facility, he was always by that door (front door). Interview with LEO LL on 08/07/24 at 04:09 PM revealed she responds frequently to calls at the facility. When asked if she observed R5 seated by the front doors in his wheelchair when she enters the facility, LEO LL stated He is always there! LEO LL stated unless he was in bed, he was always by the front door. LEO LL stated she did not want to say he was non-verbal but every time she entered the facility, he is right there, and I say 'Hello' and he does not respond. LEO LL further stated the facility was better, but not what it could or should be. (continued on next page)

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/05/24 at 11:38 PM, CNA N stated when she arrived for her 06:00 PM shift R5 was usually eating and had not wrapped up eating until around 07:00 PM or 07:30 PM. CNA N stated when R5 finished eating he walked his wheelchair down to his room. CNA N stated the staff did the check and change. CNA N stated R5 gets up on his own in the middle of the night and staff just did the check and change to see if he was dry, just in case. When asked where she typically saw R5, CNA N responded R5 was off to the right as soon as you come in the front doors, with a bed side table. When asked why R5 was positioned in that area, CNA N stated she did not know and was not told that was where he likes to be, she said she thought that is just where he is. During an interview with CNA II on 08/06/24 at 12:25 AM, when asked where she typically saw R5 when she came on shift, CNA II stated R5 was pretty much always by the front by the door. CNA II stated R5 ate over there too. CNA II stated R5 had really jerky movements and movements were harsh. When asked why R5 was positioned in that same location each day, she said I absolutely have no clue. During an interview with Administrative Nurse C on 08/06/24 at 03:43 AM revealed R5 usually was found by the right-hand side upon entering the facility. Administrative Nurse C said R5 had tardive dyskinesia and moved a lot, had anxiety, and became overly stimulated in the dining room. Administrative Nurse C said if you asked R5, that was his preference. Administrative Staff C further stated some days R5 would talk and then other days he would not and then stated R5 really would not talk, and normally wanted to go to his room and then would come back, self-propelling his wheelchair to the same spot. Administrative Staff C stated she believed this should be on R5's care plan. During an interview with Administrative Nurse B on 08/06/24 at 04:45 AM, Administrative Nurse B did not know why R5 sat in the same area. She stated R5 could move himself and he chooses to sleep and then he sits by the door. Administrative Nurse B said the facility tried with him like they tried with other residents where it (movements) could upset other residents, so they remove the residents from the dining area to not upset other residents. Administrative Nurse B said it was like when they moved R4 because she would yell help and it was upsetting other residents, so they moved R4 by the television area to eat, since she could not feed herself. Administrative Nurse B could not say why R5 continued to sit by the door or if the facility had spoken with R5 to see if he still wanted to sit by the door. During an electronic interview with Social Services (SS) L on 08/09/24 at 01:29 PM revealed SS L and the Activities Director assessed resident preferences on admission, quarterly, annually and with significant changes, and as needed. SS L noted resident preferences were on the Care Plan and Kardex and said if it was a critical preference SS L and the Activities Director met with staff directly to inform them. SS L further noted there was a communication book used to communicate changes to staff. The facility failed to ensure the staff did not involuntarily seclude R5, when facility staff did not assess for his preference of location for spending the majority of his time and when staff removed his wheelchair from his room, positioned it in the hallway, and closed the door to his room at night.

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F 0622 Level of Harm - Actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. 37026 The facility census totaled 31, with 16 included in the sample, and one resident reviewed for discharge requirements. Based on observation, interview, and record review the facility failed to provide evidence Resident (R) 1 met discharge requirement as outlined in the State Operations Manual, Appendix PP when the facility issued an involuntary discharge notice to R1, but failed to recognize the impact to R1 after R3 entered her room, uninvited, attempted to get in her bed, touched her private parts, and the facility failed to recognize the impact to R1's psychosocial wellbeing. Since the incident with R3, facility staff reported R1 isolated herself more, changed in her day-to-day behavior, and R1 reported she felt punished by the facility, embarrassed at multiple requests for skin checks of her private parts, and had to minimize her existence in her daily life. Findings included: - Review of the facility provided Discharge Letter for R1 dated 06/21/24 revealed the facility would discharge the resident thirty days from the date of the letter as necessary for the resident's welfare and noted the resident's needs could not be met in the home because the action and inaction of the resident's guardian. The letter stated the facility was unable to communicate with the resident without guardian present per guardians request. The letter further stated the resident's guardian is not available by phone 24/7. The letter stated the resident's guardian called the local police on facility administration and wanted to press harassment charges for an unknown reason to the facility and law enforcement. Review of the facility provided Discharge Letter for R1 dated 07/12/24 revealed the facility would discharge the resident thirty days from the date of the letter as necessary for the resident's welfare and noted the resident's needs could not be met in the home because the action and inaction of the resident's guardian. The letter lacked any further documentation regarding the guardian as identified in the 06/21/24 letter. Review of R1's Electronic Health Record (EHR) revealed the resident had the following diagnoses: paranoid schizophrenia (mental disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought), major depressive disorder (major mood disorder which causes persistent feelings pf sadness), need for assistance with personal care, post- traumatic stress disorder (PTSD- mental disorder characterized by an acute emotional response to a traumatic event or situation involving severe environmental stress), problems related to living in a residential institution, and suicidal ideation. Review of the 01/26/24 Annual Minimum Data Set [MDS] Assessment revealed the resident had a Brief Interview for Mental Status score of 15, which indicated intact cognition. The resident had a total mood severity score of zero, which indicated no depression. The resident reported never feeling lonely or isolated from those around her. The resident had no behaviors present during the observation period. (continued on next page)

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F 0622 Level of Harm - Actual harm Residents Affected - Few	Review of the 04/26/24 Quarterly MDS Assessment revealed the resident had no changes in BIMS or Mood Severity Scores but reported rarely feeling isolated from those around her. The resident used a walker and wheelchair for mobility. Review of the resident's Care Plan revealed the following: 06/20/24 - Staff would know the resident had depression, PTSD, and schizoaffective disorder. 07/24/24 - Staff were to know the resident had paranoid delusions and hallucinations starting on 6/19/24, evidenced by frequent false 911 calls, denying staff to provide cares, and fixating on management. 06/20/24 - Staff were to assist the resident with placement to a facility that can meet her psych needs. 06/05/24 - Staff would know the resident had a long-standing belief that a people were following her and had lived in the walls of a facility she lived in prior. The resident further believed the people hurt her neighbors when she lived in the community. The resident did not like to talk about the situation and would have staff check her room to ensure they were not there. Staff were to reassure her that the people were not at the facility if they saw her becoming upset. 06/20/24 - Staff would know the resident did not accept her mental health diagnosis and would become upset if discussed in front of her. Staff were to reassure the resident. 06/05/24 - Staff would know the resident had attention seeking behaviors at times and would often report items as missing that were found later, hidden in other areas. She often made false accusations related to her paranoid schizophrenia diagnosis. The resident would become paranoid that her medication had been tampered with or her water was being poisoned. At times she would choose to sit herself on the floor. 06/20/24 - Staff would know the resident had a geriatric psychiatric practitioner to help with her depression. 06/05/24 - Staff would know the resident accused people of doing things at times that could not be possible due to her hallucinations and delusions. Staff would investigate allegations the resident voiced. 06/20/24 - Staff would educate the resident about making unnecessary calls to 911 and how it causes those with legit emergency from being seen in a timely matter. 05/20/24 - Stop sign banner applied to the door to prevent unwanted entry. 06/20/24 - Staff were to determine reason for refusal (of cares), document, and return later and try again. The resident's care plan lacked any interventions, which recognized the widespread impact of trauma, signs and symptoms of trauma and/or knowledge of the resident's trauma related to an incident on 05/19/24, the resident voiced as traumatic to her, when R3 entered the resident's room, took R1's belongings, tried to lay in her bed, touched her private parts, and staff assisted the resident out of her room. The care plan further lacked staff interventions related to her PTSD diagnosis. (continued on next page)

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F 0622 Level of Harm - Actual harm Residents Affected - Few	R1's care plan further lacked evidence of an individualized discharge plan, which identified interventions intended to meet the resident's discharge goals, reason for discharge, needs that must be addressed before the resident could be discharged , changes in the resident's condition which had the potential to impact the discharge plan, and/or post discharge needs. Review of the 05/19/24 at 05:13 PM Nurse Note revealed the resident reported R3 entered her room, took her belonging, stated R3 tried to lay in her bed, touched her, and was assisted out of her room at the time. The facility notified the resident's provider and family. Review of the 05/19/24 at 07:49 PM Nurse Note revealed staff assessed the resident's skin with no skin issues noted and the resident denied pain. The facility educated staff on the importance of staying one-on-one with R3. The note lacked any evidence the facility assessed the resident's psychosocial wellbeing at the time and/or implemented interventions related to the resident's feeling about the incident with R3. Review of the 05/19/24 at 07:53 PM revealed later R1 reported the resident touched her in her private area while sleeping, but did not say anything till supper time. The note lacked any follow up or assessment of the resident's psychosocial wellbeing. The resident's care plan further lacked any direction to staff related to the incident, which occurred earlier in the day other than putting a stop sign on the resident's door to prevent unwanted entry. Review of the 05/19/24 at 11:04 PM Nurse Note revealed the resident declined a skin assessment at this time. The note lacked any interventions related to assessing the resident's psychosocial wellbeing. Review of the 05/20/24 at 09:10 AM Administrator Note revealed facility staff offered to send the resident to the emergency room for further treatment and stated she would make an appointment at her primary care provider. The Director of Nursing completed a skin assessment at this time with no new findings. Review of the Social Services Progress Note dated 05/21/24 at 11:39 AM revealed due to R1's allegations against R3 the Social Service Designee (SSD) reached out to the resident's mental health provider to schedule a zoom call for Thursday (05/23/24, five days after R1 reported being touched by R3). The SSD also reached out to Social Worker (SW) HH to see if she would see if it would be possible for her to see R1 twice a week for three weeks. SW HH did not know if time would allow for her visits but would let the facility know. The resident's care plan lacked any evidence the SSD, put any further interventions related to R1's psychosocial wellbeing in place during the time she was waiting to be seen by her mental health practitioner and/or social worker. Review of the 05/21/24 at 01:44 PM Social Service Progress Note revealed the SSD reached out, through email, to the resident's Guardian to get permission for the resident's mental health practitioner to do a Zoom call on Thursday, the facility would wait for the Guardian's response. Review of the 05/21/24 at 03:15 PM Nurse's Note revealed staff attempted to do a skin assessment on the resident twice. The resident voiced she had no skin problem and did not need a skin check. (continued on next page)

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F 0622 Level of Harm - Actual harm Residents Affected - Few	Review of the 05/23/24 at 10:02 AM Social Service Progress Note revealed the SSD set up a Zoom call for the resident with her mental health provider just to make sure she is stable after the incident that occurred earlier in the week. The SSD noted she reached out to the resident's Guardian on 05/21/24 to get permission to have R1 seen, but she never responded to email. The SSD stated the Zoom appointment would stay open until noon incase R1's Guardian responded to the e-mail. The note lacked evidence the facility made any attempt since 05/21/24 to contact R1's Guardian or attempted any other means of communication since the original e-mail, two days prior. The facility further failed to document any attempts to ask the resident how she felt about talking to her mental health provider about the incident that occurred earlier in the week. Review of the 05/27/24 at 01:16 AM Nurse Note revealed the resident's Guardian called the facility to inquire about staff in the resident's room looking at her skin. She asked the staff to leave the resident's room at that time stating she had been traumatized enough. She then asked the staff if they took R1's clothes off to look at her skin or her private parts. The nurse assured the Guardian staff completed the resident's skin assessment earlier in the day and that no one had taken resident' clothes off to look at her private parts. The guardian stated to facility staff I don't want no one talking to her or going in her room unless they get permission from me first. The guardian asked staff to leave the resident alone and stated the staff present just did not listen. The guardian then asked staff again to be called before speaking to R1 and/or performing any cares on the resident. The EHR lacked evidence the facility followed up with R1 about her wishes regarding the guardian's request. Review of the 06/07/24 at 11:32 AM Social Service Progress Note revealed the SSD received a call from R1's Guardian stating the resident had some missing items. The SSD and Director of Nursing asked the resident about the missing items with the resident's Guardian on the phone. The resident's Guardian stated she was going to document the conversation as the facility asked the resident what was missing. The resident opened up a box with a lot of tea bags noting some of them were missing. The SSD asked the resident how she kept track of her teas and the resident reported one specific flavor was missing. The SSD pointed out inconsistencies in the resident's report. The writer stated the Guardian interrupted past allegations that the facility felt was resolved. The SSD called the conversation contradicting. The writer asked R1 if she felt safe and the resident's Guardian told the resident not to answer the question. The facility offered to replace the tea and left the room. The facility further failed to follow up on the resident's concerns of someone being in her room uninvited, unsupervised. Review of the 06/07/24 at 12:07 PM Social Service Progress Note revealed the resident's Guardian never responded to requests to give permission to do a Zoom call with the resident. The 06/07/24 at 11:32 AM (approximately 35 minutes earlier) Social Service Progress Note indicated the SSD spoke to the resident's Guardian on the phone and in the presence of the resident but failed to ask about the Zoom call for the resident. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Anew Healthcare Oxford		STREET ADDRESS, CITY, STATE, ZIP CODE 200 S Ohio St Oxford, KS 67119	

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F 0622 Level of Harm - Actual harm Residents Affected - Few	Review of the 06/16/24 at 04:00 AM Incident Note revealed R1 requested for the nurse to check on a rash located under her breast. A Certified Nurse Aide (CNA) accompanied the nurse to the resident's room, but the resident requested the aide (who is also female) to step outside. The CNA explained to the resident that they were informed by management to have two people in her room at all resident visit for safety concerns. The resident was on the phone at the time of the incident and the resident declined the nurse's cares stating she did not need her anymore and further stated her guardian would check on her, so the nurse and CNA left her room. EMS arrived at the facility at 03:35 AM stating the resident called them. EMS later left the facility without the resident when they reported the resident did not want to go to the hospital. Review of the resident's EHR and plan of care lacked any evidence/justification R1 required two staff present during her cares. Review of the 06/19/24 at 01:34 PM Nurse Note revealed the writer went to the resident's room with another staff member to do a skin assessment and the resident refused. Review of the resident's EHR and plan of care lacked any evidence/justification R1 required two staff present during her cares. Review of the 06/26/24 at 10:05 AM Plan of Care Note revealed the resident declined to attend the care plan meeting and her representatives attended via Zoom. One of the resident's representatives asked the facility about the process of discharging the resident and they were told they would have to transfer the resident to the receiving facility and let them know the discharge date once it was decided. The representatives stated they did not receive the thirty-day discharge notice the facility issued on 06/24/24. The Administrator informed the resident's guardian the facility sent it on 06/21/24. The representatives asked the facility about the appeal date and the Administrator stated she would send the appeals process through electronic mail. Review of the 06/26/24 at 01:04 PM Late Entry Administrator Note revealed the facility resent a thirty-day discharge notice and a process to appeal the thirty-day notice. The facility would continue to monitor and support. The resident's care plan lacked any evidence the facility put in interventions related to the resident's involuntary discharge from the facility and/or her psychosocial wellbeing after being told she would have to relocate from her home of five, almost six, years. The resident's care plan continued to lack rationale or direction for the use of two staff when interacting with the resident and continued to lack trauma informed care related to R3 entering R1's room and touching her private parts. Review of 06/29/24 at 09:44 PM Nurse Note revealed the resident refused to allow two staff to monitor her during her shower and only allowed one staff member. Staff notified the administrator. The resident's record and care plan continued to lack a rationale for the use of two staff for cares of the resident, when the resident continued to voice concerns with two staff present for cares. (continued on next page)

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F 0622 Level of Harm - Actual harm Residents Affected - Few	An observation of the resident on 07/31/24 at 04:09 PM during an interview at the same time revealed the resident sat on her bed with her telephone propped on the bed next to her and her Guardian on the line. The resident appeared clean and well groomed. She originally presented with combed hair, was well dressed, and had an overall pleasant affect and offered the surveyors a place to sit in her room. Once the resident began talking about her feelings related to past events, which occurred at the facility her mood became more somber and timid, and her body language began to change. The resident began to have furrowed brows, became teary eyed at times, and her voice fluctuated with frustration/defeat over how the facility handled the incidents with R3. Over the course of the conversation the resident reported she felt she had to diminish her presence for fear of retribution and the surveyor noted the resident's shoulders started to fold toward each other and her hands folded into her lap as she made her size smaller throughout the course of the conversation without realizing it. R1 mentioned there were two staff whom she considered close to her before but were treating me bad because they wanted to be in [Administrative Staff A's] good graces, and that was upsetting. When R1 stated this her eyes welled with tears, and she then looked down toward the floor and was silent. (continued on next page)

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F 0622 Level of Harm - Actual harm Residents Affected - Few	An Interview with R1 and her representative at 04:09 PM on 07/31/24 revealed one day she was not feeling great due to her back pain. She was sleeping and felt a hit in her private parts and described R3 was in her room again. R1 stated R3 would come into the room at times when she was changing her bra and panties. R1 stated at one time R3 was in her room playing in water in her bathroom, she pulled her call light, and when staff responded they could not handle him or get him out. R1 reported at one point staff had to pick R3 up and put him in his chair to get him out of her room. R1 stated she was not going to say anything originally but was upset and wanted the facility to know about it, and it was embarrassing. R1 felt staff were vindictive toward her since the incident occurred and she reported it. She further reported staff told her R3 just climbed in most resident's beds and that he had the mentality of a five-year-old. The resident's representative said she asked the facility what do you mean, he touched my [relationship to the resident] and the facility responded that R3's arm slipped and probably hit the top of R1's thigh. R1 stated she had multiple missing items and felt R3 was responsible for taking the items out of her room. R1 reported after the incident with R3 many staff, at various times asked to do skin checks on the resident (private area) and insisted that she should be seen the hospital. The resident told the nurses and administrative staff she did not need to go to the hospital. She said she was sleeping with covers on at the time of the contact and was sure there was no injury such as bruising or scratching. R1 reported just because there were not bruises or scratches does not mean R3 did not attempt to get into bed with her and did not hit her private areas. (The resident re-enacted how she was laying in her bed at the time of the contact). R1 stated she knew if she went to the hospital with no bruises or scratches it was going to make her look bad. After the incident with R3, R1 stated the facility took all rights away from her. She could no longer have one staff performing cares and even housekeeping staff were required to have two people in the room and she could no longer leave the room if housekeeping was in the room. Two staff now had to watch her shower and it was very upsetting to her. R1 reported she bathed herself in her sink at times because she did not want so many staff watching her shower. R1 reported the floor of the bathroom became slippery when bathing herself and further reported being fearful of a fall as her balance and stamina were not always the best. R1 reported if the facility had been supervising R3, she would not have had to go through this and felt like the facility treated her like she did something wrong. She reported being at the facility for the last five years with no concerns and now she has been issued a discharge notice from the facility. R1 stated she called her Guardian when staff were in the room for her protection and was glad the Guardian was involved in her care. The Guardian expressed she told staff to leave the resident alone unless they called her because of the frequent requests to do skin checks after the incident with R3. The resident reported the facility has further filed an Adult Protective Services report against her Guardian for speaking up for her. The resident voiced fears a new facility might persecute her based on what this facility told them about her. During a phone interview on 08/05/24 at 12:44 PM with Law Enforcement Officer (LEO) GG he reported R1 had an iPad stolen at one time and the facility did replace it, but never did prove who took it from her room. LEO GG reported R3 was not appropriately placed at the facility and noted the facility could not meet his needs. Regarding the battery incident between R1 and R3 he stated staff talked about R3's rights, but LEO GG then stated, what about [R1's] rights?. LEO GG further stated the facility treated R1 like she was the one at fault for the encounter. LEO GG stated the police department was called many times over the last year, they respond to calls at the facility approximately two to three times a week, and approximately only two were not legitimate out of all of the calls for the year. (continued on next page)

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F 0622 Level of Harm - Actual harm Residents Affected - Few	During an interview with CNA N on 08/05/24 at 11:38 PM revealed she knew what cares to provide residents by looking at their plans of care. CNA N reported she gave the resident showers, did not have two people present every time and the resident did fine. CNA N reported she has had no concerns with the resident since she started working at the facility. The incident with R3 happened before she started but heard that is why R3 required one-on-one supervision. CNA N reported the resident had no behaviors, delusions, hallucinations, and remembered things they talked about during showers from week to week. CNA N reported having no trauma informed care training and being unaware of any interventions related to trauma for R1. During an interview on 08/06/24 at 12:24 AM with CNA II revealed she heard the resident had called the cops but was not there for the calls. CNA II reported the resident isolates herself. CNA II reported staff were not allowed to go in the resident's room and could only talk to her through the door. She reported she did not try to go in the resident's room too much but did pick up her trash and give her water. CNA II stated she heard the resident's Guardian would incite behaviors from the resident, but she was not there for it and thought it might just be hearsay. CNA II reported having no trauma informed care training and being unaware of any interventions related to trauma for R1. During an interview on 08/06/24 at 03:42 AM with Administrative Staff C revealed the resident kept to herself and did not want staff in her room. Administrative Staff C reported the resident's outlook at the facility had changed over the last year and she had a different outlook, behavior wise. She reported the resident did not seem to be happy at the facility and she tried hard to fix the problem and accommodate resident needs. Administrative Staff C reported she heard the resident's story about R3 changed three times, but the Director of Nursing and Administrator were handling that situation. She reported R1 as more secluded since the incident with R3. Staff offered skin assessments, but R1 refused. Administrative Staff C said R1 was very different than when she started a few years ago and noted the resident has not called 911 recently. During an interview at 04:43 AM on 08/06/24 with Administrative Staff B revealed R3 used to walk around until after the incident with R1. Administrative Staff B reported the resident originally reported R3 tried to get into bed with her but then told her Guardian that R3 touched her private parts. Administrative Staff B reported the resident refused to have skin checks of her private parts. She stated the resident and Guardian wanted to file charges against R3 and since she was not happy corporate said they could help R1 find another facility. R1 reported being happy at the facility until R3 came and Administrative Staff B stated R3 was still a human too. When asked about how the facility handled R1's psychosocial wellbeing and/or history of trauma Administrative Staff B reported they offered for her to go to the ER, but she refused. Administrative Staff B confirmed the facility had not addressed R1's psychosocial impact from the incident with R3, had not addressed potential past trauma's R1 may have had, and not viewed the incident with R3 as traumatic to R1. During an electronic mail interview with R1's Guardian dated 08/07/24 at 10:52 AM revealed the facility had not assessed R1 for any past trauma that she was aware of. R1's Guardian stated the facility listed information that was not correct concerning R1's history in the care plan and noted they did not reach out to her or the resident's other family members for further information. R1's Guardian stated she did not believe that R1 received any visits from SSD L, when R1 was assaulted by a male resident that was uninvited to her room. The Guardian stated she asked the facility to call her when they talked to the resident about the incident with R3 because a major trust factor has been broken. (continued on next page)

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F 0622 Level of Harm - Actual harm Residents Affected - Few	Interview with LEO LL on 08/07/24 at 04:09 PM revealed R1 and her Guardian felt like they were targeted by staff at the facility and administrative staff. LEO LL felt the facility tried to evict R1 based on the incident with R3. LEO LL stated she was not sure if the eviction was issued out of spite, but stated administrative staff made law enforcement feel like the facility could not meet R1's expectations. Review of the undated (copyright 2023) facility policy Transfer and Discharge revealed the facility would permit each resident to remain in the facility, and not initiate transfer or discharge the resident from the facility except in limited circumstances. The facility failed to provide evidence R1 met discharge requirement as outlined in the State Operations Manual, Appendix PP when the facility issued an involuntary discharge notice to R1, but failed to recognize the impact to R1 after R3 entered her room, uninvited, attempted to get in her bed, touched her private parts, and the facility failed to recognize the impact to R1's psychosocial wellbeing. Since the incident with R3, facility staff reported R1 isolated herself more, changed in her day-to-day behavior, and R1 reported she felt punished by the facility, embarrassed at multiple requests for skin checks of her private parts, and had to minimize her existence in her daily life.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 37026 The facility reported a census of 31, with 16 in the sample and one reviewed for involuntary discharge. Based on observation, interview, and record review the facility failed to ensure the contents of an involuntary, facility-initiated discharge included all required elements at the time they provided the notice to Resident (R) 1. Findings included: - Review of the discharge letter provided to R1 on 06/21/24 and again on 07/12/24 revealed it lacked required elements, which included information regarding specific instructions on how to obtain an appeal form and information regarding obtaining assistance completing and submitting the appeal form, specifically. An observation of R1 at 04:09 PM on 07/31/24 revealed the resident sat with a furrowed brow, became teary eyed, and voiced concerns over her involuntary, facility-initiated discharge notice from the facility. During an interview with R1 and her Guardian, who was called during the interview at the resident's request, at 04:09 PM on 07/31/24 R1 stated she was happy at the facility for five years and did not want to move until R3 entered her room, uninvited, and touched her private parts but now felt like she had to based on actions the facility was taking to discharge her. R1 and her Guardian stated they were appealing the move because they wanted to ensure they found appropriate placement for the resident, and the receiving facility would be getting accurate information in the resident's care plan. Both R1 and her representative felt the Guardian's request to be called to protect her family member when staff were continuously asking the resident to commit to a skin assessment that she refused after reporting unwanted, non-consensual, physical touching, from another resident who wandered into her room was an unfair reason for discharge from the facility. (Multiple requests for skin assessments were verified in R1's progress notes on (05/19/24 at 11:04 PM, 05/20/24 at 09:10 AM, 05/21/24 at 03:15 PM (twice), 05/27/24 at 01:16 AM). During an interview at 04:43 AM on 08/06/24 with Administrative Nurse B revealed the resident refused to have skin checks of her private parts. She stated the resident and Guardian wanted to file charges against R3 and since she was not happy corporate said they could help R1 find another facility. During an interview at 06:07 AM on 08/06/24 Administrative Staff A stated the facility attorney wrote the discharge letter. Review of the Transfer and Discharge policy dated 05/22/24 revealed a transfer/discharge notice would include information on how to obtain an appeal form and information on obtaining assistance in completing and submitting the appeal hearing request. The facility failed to ensure the contents of an involuntary, facility-initiated discharge included all required elements at the time they provided the notice to Resident (R) 1.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 37026 The facility census totaled 31 with 16 residents included in the sample. Based on interview and record review the facility failed to ensure Residents (R) 1, R2, R3, R4, R5, and R11's care plans were revised based on each resident's changing goals, preferences, the needs of the resident, and in response to current interventions required for the resident. Findings included: - Resident (R)1's Care Plan lacked any interventions, which recognized the widespread impact of trauma, signs and symptoms of trauma and/or knowledge of the resident's trauma related to an incident on 05/19/24, the resident voiced as traumatic to her, when R3 entered the resident's room, took R1's belongings, tried to lay in her bed, touched her private parts, and staff assisted the resident out of her room. The Care Plan further lacked specific staff interventions related to her post traumatic stress disorder diagnosis. The resident's Care Plan lacked evidence the resident appointed a representative/guardian and/or her wishes related to the representative/guardian being present during interactions of her choice with staff. The resident's Care Plan lacked an update when staff reported to the resident, she required two staff for all interactions for safety concerns. R1's Care Plan further lacked evidence of an individualized discharge plan, which identified interventions intended to meet the resident's discharge goals, reason for discharge, needs that must be addressed before the resident could be discharged , changes in the resident's condition which had the potential to impact the discharge plan, and/or post discharge needs. The resident's Care Plan lacked evidence the facility provided medically related social services to develop a person-centered care plan for R1 when R3 came into her room, touched her private areas and R1 had a change in behaviors after the stressful event. Review of R2's Care Plan lacked any instruction to staff or interventions related to the resident having a low hemoglobin, at risk for internal bleeding, and/or recently receiving blood products. Review of R3's Care Plan revealed no focus dedicated solely to his Gastrostomy-tube (G-tube). The interventions lacked instructions for staff in preventing G-tube dislodgment/displacement and further lacked interventions for staff in case it became dislodged or pulled out. The Care Plan further lacked mention of the prior incident(s) where R3's G-tube was pulled out and that it required EMS transport and immediate treatment. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the 05/09/22, revised 05/14/22 Care Plan for R4 included a focus that she was unable to participate in most activities due to mobility and included only one staff intervention dated 07/03/24, which instructed staff to provide Monthly calendar each month and lacked any further direction to staff. R4's care plan included a focus that R4 has oral/dental health problems r/t to edentulous [completely toothless] oral cavity and included an intervention dated 07/17/24 R4 had oral pain noted d/t possible cavities: Give Bactrim DS per orders but lacked interventions related to providing oral cares. The Care Plan further included another focus, dated 07/16/24, which noted The resident has tooth infection. R4's Care Plan had an unfinished focus, initiated 05/09/22, revised 05/14/22, as follows: [R4] has impaired cognitive function/dementia or impaired thought processes r/t [related to]. R4's Care Plan had an unfinished focus, initiated 05/09/22, revised 05/14/22, as follows: [R4] has bowel incontinence r/t [related to]. The Care Plan for R5's lacked any evidence of his preference to sit by the front door, eat by the front doors in his wheelchair, and use of a bed side table staff provided, and/or spending most of his time near the front doors, seated in his wheelchair, in front of the activity calendar wall area; nor, did the care plan account for keeping the resident's wheelchair in the hallway at night, outside of his room. Review of R11's Care Plan lacked any updates as of 08/07/24 related to the resident having increased tearfulness and statements indicating he felt more depressed. The care plan lacked any direction to staff to monitor the resident for increased auditory and visual hallucinations, which included expressions he had thoughts to do naughty things with other residents per R11 on 07/14/24. R11's Care Plan further lacked any instruction to staff to assist the resident to go outside more per his request and/or encouraging the resident to walk to dine per his desire to ambulate more. Review of care plans for R1, R2, R3, R4, R5, and R11 lacked individualization to reflect their status and guide staff with interventions related to each resident's specific care needs. An Interview with R1 and her representative at 04:09 PM on 07/31/24 revealed R1 stated the facility took all rights away from her. She could no longer have one staff performing cares and even housekeeping staff were required to have two people in the room and she could no longer leave the room if housekeeping was in the room. Two staff now had to watch her shower and it was very upsetting to her. R1 reported she bathed herself in her sink at times because she did not want so many staff watching her shower. R1 reported the floor of the bathroom became slippery when bathing herself and further reported being fearful of a fall as her balance and stamina were not always the best. She reported being at the facility for the last five years with no concerns and now she has been issued a discharge notice from the facility. The resident showed the surveyors a copy of her current Care Plan, which did not accurately represent the cares she required. The resident voiced fears a new facility might persecute her based on what this facility told them about her and based on the information from the resident's inaccurate plan of care. During a telephone interview with Law Enforcement Officer (LEO) GG on 08/05/24 at 12:44 PM he revealed if the residents were able to be ambulatory and able to do things, they look good, if they are not and not able to do anything and be vocal, then they were not getting the care. LEO GG said day shift and night shift are not the same and stated night shift were never in the resident's rooms and every time LEO GG went into the facility at night, they were not providing cares. (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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with CNA N on 08/05/24 at 11:38 PM revealed she knew what cares to provide residents by looking at the plan of care. Interview with CNA II on 08/06/24 at 12:25 AM revealed she knew what cares to provide residents by looking at resident charts. During an interview with Administrative Nurse C on 08/06/24 at 03:43 AM revealed the facility reviewed resident care plans frequently. During an electronic mail interview with R1's Guardian dated 08/07/24 at 10:52 AM revealed the facility listed information that was not correct concerning R1's history in the care plan and noted they did not reach out to her or the resident's other family members for further information. During an electronic mail interview with SSD L on 08/09/24 at 01:29 PM she reported the SSD and Activities Director assessed residents for their preferences. SSD L stated the resident's preferences were on the resident's care plan and Kardex. If the situation was critical, they would meet with staff to inform them of the resident's preferences. The SSD reported the facility had a communication book they kept resident preferences in. Review of the undated policy Comprehensive Care Plans revealed the facility would care plan would describe, at a minimum the following: 1. Services that would be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. 2. Any services that would otherwise be furnished, but not provided due to the resident's exercise of his or her right to refuse treatments. 3. The resident's goals for admission, desired outcomes, and preferences for future discharge. 4. Discharge plans as appropriate. 5. Resident specific interventions that reflected the resident's needs and preferences and aligned with the resident's cultural identity. 6. Individualized interventions for trauma survivors that recognized the inter-relation between trauma and symptoms of trauma, as indicated. Trigger-specific interventions will be used to identify ways to decrease the resident's exposure to triggers which re-traumatize the resident, as well as identify ways to mitigate or decrease the effect of the trigger on the resident. The facility failed to ensure Residents (R) 1, R2, R3, R4, R5, and R11's care plans were revised based on each resident's changing goals, preferences, the needs of the resident, and in response to current interventions required for the resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175450	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/13/2024
NAME OF PROVIDER OR SUPPLIER Anew Healthcare Oxford		STREET ADDRESS, CITY, STATE, ZIP CODE 200 S Ohio St Oxford, KS 67119	

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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 0659 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care by qualified persons according to each resident's written plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35717 The facility reported a census of 31 residents, with 16 residents sampled. Based on observation, interview, and record review, the facility failed to ensure qualified staff performed a medical technique to assess for a resident's level of consciousness, when two Certified Nurse Aides (CNA) performed a sternal rub on an unresponsive resident prior to notifying the Licensed Nurse (LN). Findings included: - Review of an Alert Note dated 07/24/24 at 05:15 AM revealed Licensed Nurse (LN) S documented the following regarding Resident (R) 4: Resident at 0115 [01:15 AM] presented with lethargy unable to arouse, sternum rub attempted without success, all lung lobes crackles throughout O2 sat unable to obtain, R 28 BP 130/68 T 98 P 88 BS 167. Resident eyes fluttering very minimal urine output. LN contacted the physician, who contacted the LN writer and gave the order to send R4 to the ER. The LN contacted EMS, local law enforcement, and EMS arrived and transported the resident to the local hospital at 01:45 AM. The LN documented she sent the notification to Administrative Staff A, Administrative Nurse B, and Administrative Nurse C. Per the signed and notarized witness statement dated 07/24/24, CNA N documented on 07/24/24 at about 01:00 AM she and CNA P were starting rounds, beginning with R4. Upon entering the room R4 still seemed to not feel well as passed down from first shift staff. CNA P laid the bed flat to change R4's brief. CNA N documented that CNA P verbalized R4 barely had any output and how that was not normal. CNA N documented that after elevating the head of the bed, CNA N and CNA P both noticed a flushed look on R4's face, pale lips, wheezing in her lungs that sounded like phlegm, and her eyes were fluttering. CNA N documented that CNA P did a sternum rub on R4's chest and R4 did not respond, and CNA P went to the LN to inform her of R4's condition, while CNA N stayed in R4's room. Per the signed and notarized witness statement dated 07/24/24, CNA P documented on 07/23/24 she saw R4 about 11:40 PM and she seemed to be normal. She opened her eyes and was awake. Just seemed tired. CNA P noted R4 was dry and had been dry all night. On 07/24/24 CNA P noted she started her next rounds around 01:00 AM and she and CNA N went to R4's room to change her first. CNA P noted she and CNA N cleaned R4's room and her wheelchair, then went to change R4, and noted she looked find just seemed tired. CNA P noted when she laid R4's bed flat, so they could roll her to change her, she noticed R4 had very little pee in her brief. CNA P documented that as they set R4 back up, she noticed that her breathing was heavy in her stomach and sounded like phlegm possibly in her throat or lungs when she would breath (sic). Her lips were turning purple. Her eyes were rolling back in her head and wasn't responding to the sternal rub. CNA P documented she immediately went and told LN S. Per the 07/24/24 signed and notarized Witness Statement by Licensed Nurse (LN) S revealed at 01:15 AM that morning Certified Nurse Aide (CNA) P came to the nurse's room and stated to her that R4 was not acting like herself and she'd tried sternum rub and [R4] would not wake up. Review of the facility Nurse Aide Competency Review revealed no mention of sternal rub medical technique. The footer of each page contained Nurse [NAME] Competency. (continued on next page)

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F 0659 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with CNA N on 08/05/24 at 11:38 PM revealed the 07/24/24 incident with R4, CNA N stated that R4 did not respond to sternal rub, and she stayed in the room with R4 while CNA P told the nurse. CNA N stated she had received report that R4 was a little worse today and not active or talkative. During an interview with Administrative Nurse B on 08/06/24 at 04:45 AM, revealed some CNAs had training, and others were not supposed to do sternal rubs on residents. The facility failed to ensure only qualified staff performed medical techniques to assess for a resident's level of consciousness.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35717 The facility reported a census of 31 residents, with 16 residents sampled. Based on observation, interview, and record review, the facility failed to ensure staff provided Activities of Daily Living (ADL) care to dependent residents to ensure their highest physical, mental, and psychosocial well-being and to decrease the risk of infection. On [DATE] when Emergency Medical Services (EMS) transferred Resident (R) 4 they noted her brief needed changed and she had odor; the local hospital further described R4 as looking disheveled and malodorous. Findings included: - The signed [DATE] Medication Review Report in the Electronic Health Record (EHR) revealed R4 had diagnoses which included the following: dysphagia (swallowing difficulty), hydronephrosis (swelling of kidneys due to build up of urine, when it cannot drain), chronic kidney disease stage 1 (mild kidney damage with normal kidney function), history of traumatic brain injury, personal history of urinary (tract) infection, quadriplegia (inability to move the arms, legs and trunk of the body below the level of an associated injury to the spinal cord), muscle weakness, and dysphagia following other cerebrovascular disease. The [DATE] Annual Minimum Data Set (MDS) revealed R4 had a Brief Interview for Mental Status score of 9, indicating moderate cognitive impairment. The MDS noted R4 did not reject care. R4 had impairment to both sides of her upper and lower extremity regarding functional limitation in range of motion and used a wheelchair for mobility. R4 was dependent on staff for oral hygiene, toileting, shower/bathing, dressing and personal hygiene, and was dependent on staff for mobility. R4 was always incontinent of bladder and occasionally incontinent of bowel. R4 weighed 264 pounds. The MDS noted R4's primary medical condition was quadriplegia. The [DATE] Urinary Incontinence/Indwelling Catheter Care Area Assessment revealed the resident was always incontinent, but the CAA was not completed. The [DATE] Quarterly MDS revealed she had a BIMS score of nine and continued to have functional range of motion impairment to both sides of her upper and lower extremity, required substantial/maximal assistance with eating, and was dependent on staff for her self-care and mobility. The MDS noted she was frequently incontinent of urine and bowel. R4 had no swallowing disorder noted and weighed 262 pounds. R4 received antianxiety and antidepressant medications. The resident did not receive oxygen or any special treatments, procedures, and programs. The [DATE] Care Plan included the following staff interventions/tasks regarding R4: [DATE], revised [DATE] - R4 required assistance with feeding, should sit upright for all meals and for 30 minutes afterward, and should take all meals in the dining hall for safety. The resident used a lidded cup with a built-in straw to protect from spilling and maintain her independence. [DATE], revised [DATE] - R4 had an ADL self-care performance deficit related to her diagnoses of CVA and quadriplegia and staff were to report any changes to the nurse. R4 required total assistance of two staff for transfers and use of a mechanical lift. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[DATE], revised [DATE] - R4 was totally dependent on two staff for toilet use. [DATE], revised [DATE] - R4 had bowel incontinence r/t [related to] and did not finish the care plan focus. The following staff intervention to provide peri-care after each incontinent episode. A [DATE], revised [DATE], intervention included to check and change every two hours and PRN (as needed). A [DATE] Care Plan focus noted R4 had a urinary tract infection and included the staff interventions to check and change R4 every two hours for incontinence; wash, rinse, and dry soiled areas. A [DATE] Care Plan focus noted R4 had a tooth infection and included staff to administer 1 tablet of Bactrim (antibiotic) DS Oral Tablet ,d+[DATE] MG, by mouth two times a day for R4's tooth infection for seven days. The [DATE] at 10:19 PM Nurse Note documented the resident refused her shower today and stated she did not want one due to not getting up today and said, another day. The [DATE] at 08:21 AM Nurse Note documented the resident was up for breakfast this morning in good spirits, eating pureed diet and tolerating well, with no emesis (vomiting). The [DATE] at 10:37 PM Nurse Note documented the resident had an elevated temperature at 07:00 PM of 100.2 (degrees F) and received her scheduled ibuprofen prior, no complaints made by resident, alert in bed, with no nausea or vomiting noted. Temperature noted at 97.3 (degrees F). Review of an Alert Note dated [DATE] at 05:15 AM revealed Licensed Nurse (LN) S documented the following regarding R4: Resident at 0115 [01:15 AM] presented with lethargy unable to arouse, sternum rub attempted without success, all lung lobes crackles throughout O2 sat unable to obtain, R 28 BP ,d+[DATE] T 98 P 88 BS 167. Resident eyes fluttering very minimal urine output. LN contacted the physician, who contacted the LN writer and gave the order to send R4 to the ER. The LN contacted EMS, local law enforcement, and EMS arrived and transported the resident to the local hospital at 01:45 AM. The LN documented she sent the notification to Administrative Staff A, Administrative Nurse B, and Administrative Nurse C. Per a witness statement (which did not have a back page to identify name, date, or notarization) revealed a CNA documented the following regarding R4 on [DATE]: They got R4 up for breakfast, chatted with her and she acknowledge the CNA's presence. She was not feeling well but she wanted up for breakfast. She only ate a couple of bites of oatmeal but did eat her gelatin. The CNA statement noted they came around a few times to offer her water, which she took a few sips of. She refused lunch, and I got her more water. She did not look like she felt good any time I passed, so I informed the nurse that she didn't look very good. For dinner she stayed in bed and we gave her a chocolate shake and water. At dinner she was lightly wet so we changed her, but not much was on her. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Per the signed and notarized witness statement dated [DATE], Certified Nurse Aide (CNA) R documented she started her shift on [DATE] at 06:00 PM and noted R4 did want to get up for breakfast, however, did not want to eat much. CNA R documented she provided R4 with some gelatin and a health shake, and R4 laid back down. CNA R and another CNA changed R4 and made sure she was dry and comfortable. CNA R documented they reported to LN G that R4 wasn't feeling well and really didn't want to get up for lunch! CNA R said we were told she was being treated for a UTI and to push fluids. She did drink water and shakes for us through out our shift at 6pm the night shift came in, we did rounds with them . we adjusted her in bed. We reported how she had been feeling. She was responding to us well at that time. Per the signed and notarized witness statement dated [DATE], CNA N documented on [DATE] at about 01:00 AM she and CNA P were starting rounds, beginning with R4. Upon entering the room R4 still seemed to not feel well as passed down from first shift staff. CNA P laid the bed flat to change R4's brief. CNA N documented that CNA P verbalized R4 barely had any output and how that was not normal. Per the signed and notarized witness statement dated [DATE], CNA P documented on [DATE] she saw R4 about 11:40 PM and she seemed to be normal. She opened her eyes and was awake. Just seemed tired. CNA P noted R4 was dry and had been dry all night. On [DATE] CNA P noted she started her next rounds around 01:00 AM and she and CNA N went to R4's room to change her first. CNA P noted she and CNA N cleaned R4's room and her wheelchair, then went to change R4, and noted she looked fine just seemed tired. CNA P noted when she laid R4's bed flat, so they could roll her to change her, she noticed R4 had very little pee in her brief. Per the [DATE] signed and notarized Witness Statement by Licensed Nurse (LN) S revealed at 01:15 AM that morning Certified Nurse Aide (CNA) P came to the nurse's room and stated to her that R4 was not acting like herself and she'd tried sternum rub and [R4] would not wake up. LN S documented Labor breathing noted LN S documented that during report (coming onto her shift) she had received no information from any staff, prior to 01:15 AM, that anything was going on with R4. LN S documented EMS assessed and transferred R4 to the gurney and left with R4 at approximately 01:45 AM. Review of the [DATE] Emergency Department (ED) Nursing Documentation for R4 revealed the following: Appears in poor health, Appears toxic, Tense, Severe distress and Poorly groomed, Disheveled, Malodorous. Review of the local hospital Patient Progress Notes dated [DATE] at 09:07 AM revealed the urinary catheter tubing contained a creamy white/green substance. At 09:08 AM, progress note revealed it was 25 ml of white/green urine. The hospital record review revealed R4 died at the hospital on [DATE] at 09:08 AM, approximately 8 hours after staff found her unresponsive. Interview with CNA N on [DATE] at 11:38 PM revealed CNA N and CNA P saw R4 going out with EMS. CNA N stated R4 was actually a very heavy wetter but stated when she checked on R4 she was dry, then she was barely wet like a quarter sized spot in her brief when they changed her at approximately 01:00AM on [DATE]. CNA N confirmed she did not change R4's brief upon arrival on her shift and did not change her brief earlier in her shift because she was dry. CNA N stated she had received report that R4 was a little worse today and not active or talkative. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Anew Healthcare Oxford	200 S Ohio St Oxford, KS 67119

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with CNA II on [DATE] at 12:25 AM revealed she worked with R4 two days prior to the incident and said R4 seemed okay, but you never know. CNA II said CNAs are hands on and they know about changes in residents and the CNAs keep the residents cleaned up. CNA II stated the electronic charting for CNAs only allowed for a checkmark on whether a resident was continent or incontinent. During an interview with Administrative Nurse C on [DATE] at 03:43 AM revealed she knew R4 was being treated for a UTI and tooth infection. Administrative Nurse C said she thought R4 was getting better, was up for a meal and she was doing okay, so when she found out about the outcome to R4, she was shocked. Administrative Nurse C was told they transferred R4 out to the ED. Administrative Nurse C stated she expected staff to report to a licensed nurse if a resident was not voiding within so many hours and further stated to be honest R4 was always wet no matter what, but sometimes she did not drink as much as other times. Administrative Nurse C stated the CNAs task charting included checkmarks to indicate if a resident voided or not but verified it did not allow for an amount or urine description. Administrative Nurse C said they were pushing fluids for R4, would encourage fluids, expected staff to report if a resident had no output and for staff to follow up. When asked about the lack of output for R4 and EMS transport, Administrative Nurse C stated she was probably dehydrated and not doing too hot, but if a resident was not voiding the staff should have reported that and then said, poor communications. During a telephone interview with Law Enforcement Officer (LEO) GG on [DATE] at 12:44 PM revealed LEO's have responded to lots of calls to the facility over the past almost two years and estimated that number to be over 300 calls. LEO GG said the nurse did not remain in R4's room, she left the room and when one of his officers arrived the resident was in her room alone. LEO GG said it was accurate to say that R4 looked disheveled and was malodorous. LEO GG said if the residents were able to be ambulatory and able to do things, they look good, if they are not and not able to do anything and be vocal, then they were not getting the care. LEO GG said day shift and night shift are not the same and stated night shift were never in the resident's rooms and every time LEO GG went into the facility at night, they were not providing cares. Interview with LEO LL on [DATE] at 04:09 PM revealed she was the responding officer to the [DATE] incident regarding R4. LEO LL stated she had a healthcare background (prior CNA/EMT) and stated yes, the resident was disheveled and malodourous. LEO LL stated in the ambulance EMS noted R4's brief was soiled, and she had odor. LEO LL stated, in her opinion, when she walked into R4's room, she could say her hair had not been brushed and noted it smelled like her brief needed changed and could not stay it smelled like a it was a considerable amount, but it was noticeable. LEO LL further stated the facility was better, but not what it could or should be. The facility failed to ensure staff provided ADL care to dependent, quadriplegic R4.

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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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37026 The facility census totaled 31 with 16 included in the sample and 3 residents reviewed for changes in their condition. Based on observation, interview, and record review the facility failed to properly identify and monitor Resident (R) 2 when he received blood/blood products at the hospital on 06/07/24 between 10:55 AM and 07:27 PM. Upon the resident's return from the hospital, the facility failed to monitor the resident for signs of adverse reaction, which included respiratory distress or bronchospasm. At approximately 11:13 PM the resident used his emergency call light to inform staff he was having a hard time breathing. After 10 to 15 minutes of waiting on the nurse with no response the resident called EMS himself and his roommate assisted in reporting concerns to EMS. When the nurse entered the resident's room, she failed to obtain the resident's vital signs even after the resident reported respiratory distress and being scared. The nurse scolded the resident for not waiting on nursing staff response before calling EMS himself and documented the resident's actions as being rude. The resident was sent back to the hospital due to low oxygen levels and exacerbation of chronic obstructive pulmonary disease with (acute) exacerbation (COPD - progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing). Findings included: - Review of Resident (R) 2's Electronic Medical Record (EMR) revealed the residents had diagnoses of congestive heart failure (CHF - a condition with low heart output and the body becomes congested with fluid), and chronic obstructive pulmonary disease with (acute) exacerbation (COPD - progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing). Review of the 02/06/24 Admission Minimum Data Set (MDS) assessment revealed the resident had a BIMS of 15, which indicated intact cognition. The resident had shortness of breath or trouble breathing with exertion. The resident's record lacked developed Care Area Assessments. Review of the 07/12/24 Quarterly Minimum Data Set (MDS) assessment revealed the resident had a Brief Interview for Mental Status score of 15, which indicated intact cognition. The resident had no behaviors at the time of the assessment. The resident had diagnoses of pneumonia, asthma, respiratory failure, and COPD. The resident had shortness of breath or trouble breathing with exertion and shortness of breath or trouble breathing when lying flat. The resident received oxygen therapy while a resident at the facility. Review of the resident's Care Plan revealed the following interventions: 04/22/24 - Staff would give medications as ordered by the physician and monitor/document side effects and effectiveness. 04/22/24 - Staff would monitor for signs/symptoms of respiratory distress and report to the physician as needed, which included: respirations, pulse oximetry, increased heart rate, restlessness, diaphoresis, headaches, lethargy, confusion, atelectasis, hemoptysis, cough, pleuritic pain, accessory muscle usage, skin color. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	04/22/24 - Staff would know the resident's oxygen settings via nasal prongs would run at two to three liters per minute to keep oxygen saturation levels above 90%. 05/17/24 - Staff would give the resident breathing treatments per orders and monitor lung sounds before and after the treatments, monitor oxygen saturation levels per orders, and document how much time in minutes it took to administer the treatment from start to finish. 05/17/24 - Staff would monitor the resident every shift for shortness of breath when lying flat and document on the medication administration record and/or nurse's notes. 06/04/24 - Staff would know the resident required oxygen therapy and breathing treatments related to ineffective gas exchange due to COPD with exacerbation, history of pneumonia, acute respiratory failure, and congestive heart failure. The resident's care plan lacked any instruction to staff or interventions related to the resident having a low hemoglobin, at risk for internal bleeding, and/or recently receiving blood products. Review of the 06/04/24 at 04:17 PM Skilled Note revealed the resident had shortness of air during exertion, at times when resting, and the resident could not lay flat due to his COPD. The resident wore oxygen via nasal cannula and required scheduled breathing treatments. The resident had wheezing present in the upper and lower lobes. Review of the 06/07/24 at 09:33 AM (late entry) Social Service Progress Note revealed the resident transferred to a local hospital via Emergency Medical Services (EMS) when the resident called 9-1-1. The charge nurse had the resident sign bed hold paperwork before transport from the facility. Review of the 06/07/24 at 10:55 AM Nurse Note revealed the resident had a hemoglobin (measure of blood that carried oxygen to the cells from the lungs and carbon dioxide away from the cells to the lungs) of 6.6 (low) and the writer informed the resident's physician extender of the value. The facility received new orders for the resident, which included to send the resident to the local hospital related to the hemoglobin value, the facility would draw labs on the resident, and start a stool test on the resident. Review of the 06/07/24 Emergency Department [ED] Nursing Documentation revealed after the resident received a bag of blood he wanted to return to the facility. Review of the 06/07/24 at 07:27 PM Nurse's Note revealed the resident returned from the hospital and the nurse went ahead and took the resident's VS [vital signs]. The note lacked any further assessment after the resident received blood at the hospital earlier in the day. The resident's record lacked documentation facility assessed the resident for any reaction to the blood he received at the hospital from 07:27 PM, until 11:13 PM, when he called 911 due to having a hard time breathing. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of the 06/07/24 at 11:13 PM Nurse's Note revealed the resident called 911 at 11:00 PM claiming he could not breathe. The certified nurse aide (CNA) who answered R2's emergency call light and found him on the phone with 911 notified the nurse writer of the situation. The nurse asked the resident why he called 911 without informing anybody at the facility he was having a hard time breathing. The resident shouted at the nurse claiming he was scared and he stated that was all that mattered. The writer stated the resident refused to have his vital signs taken and further stated the resident kept on shouting and being rude. Review of the [NAME] Police Department Voluntary Statement form dated 06/07/24 at 07:30 PM completed by R8 revealed his roommate R2 woke up from a nap and could not breath. R8 pushed his emergency call light and CNA BB answered the light. CNA BB ran to the nurse's station to inform the nurse on duty about the situation. After being notified by CNA BB, R8 reported the nurse took approximately 10 to 15 minutes to respond to their room. When the nurse responded to the two resident's room and R8 was on the phone with emergency dispatch she did not take R2's vital signs. The nurse told R2 he should have called her first before calling the ems. R8 then reported the nurse stormed out of their room slamming the door and when EMS arrived, they checked his oxygen level and noted it was low, so they took him to the hospital to get his oxygen level back to normal. Review of the 06/08/24 at 05:32 AM Nurse's Note revealed the Emergency Department from the local hospital called the facility to inform them the resident was stable after a possible COPD exacerbation. The nurse stated the resident had oxygen through a nasal cannula and further stated the resident's shortness of air may or may not have been a result of the pack of blood he was given earlier in the day (the resident's record lacked any documentation or assessments related receiving blood that day). Review of the Witness Statement form signed by Licensed Nurse (LN) JJ on 06/10/24 revealed on 06/07/24 CNA BB came running to the nursing station and reported R2 could not breath. LN JJ asked what was going on and CNA BB reported the resident was on the phone with 911 and he claimed he could not breathe. LN JJ reported she wondered why the resident reported he was ok 10 minutes before when he needed a medication for his pain. When the nurse arrived at the resident's room to follow on what was going on she asked the resident why he was calling 911. The resident reported he couldn't breathe that is why he called 911. She then asked the resident again why he called 911 when he knew procedures that need to be followed before calling 911 and he said he was scared and needed help from someone and that's all that matters. The nurse and resident exchanged further words (the nurse writer described the resident as being rude) and the nurse told the resident he needed to inform us in the facility before calling for help from outside because he neither informed the aides or this nurse about him having trouble breathing. Observations of the resident on 08/01/24 revealed he stayed in his room with the door closed. Administrative Nursing Staff KK did enter the resident's room and conversed with the resident. The resident had no shortness of air noted during the brief observation of the resident as he laid in his bed. During an interview with CNA N on 08/05/24 at 11:38 PM revealed she knew what cares to provide residents by looking at resident plans of care. CNA N reported she was not working when R2 called 911 the night he could not breath. She reported he did not normally call 911 and would pull his call light if he needed anything. CNA N reported she was told it was fine the resident called 911 and it was his right to do so. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Anew Healthcare Oxford		STREET ADDRESS, CITY, STATE, ZIP CODE 200 S Ohio St Oxford, KS 67119	

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During an interview on 08/06/24 at 12:24 AM with CNA II revealed the resident would call for anything and had called 911. She was not at the facility at the time he called 911 due to having a hard time breathing. During an interview on 08/06/24 at 03:42 AM with Administrative Staff C revealed the night R2 called 911 due to having a hard time breathing, it was an agency nurse working. She believed the resident sat in his room and panicked. Administrative Staff C reported the resident a had low hemoglobin earlier in the day, received blood at the hospital, and she expected the staff should be doing the vitals hourly because residents could have a reaction to the blood for hours. She would have expected staff to monitor the resident for shortness of breath and hydration. She would have expected staff to just be more attentive. During an interview at 04:43 AM on 08/06/24 with Administrative Staff B revealed the night R2 called 911 due to having a hard time breathing, there was an agency nurse working. The resident returned from the hospital after having one bag of blood. The police officer who responded stated the resident's oxygen was low and by the time he got to the facility the resident did not want the nurse in his room. If a resident returned to the facility after receiving blood, Administrative Staff B stated resident's who receive blood products should be monitored for 72 hours after if they are stable at the hospital. Review of the 07/15/24 Oxygen Administration policy revealed facility staff would assess residents for signs or symptoms of cyanosis (blue tone to skin and mucous membranes), hypoxia (rapid breathing, rapid pulse rate, restlessness, confusion) and/or laboratory results that included the resident's hemoglobin. The facility failed to properly identify and monitor R2 when he received blood/blood products at the hospital on 06/07/24 between 10:55 AM and 07:27 PM. Upon the resident's return from the hospital, the facility failed to monitor the resident for signs of adverse reaction, which included respiratory distress or bronchospasm. At approximately 11:13 PM the resident used his emergency call light to inform staff he was having a hard time breathing. After 10 to 15 minutes of waiting on the nurse with no response the resident called EMS himself and his roommate assisted in reporting concerns to EMS. When the nurse entered the resident's room, she failed to obtain the resident's vital signs even after the resident reported respiratory distress and being scared. The nurse scolded the resident for not waiting on nursing staff response before calling EMS himself and documented the resident's actions as being rude. The resident was sent back to the hospital due to low oxygen levels and exacerbation of COPD. The facility identified and implemented the following corrective actions, which were completed on 06/08/24 and included the following: 1. The resident was sent to the Emergency Department on 06/07/24 at 11:30 PM 2. The nurse was suspended pending an investigation on 06/08/24. 3. Police were aware due to the resident calling 9-1-1. 4. On 06/08/24 the facility notified the resident's physician of his breathing issue. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	5. On 06/08/24 all staff were educated on signs and symptoms of neglect. Clinical staff re-educated on neglect, including breathing issues. 6. Staff assessed the resident upon return from the hospital and increased monitoring for changes in his condition and respiratory status. 7. Licensed Nurses would be notified with any change of condition and anytime the resident was transferred out. 8. All current residents would be monitored for changes in condition with routine daily clinical start ups Monday through Friday. 9. Audits of nurse's notes and verbal questioning of residents along with taking oxygen saturation levels would be completed by the DON on 06/09/24. Due to the facility's implementation of the corrective actions completed prior to the on-site survey the deficient practice was deemed past non-compliance and existed at a scope and severity of a G.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37026 The facility census totaled 31, with 16 in the sample, and one resident reviewed for accidents. Based on observation, interview, and record review the facility failed to transfer Resident (R)16 according to her plan of care, which resulted in a fall. The facility further failed to ensure staff provided adequate supervision, while providing one-on-one supervision to the R3, and the resident fell out of bed and sustained a laceration to the back of his head. Findings included: - Review of R16's diagnoses in the Electronic Health Record (EHR) revealed the resident had the following diagnoses: muscle weakness, abnormalities of gait (manor or style of walking) and mobility, and history of falling. Review of the 02/23/24 Annual Minimum Data Set (MDS) assessment revealed the resident had short-and long-term memory problems with moderately impaired cognitive skills for decision making. The resident required a wheelchair for mobility and substantial/maximal assistance for bathing. The resident had no falls since the prior assessment. The Falls Care Area Assessment lacked development. Review of the 05/24/24 Quarterly MDS revealed the resident had a Brief Interview for Mental Status score of 00, which indicated severely impaired cognition. The resident required a wheelchair for mobility. The resident was dependent on staff for showering. The resident was dependent on staff for transfers to and from the shower/bath. The resident had no falls since the prior assessment. Review of the resident's Care Plan revealed the following interventions: 05/17/24 - Staff would know the resident required the assistance of two staff with all shower transfers. 05/17/24 - Staff would know the resident required non-skid socks or shoes on at all times. 05/28/24 - Staff would know the resident had a history of frequent falls related to limited vision in the right eye, functional limitations, and poor impulse control. 08/02/24 - Staff were educated to follow the resident's care plan. Review of the 08/01/24 at 20:24 Late Entry Nurse Note revealed at approximately 2020 the nurse heard Certified Nurse Aide (CNA) II yell from the bathhouse help. When the nurse responded she observed the resident on the shower house floor, on her back, by the door. The resident's feet were facing the transfer rail. The resident was in a brief, had gripper socks on, and gait belt. CNA II reported she had to assist the resident to the ground as the resident's legs gave out while attempting to get in her wheelchair after the shower. The resident could not be interviewed due to her cognitive status. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observations of the resident on 07/31/24 and 08/01/24 revealed the resident had no behaviors or attempts to transfer herself without staff assistance. During an interview with CNA N on 08/05/24 at 11:38 PM revealed she knew what cares to provide residents by looking at their plans of care. CNA N reported the resident used to require one person assistance during showers but requires two people now for her safety. She reported the resident is not standing tall and strong and did not stand well tonight. During an interview on 08/06/24 at 03:42 AM with Administrative Staff C verified the resident required two staff to transfer during showers and further stated she expected staff to follow the resident's care plan, which was just updated. Review of the undated (copyright 2023) policy Safe Handling/Transfers revealed the facility would ensure residents were handled and transferred safely to prevent or minimize risks for injury and provide and promote a safe, secure, and comfortable experience for the resident while keeping the employees safe in accordance with current standards and guidelines. The facility failed to transfer R16 according to her plan of care, which resulted in a fall. 35717 - The Electronic Health Record revealed Resident (R)3 was [AGE] years old and the 03/28/24 Physician Order revealed Physician U ordered R3's admission to the facility and noted his diagnoses included: cerebral palsy, down's syndrome, autism, congenital stricture of esophagus, and acute respiratory hypoxia. The 04/04/24 Annual Minimum Data Set (MDS) Assessment revealed R3 had adequate hearing, unclear speech (slurred or mumbled words), was rarely/never understood, usually understands others, had adequate vision. The staff assessment of R3's mental status revealed he had short-term memory problems and severely impaired cognitive skills for daily decision making. R3 had inattention, disorganized thinking, and altered level of consciousness continuously present and did not fluctuate. R3's mood was not assessed, and the resident had other behavioral symptoms not directed toward others and his behavioral symptoms did not have an impact on the resident, and he did not reject care. R3 exhibited daily wandering behaviors that did not place the resident at significant risk of getting to a potentially dangerous place. The MDS indicated R3 had no functional range of motion impairment to his upper or lower extremities, and he did not use a mobility device. R3 required total dependence on staff for toileting hygiene, dressing, and personal hygiene. The MDS noted R3 had aphasia, cerebral palsy, malnutrition, anxiety, respiratory failure, asthma, chronic obstructive pulmonary disease (COPD) or chronic lung disease. The resident did not have pain and did not have any shortness of breath. R3 had no falls, weighed 70 pounds, and was 52 inches tall. R3 had a feeding tube and received 51% of his total calories by artificial route and 501 cc/day or more of average fluid intake per day by tube feeding. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	06/24/24 Quarterly MDS Assessment revealed R3 had no speech (absence of spoken works), was rarely/never understood and rarely/never understand others, with highly impaired vision. R3 had short and long-term memory problems and severely impaired (never/rarely made decisions) cognitive skills for daily decision making, with continuous inattention and disorganized thinking. R3 had 1 to 3 days of other behavioral symptoms not directed toward others and no rejection of care. The resident was completely dependent on staff for all the effort regarding oral hygiene, toileting hygiene, shower/bathing, dressing, and personal hygiene. The resident did use a manual wheelchair and/or scooter. The staff assessment for R3's pain in the last 5 days revealed non-verbal sounds, facial expression, and protective body movement or postures) and R3 had indicators of pain or possible pain observed for 3 to 4 days of the last 5 days. R3 had one non-injury fall since admission or prior assessment. The resident weighed 65 pounds and was 52 inches tall and had a feeding tube while a resident. The resident had mouth or facial pain, discomfort or difficulty with chewing. The care plan special instructions sections at the top of the page, noted R3 was non-verbal and a wandering risk. The 04/22/24 Care Plan included the following interventions: 04/22/24- The resident used small disposable briefs and the staff were to check every 2-3 hours and as needed. 04/22/24, revised 05/13/24- The staff were to check every 2 hours as needed for incontinence; wash, rinse, and dry perineum, change clothing PRN, and after incontinence episodes. 04/22/24- The staff would anticipate and meet R3's needs. 04/22/24- Communication: Resident is able to: Make facial expressions, make sounds that can be interpreted as happy, and sounds that can be interpreted as upset. [R3] will sit down on the floor when he does not get what he wants or when he is unhappy. [R3] will listen and follow some basic instructions. 04/22/24- The resident required 1 staff to turn and position him in bed and as necessary. 04/22/24, revised 06/06/24- TRANSFER: The resident is independent to move between surfaces and as necessary. Requires some queuing at times. Sometimes R3 requires extensive assistance of one-to-two people when agitated or behaviors are noted. Because R3 was impulsive and had delayed cognition, foot pedals were removed from his wheelchair due to a potential tripping hazard. 05/17/24, revised 06/07/24- Ambulation/mobility: R3 is supervision as needed with some cueing and at times hands on guiding him in the right direction. Wheelchair was available to assist with mobility PRN, R3 was able to ambulate with modified (I) and required staff assistance with wheelchair for mobility. 05/10/24 - Staff were to redirect as needed to maintain safety. 05/13/24, revised 07/24/24- Staff were to assist with all daily care. 05/20/24 - Staff were to provide one-on-one during waking hours. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident's care plan lacked any direction to staff to identify what waking hours were for the resident to continue one-on-one monitoring. The Care Plan included a focus initiated 05/13/24, revised 07/24/24, noting R3 was at risk of falls related to poor communication/comprehension, unaware of safety needs, vision, and diagnosis of cerebral palsy. The staff interventions included the following: 05/13/24- anticipate and meet R3's needs. 05/13/24-Follow facility fall protocol. 05/13/24-Physical Therapy to evaluate and treat as ordered or as needed (PRN). 05/13/24- Review information on past falls and attempt to determine the cause of falls. Record possible root causes. Alter remove any potential causes if possible. Educate resident/family/caregivers/IDT as to causes. 06/20/24- Witnessed Injury Fall with minor laceration to the back of his head: Fall matt would be added, and staff would position the chair closer to R3's bed when the resident was sleeping. The 06/19/24 at 01:37 PM Skilled Note revealed R3 remained on skilled services and was dependent on staff or meals and hygiene. The resident could ambulate without assistance but was continuous one-on-one to monitor resident whereabouts at all times for safety. The 06/20/24 at 05:52 AM Nurse Note revealed R3 fell out of bed, hitting his head on the floor and obtained a small laceration (cut) to the back of his head. The note included the bleeding had stopped upon the nurse's arrival to the room, where the nurse cleaned the area with wound cleanser and noted the laceration was approximately 1 cm, V shaped, no hematoma noted at the time, and did not appear to need stitches at this time. The nurse noted the resident was developmentally disabled and did not tolerate vital signs taken. The note lacked evidence R3 was one-on-one with staff at the time of the fall. The care plan continued to lack identification of waking hours for R3. The 06/20/24 at 04:52 PM Nurse Note revealed the resident remained on fall follow-up, was stable today, and remained at his baseline. The note noted the laceration to R3's head was open to air. The 06/21/24 at 02:21 PM Nurse Note revealed the resident continued on one-on-one observation. The 06/27/24 at 03:21 PM IDT Meeting Notes included R3's care plan was reviewed and updated as needed. The resident was notified of the plan of care. Medical provider has been notified of change in condition. Upon entrance on 07/31/24 at 08:55 AM, tour hallway at 09:26 AM revealed resident in his room on one-on-one observation. The resident remained on one-to-one observation during the duration of the onsite survey on 07/31/24, 08/01/24, 08/05/24, and 08/06/24. The resident was in his wheelchair, in his bedroom, in the main commons area, in the room across from the nurse's station, and he always had one staff with him, but did not have on shoes. The resident was non-verbal and did make some small noises but spent time playing on his electronic device and in his wheelchair as staff wheeled him around, inside, and outside, of the facility. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/01/24 at approximately 11:45 AM, the surveyor observed staff pushing R3 in his wheelchair while R3 played on his electronic device. R3 had his feet dangling down with no socks on and feet looked darkened and dirty. R3 had two of his fingers in his mouth with a band of darkly discolored, visibly dirty ring around the base of those two fingers, just below the area he had in his mouth on his fingers. The LN KK began looking for gloves, did not don gloves, and then just used a few wipes to clean R3's dirty fingers. During an interview with CNA II on 08/06/24 at 12:25 AM revealed R3 could give cues as to his needs and if he wanted something he would reach for it. The resident would hit himself, would grab at staff, and grab at himself to express his needs at times. During an interview with Law Enforcement Officer (LEO) GG on 08/05/24 at 04:09 PM revealed he had been out to the facility on multiple staff to resident battery issues and neglect. LEO GG stated his office has received over 300 calls regarding the facility within the 2 years the facility has operated. LEO GG stated his staff were at the facility multiple times each week. LEO GG stated if the residents were ambulatory and able to do things, then they looked good; If they were not able to do anything for themselves or be vocal about it, then they were not getting the care from staff. During an interview with LEO LL on 08/07/24 at 04:09 PM revealed she had a healthcare background. LEO LL stated the LEO's were trying to do classes at the facility to break down the laws to get this under control. LEO LL stated as far are the training goes, she did her due diligence to look into the training records. According to one CNA training record she reviewed, she was trained on all the areas, now does that mean that they are actually doing the training? No. Maybe. Maybe Not. But they are documenting it. Interview with Administrative Nurse C on 08/06/24 at 03:43 AM revealed R3 had been on one-on-one with staff since the incident with R1(on 05/19/24) and said somebody always had an eye on him. Interview with Administrative Nurse B on 08/06/24 at 04:45 AM revealed he was one-on-one with staff, and they were looking to find him a better home. Administrative Nurse B said there just were not a lot of places for R3 and said it was not fair to him. Review of the undated (copyright 2023) policy Safe Handling/Transfers revealed the facility would ensure residents were handled .safely to prevent or minimize risks for injury and provide and promote a safe, secure, and comfortable experience for the resident .in accordance with current standards and guidelines. The facility failed to ensure staff provided adequate supervision, while providing one-on-one supervision to the resident, and R3 fell out of bed and sustained a laceration to the back of his head.

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35717 The facility reported a census of 31 residents, with 16 residents sampled. Based on observation, interview, and record review, the facility failed to ensure adequate hydration for quadriplegic, dependent Resident (R) 4, who experienced decreased urinary output and decline R4 on [DATE], just one day after she completed antibiotic treatment for a Urinary Tract Infection (UTI). On [DATE] at around 01:15 AM, staff found the resident unresponsive, cyanotic, with wet lung sounds, and with no urinary output. R4 required emergency medical services (EMS) response and treatment to include a systolic blood pressure of 44 millimeters of mercury (mmHg) and could not obtain her diastolic pressure. EMS took R4 to the local hospital for treatment. The Emergency Department (ED) staff documented R4 appeared in poor health, appeared toxic, in severe distress, with flat jugular veins, cyanotic nail beds, lethargic, confused, only made sounds of moan/groans, and appeared poorly groomed, disheveled, malodorous. The ED placed a urinary catheter and noted 10 milliliters (ml) of dark orange/red urine with obvious pus and R4 required placement of an intraosseous to her right lower tibia (shinbone). The hospital admitted R4 with acute respiratory failure, pneumonia (inflammation of the lungs), sepsis (life threatening systemic reaction that develops due to infections which cause inflammation throughout the entire body), and comfort care with an onset date of [DATE]. Hospital staff noticed 25 ml of a creamy white/green substance in R4's urinary catheter tube and R4 died at 09:08 AM on [DATE]. Findings included: - The EHR revealed Resident (R)4 was [AGE] years old and admitted to the facility on [DATE]. The signed [DATE] Medication Review Report in the Electronic Health Record (EHR) revealed R4 had diagnoses which included the following: dysphagia (swallowing difficulty), anemia (inadequate number of healthy red blood cells to carry adequate oxygen to body tissues), generalized anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), chronic pain due to trauma, chronic pain syndrome, hypertension (high blood pressure), hydronephrosis (swelling of kidneys due to build up of urine, when it cannot drain), chronic kidney disease stage 1 (mild kidney damage with normal kidney function), history of traumatic brain injury, personal history of urinary (tract) infection, hypocalcemia (abnormally low level of calcium in the blood), quadriplegia (inability to move the arms, legs and trunk of the body below the level of an associated injury to the spinal cord), muscle weakness, type 2 diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), dysphagia following other cerebrovascular disease. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	The [DATE] Annual Minimum Data Set (MDS) revealed R4 had a Brief Interview for Mental Status score of 9, indicating moderate cognitive impairment. The MDS noted R4 did not reject care but did have a worsening of verbal behavioral symptoms directed towards others which occurred one to three days of the seven-day observation period. R4 had impairment to both sides of her upper and lower extremity regarding functional limitation in range of motion and used a wheelchair for mobility. R4 required supervision or touching assistance with eating and was dependent on staff for oral hygiene, toileting, shower/bathing, dressing and personal hygiene, and was dependent on staff for mobility. R4 was always incontinent of bladder and occasionally incontinent of bowel. R4 weighed 264 pounds. R4 received daily injections of insulin and received antianxiety and hypoglycemic medications. The resident was not on oxygen therapy. The MDS noted R4's primary medical condition was quadriplegia. The MDS further indicated R4 had cerebrovascular accident (CVA/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), renal (pertaining to kidneys) insufficiency, renal failure, and End Stage Renal Disease (ESRD, a terminal disease of the kidneys) indicated. The [DATE] Urinary Incontinence/Indwelling Catheter Care Area Assessment revealed the resident was always incontinent, but the CAA was not completed. The [DATE] Quarterly MDS revealed she had a BIMS score of nine and no change in behavioral symptoms since the prior assessment. The resident continued to have functional range of motion impairment to both sides of her upper and lower extremity, used a wheelchair for mobility, required substantial/maximal assistance with eating, and was dependent on staff for her self-care and mobility. The MDS noted she was frequently incontinent of urine and bowel. R4 had no swallowing disorder noted and weighed 262 pounds. R4 received antianxiety and antidepressant medications. The resident did not receive oxygen or any special treatments, procedures, and programs. The [DATE] Care Plan included the following staff interventions/tasks regarding R4: [DATE] - Sometimes R4's response was not to actual pain, but an anticipation of pain, as R4 has been known to say that hurts ow or even curse at staff before they touch her. [DATE], revised [DATE] - Staff would remind R4 she needed to swallow an extra time after every ,d+[DATE] bites to make sure she removed any residual food from her mouth, to help with choking and aspiration risks. R4 required assistance with feeding, should sit upright for all meals and for 30 minutes afterward, and should take all meals in the dining hall for safety. The resident used a lidded cup with a built-in straw to protect from spilling and maintain her independence. [DATE], revised [DATE] - R4 had an ADL self-care performance deficit related to her diagnoses of CVA and quadriplegia and staff were to report any changes to the nurse. R4 required total assistance of two staff for transfers and use of a mechanical lift. [DATE], revised [DATE] - R4 was totally dependent on two staff for toilet use. [DATE], revised [DATE] - R4 had bowel incontinence r/t [related to] and did not finish the care plan focus. The following staff intervention to provide peri-care after each incontinent episode. A [DATE], revised [DATE], intervention included to check and change every two hours and PRN (as needed). (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	A [DATE] Care Plan focus noted R4 had a urinary tract infection and included the staff interventions to check and change R4 every two hours for incontinence; wash, rinse, and dry soiled areas; give antibiotic therapy as ordered; Monitor/document for side effects and effectiveness and administer Macrobid (antibiotic) Oral Capsule 100 MG, give 1 capsule by mouth two times a day for UTI for 10 days. The staff were to obtain and monitor lab/diagnostic work as ordered and report the results to the physician and follow up as indicated. A [DATE] Care Plan focus noted R4 had a tooth infection and included staff to administer 1 tablet of Bactrim (antibiotic) DS Oral Tablet ,d+[DATE] MG, by mouth two times a day for R4's tooth infection for seven days. The [DATE] at 05:47 PM Health Status Note included R4 remained in bed the entire first shift. She was not feeling well, however, was not able to verbally convey what was not feeling well. She consumed 480 cubic centimeters (cc) of health shakes today at breakfast and lunch meals but otherwise was not eating today. Her vital signs remained within normal limits and staff placed her in the Provider Book for a full assessment. The [DATE] at 08:42 AM Nurse Note included R4 was not feeling well for the past couple of days. She remained without a fever; however, she declined getting up again this morning and on Wednesday. She was up in her chair yesterday (Thursday) morning; however, she did not eat, she only took fluids at breakfast and lunch. Labs were ordered yesterday, to be drawn today, and a urinalysis (UA) with culture and sensitivity (C&S) if indicated. This morning R4 began coughing and her chest was congested and had some Ronchi as evidenced by a rumbling (sound) upon expiration to her right (R) upper and mid lobe, and her R lower lobe was difficult to auscultate anteriorly. She was not able to cough hard enough to expectorate her phlegm at the time. The left (L) upper lobe presented with rales. R4 had no fever, but her face was very flushed. Her temperature measured 98.4 degrees Fahrenheit by noncontact thermometer to her forehead, pulse measured 102 beats per minute (bpm), Respirations were 19, blood pressure was ,d+[DATE] millimeters of mercury (mmHg). The staff made notifications and received an order for a chest X-ray and obtained a UA per straight catheterization with assistance of three staff. The [DATE] at 11:59 AM Nurse Note revealed R4's chest x-ray revealed no acute pulmonary or pleural abnormality is identified and noted the resident continued coughing with some mucous that she could not spit up. The [DATE] at 03:18 AM Order Note revealed the Macrobid Oral Capsule 100 MG, 1 capsule by mouth, two times a day for UTI for ten days, noted This dose fails a general dose range check based on drug inputs and/or the patient information provided. This drug's dose should be adjusted based on renal function. Manual screening is required. A secondary Order Note from [DATE] at 03:18 AM revealed a mild drug interaction: The antimicrobial effectiveness of Macrobid Oral Capsule 100 mg may be decreased by Milk of Magnesia Oral Suspension 400 mg per 5 ml. A Nurse Note dated [DATE] at 12:40 PM noted an order for Amoxicillin (antibiotic) 500 mg three times a day for 10 days and Ibuprofen 600 mg twice a day for 7 days. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	A [DATE] at 12:46 PM Order Note included the system has identified a possible drug allergy for the following order: Amoxicillin Oral Tablet 500 MG (Amoxicillin), give 1 tablet by mouth three times a day for tooth infection. Another [DATE] at 01:42 PM Order Note included a moderate severity drug interaction between Bactrim DS Oral Tablet ,d+[DATE] mg (sulfamethoxazole-trimethoprim) and Losartan Potassium tablet 50 MG and noted the coadministration of angiotensin II receptor antagonist and trimethoprim may increase the risk for hyperkalemia (higher than normal potassium levels in the blood) especially in the elderly. A [DATE] at 09:23 AM Nurse Note included the speech therapist changed R4's diet to puree diet due to her change in condition. The [DATE] at 10:19 PM Nurse Note documented the resident refused her shower today and stated she did not want one due to not getting up today and said, another day. The [DATE] at 08:21 AM Nurse Note documented the resident was up for breakfast this morning in good spirits, eating pureed diet and tolerating well, with no emesis (vomiting). The [DATE] at 10:37 PM Nurse Note documented the resident had an elevated temperature at 07:00 PM of 100.2 (degrees F) and received her scheduled ibuprofen prior, no complaints made by resident, alert in bed, with no nausea or vomiting noted. Temperature noted at 97.3 (degrees F). Review of an Alert Note dated [DATE] at 05:15 AM revealed Licensed Nurse (LN) S documented the following regarding R4: Resident at 0115 [01:15 AM] presented with lethargy unable to arouse, sternum rub attempted without success, all lung lobes crackles throughout O2 sat unable to obtain, R 28 BP ,d+[DATE] T 98 P 88 BS 167. Resident eyes fluttering very minimal urine output. LN contacted the physician, who contacted the LN writer and gave the order to send R4 to the ER. The LN contacted EMS, local law enforcement, and EMS arrived and transported the resident to the local hospital at 01:45 AM. The LN documented she sent the notification to Administrative Staff A, Administrative Nurse B, and Administrative Nurse C. Per a witness statement (which did not have a back page to identify name, date, or notarization) revealed a CNA documented the following regarding R4 on [DATE]: They got R4 up for breakfast, chatted with her and she acknowledge the CNA's presence. She was not feeling well but she wanted up for breakfast. She only ate a couple of bites of oatmeal but did eat her gelatin. The CNA statement noted they came around a few times to offer her water, which she took a few sips of. She refused lunch, and I got her more water. She did not look like she felt good any time I passed, so I informed the nurse that she didn't look very good. For dinner she stayed in bed and we gave her a chocolate shake and water. At dinner she was lightly wet so we changed her, but not much was on her. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Per the signed and notarized witness statement dated [DATE], Certified Nurse Aide (CNA) R documented she started her shift on [DATE] at 06:00 PM and noted R4 did want to get up for breakfast, however, did not want to eat much. CNA R documented she provided R4 with some gelatin and a health shake, and R4 laid back down. CNA R and another CNA changed R4 and made sure she was dry and comfortable. CNA R documented they reported to LN G that R4 wasn't feeling well and really didn't want to get up for lunch! CNA R said we were told she was being treated for a UTI and to push fluids. She did drink water and shakes for us through out our shift at 6pm the night shift came in, we did rounds with them . we adjusted her in bed. We reported how she had been feeling. She was responding to us well at that time. Per the signed and notarized witness statement dated [DATE], CNA N documented on [DATE] at about 01:00 AM she and CNA P were starting rounds, beginning with R4. Upon entering the room R4 still seemed to not feel well as passed down from first shift staff. CNA P laid the bed flat to change R4's brief. CNA N documented that CNA P verbalized R4 barely had any output and how that was not normal. CNA N documented that after elevating the head of the bed, CNA N and CNA P both noticed a flushed look on R4's face, pale lips, wheezing in her lungs that sounded like phlegm, and her eyes were fluttering. CNA N documented that CNA P did a sternum rub on R4's chest and R4 did not respond, and CNA P went to the LN to inform her of R4's condition, while CNA N stayed in R4's room. CNA N documented the LN S arrived and took vitals and could not get an O2 reading on R4. CNA N documented the LN then decided to send R4 to the hospital and the nurse made the call, then waited in R4's room until EMS arrived, while CNA N and CNA P continued our rounds as the Nurse gave EMS & Cops info. The other aide went back to [R4's] room to relay her info as well while I finished with other resident. As I finished with other resident [R4] was wheeled out. Per the signed and notarized witness statement dated [DATE], CNA P documented on [DATE] she saw R4 about 11:40 PM and she seemed to be normal. She opened her eyes and was awake. Just seemed tired. CNA P noted R4 was dry and had been dry all night. On [DATE] CNA P noted she started her next rounds around 01:00 AM and she and CNA N went to R4's room to change her first. CNA P noted she and CNA N cleaned R4's room and her wheelchair, then went to change R4, and noted she looked find just seemed tired. CNA P noted when she laid R4's bed flat, so they could roll her to change her, she noticed R4 had very little pee in her brief. CNA P documented that as they set R4 back up, she noticed that her breathing was heavy in her stomach and sounded like phlegm possibly in her throat or lungs when she would breath (sic). Her lips were turning purple. Her eyes were rolling back in her head and wasn't responding to the sternal rub. CNA P documented she immediately went and told LN S, who gathered equipment and responded, obtained R4's blood sugar and vitals, listened to her lungs, but could not get R4's O2 saturation. CNA P documented the LN then went back to the nurse's station while CNA N stayed in the room with R4. The nurse then called the cops, and the physician and CNA P went back down to the room to tell CNA N R4 was being sent out. CNA P documented that she and CNA N then continued their rounds and went to the next room. CNA P further documented Not too long after going to our next room I went back down to the nurses station where I seen the nurse [LN S] and a female cop meet in the hallway right outside the nurse's station. The nurse [LN S] gave the cop paper work on [R4]. They then went down to [R4's] room. I then met the cop and [LN S] down in [R4's] room a few min. later. I gave the cop a run down of what happened when I was with [R4]. I then left the room and was walking down the hallways and seen a male EMT at the nurses station. I told the EMT that the cop and nurse [LN S] were in [R4's] room and where [R4's] room was. I then got back to doing my rounds. A little bit later I seen the EMT(s) wheeling [R4] out and the nurse [LN S] walking with them. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Per the [DATE] signed and notarized Witness Statement by Licensed Nurse (LN) S revealed at 01:15 AM that morning Certified Nurse Aide (CNA) P came to the nurse's room and stated to her that R4 was not acting like herself and she'd tried sternum rub and [R4] would not wake up. LN S documented she then grabbed the stethoscope, blood pressure cuff, thermometer, glucometer, oxygen saturation (O2) monitor, and went to R4's room with the CNA. She documented she went to R4s room, turned the overhead light on and noted the resident was her WNL [Within Normal Limits] pale skin color no sweating noted eyes mostly closed fluttering. LN S noted she could hear liquid in R4's lungs and attempted but could not obtain R4's O2 saturation reading, attempting on two of R4's left fingers (the statement lacked evidence LN S provided oxygen to R4 at this time). LN S documented Labor breathing noted and said R4's vital signs measured as follows: blood pressure was ,d+[DATE] millimeters of mercury (mmHg), respirations were 28 (BPM - breaths per minute) (normal range for an adult female at rest is ,d+[DATE] BPM), pulse was 88 (beats per minute), and temperature was 98.0 (degrees Fahrenheit). LN S noted she then went to get glucometer strips and left the CNAs in R4's room and came right back to obtain R4's blood sugar, noted as167. LN S documented she used the stethoscope and could hear crackles throughout all lung lobes. LN S further documented that before she attempted to get an O2 sat, she tried sternum rub, shaking resident arms and hollering to her without response (the witness statement continued to lack evidence O2 was provided to R4). LN S documented that during report (coming onto her shift) she had received no information from any staff, prior to 01:15 AM, that anything was going on with R4. LN S documented she had not noticed any issues with R4 during her before bed treatment, when she gave her roommate her breathing treatment (11:30 PM), or removed the roommate's breathing treatment mask at 12:09 AM. LN S noted she went to call the physician at 01:13 AM according to her phone log (and she noted the facility clock showed it was at 01:20 AM) and LN S said she waited three minutes and received a call back from a physician. LN S stated she explained the situation and asked if she could send R4 to the ER, the physician and LN S had a discussion over R4's status, vitals, lung sounds, and breathing, and the physician gave the order to send R4 to the ER. LN S then said, while she was still at the nurse's station after she hung up with the physician, she then called 911, filled out all paperwork, and printed all papers, then ran to the restroom. LN S documented that when she came out of the restroom, she saw a law enforcement officer in the hallway and ran down to them with the printed papers. LN S documented she and the law enforcement officer then went to R4's room and found R4 alone in her room with no staff present. LN S documented that shortly after another responder appeared, they retrieved R4's vital signs, and after reading the resident's O2 saturation level, LN S then asked the responder do you want me to get O2? and the responder stated, yeah that probably be a good idea. LN S then left the room to get O2 tubing then headed to get an O2 tank as EMS arrived so she led EMS to R4's room. EMS assessed and transferred R4 to the gurney and left with R4 at approximately 01:45 AM. LN S documented she then texted the notification to Administrative Staff A, Administrative Nurse B, and Administrative Nurse C. Review of the [DATE] Emergency Department (ED) Nursing Documentation for R4 revealed the following: Physical Assessment as Appears in poor health, Appears toxic, Tense, Severe distress. Skin: Pale, Mottled Respiratory: Left Lung Sounds: Rales/Crackles, Right Lung Sounds: Rales/Crackles Cardiovascular: Edema: 3+ pitting: BLE Neurologic: Level of Consciousness: lethargic, confused; Verbal Response: only sounds/moan/groans (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Psychiatric: Appearance: Poorly groomed, Disheveled, Malodorous The Patient Progress Notes from the local hospital dated [DATE] at 02:18 AM revealed R4's blood pressure was ,d+[DATE] mmHg, and her pulse was 112 beats per minute. At 02:31 AM R4's blood pressure was , d+[DATE] mmHg, and her pulse was 113 beats per minute. The [DATE] ED Nursing Note regarding R4 on [DATE] included: At 05:17 AM, due to unsuccessful attempts to place a central line, the ED placed an intraosseous (IO, process of injecting medication/fluids/blood products directly into the bone marrow) to R4's right proximal tibia. Review of the labs collected by the local hospital on [DATE] at 02:39 AM revealed the resident had a platelet count of 67 (Low=130 and High=400). R4 had critically high Lactic Acid lab results which measured 3.7 millimoles per liter (mmol/L) (Low=0.70 and High=2.00). Review of the ED Provider Documentation Report for R4 from [DATE] revealed the following: Chief Complaint and Reason for Visit: Acute Respiratory Failure, pneumonia, sepsis, comfort care. Final Impression: Sepsis, left lower lobe pneumonia, pulmonary edema. Quadriplegic. Current Condition: Critical Per the United States Centers for Disease Control (CDC) and Prevention website, dated [DATE], revealed Sepsis is listed as the body's extreme response to an infection. It is a life-threatening medical emergency. The website further stressed the importance of early recognition and timely treatment of sepsis, reassessment of antibiotic needs and prevention of infections. Review of the chest X-Ray Report on [DATE] at 03:06 AM revealed R4 had airspace infiltrate and atelectasis in the left lower lobe of her lung, with no heart failure present. The report noted the left lower lobe infiltrate and atelectasis was mostly new compared to the last exam on [DATE] (12 days prior). The hospital record review revealed R4 died at the hospital on [DATE] at 09:08 AM, approximately 8 hours after staff found her unresponsive. Interview with CNA N on [DATE] at 11:38 PM revealed the nurse's usually do the vital signs and stated she had only taken vitals once. Regarding the [DATE] incident with R4, CNA N stated that R4 did not respond to sternal rub, and she stayed in the room with R4 while CNA P told the nurse. Then, when the LN came back to the room, CNA N and CNA P continued their rounds with residents. CNA N stated by the time they finished the next room, they saw R4 going out with EMS. When asked about R4's earlier in her shift, CNA N stated R4 was actually a very heavy wetter but stated when she checked on R4 she was dry, then she was barely wet like a quarter sized spot in her brief when they changed her at approximately 01:00AM on [DATE]. CNA N confirmed she did not change R4's brief upon arrival on her shift and did not change her brief earlier in her shift because she was dry. CNA N stated she had received report that R4 was a little worse today and not active or talkative. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Interview with CNA II on [DATE] at 12:25 AM revealed she received training about a week ago over R4, not outwardly about R4, but just about a lack of oxygen and to put oxygen on the resident if their O2 was down and to ensure things were done properly. CNA II stated she worked with R4 two days prior to the incident and said R4 seemed okay, but you never know. CNA II said CNAs are hands on and they know about changes in residents and to report any change to the nurse. CNA II stated she does take vitals and if a resident displayed abnormal breathing or too high or low of blood pressure, she would report that to the nurse. CNA II stated the CNAs report the color of urine, such as urine color of concern like red or orange, brown/black, orange or anything cloudy, need reported or if the urine is chunky, as she had seen chunky urine. CAN II stated if a resident had a UTI the nurses let the CNA staff know and the CNAs encourage fluids and keep the residents cleaned up. CNA II stated the electronic charting for CNAs only allowed for a checkmark on whether a resident was continent or incontinent. During an interview with Administrative Nurse C on [DATE] at 03:43 AM revealed she knew R4 was being treated for a UTI and tooth infection and stated they were monitoring signs and symptoms. Administrative Nurse C said she thought R4 was getting better, was up for a meal and she was doing okay, so when she found out about the outcome to R4, she was shocked. Administrative Nurse C was told they transferred R4 out to the ED. Administrative Nurse C stated she expected staff to report to a licensed nurse if a resident was not voiding within so many hours and further stated to be honest R4 was always wet no matter what, but sometimes she did not drink as much as other times. Administrative Nurse C expected staff to report any change in condition. Administrative Nurse C stated the CNAs task charting included checkmarks to indicate if a resident voided or not but verified it did not allow for an amount or urine description. Administrative Nurse C said they were pushing fluids for R4, would encourage fluids, expected staff to report if a resident had no output and for staff to follow up. When asked about the lack of output for R4 and EMS transport, Administrative Nurse C stated she was probably dehydrated and not doing too hot, but if a resident was not voiding the staff should have reported that and then said, poor communications. During an interview with Administrative Nurse B on [DATE] at 04:45 AM, revealed R4 was able to get up that morning and barely ate breakfast, but that night Administrative Nurse B received a text stating that R4 was at the hospital with an O2 saturation level of 77%, and the nurse did not call to notify her. Administrative Nurse B said when she came in that morning ([DATE]) she did not even know what happened, had the police not called and told the facility that the vital signs the nurse obtained did not align with what EMS reported or else she would not know that. Administrative Nurse B said if the staff could not get the O2 saturation level on a resident, she expected the staff to put oxygen therapy on, but then said the LN failed to administer O2 to R4. Administrative Nurse B stated she heard that the nurses were not in the room with R4 the whole time and further said she expected the staff to stay in the room with residents in distress. Administrative Nurse B stated she did call the nurse in as the police officer said he was going to press charges. The nurse stated she needed to go to the bathroom real bad, she confirmed she could not get the resident's O2 saturation level, she said she did not put oxygen on the resident, and then confirmed she asked the officer if she should put the oxygen on R4. Administrative Nurse B stated some CNAs had training, and others were not supposed to do sternal rubs on residents. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	During a telephone interview with Law Enforcement Officer (LEO) GG on [DATE] at 12:44 PM revealed LEO's have responded to lots of calls to the facility over the past almost two years and estimated that number to be over 300 calls. LEO GG noted he was just in the facility recently to address a resident (R4) with difficulty breathing and with wet lungs that you could hear without a stethoscope. LEO GG said the nurse did not remain in R4's room, she left the room and when one of his officers arrived the resident was in her room alone. LEO GG stated he responded to the call as an EMT and said when he arrived CNA P was walking down the hall towards him and he yelled which room? and CNA P continued to walk down the hallway in no hurry, probably about 1 to 3 minutes to wait, and then stated the room, and it was the room she had just come out of. LEO GG stated that was very frustrating as time counts in emergency response situations. LEO GG stated that is a problem and R4 needed positive pressure ventilation to get the water out of her lungs and he could not believe she did not have oxygen on her. LEO GG said after he arrived to the resident's room and they got an oxygen saturation level on her of 77% the LN then asked if she should put oxygen on R4 and he said yes, that is probably a good idea and further stated she should have put that on first thing that is why they do the ABC's, A is Airway. LEO GG said in a very exacerbated tone, to have a nurse look at me and say, 'do you want me to get oxygen?' and to look at R4 I am thinking why are you not bagging her or something? To have the nurse just say she had to pee, I just can't believe it. LEO GG further stated the LN gave him a blood pressure number for R4 that was impossible to be accurate (,d+[DATE]), considering that when they arrived to get the blood pressure, they could not even get a diastolic number and her systolic was in the 60's. LEO GG said it was accurate to say that R4 looked disheveled and was malodorous. LEO GG said if the residents were able to be ambulatory and able to do things, they look good, if they are not and not able to do anything and be vocal, then they were not getting the care. LEO GG said day shift and night shift are not the same and stated night shift were never in the resident's rooms and every time LEO GG went into the facility at night, they were not providing cares. Interview with LEO LL on [DATE] at 04:09 PM revealed she was the responding officer to the [DATE] incident regarding R4. LEO LL stated she had a healthcare background (prior CNA/EMT) and stated she did not agree with how the facility staff handled the incident involving R4, in any way. She stated in any kind of healthcare, if the person is struggling to breathe, you get oxygen on them and it did not even matter what their O2 saturation is, you put oxygen on a person when they are struggling like R4. LEO LL stated when she arrived at the facility the dispatch had told her the room number, but when LEO LL walked in there were not staff in the commons area, no staff in the nurse's station, no staff in the hallway. When LEO LL walked by the room number given to her by dispatch, she thought it was the wrong number since no staff were in the room and the lights were mostly off, so she walked back to the nurse's station and ran into LN S. LEO LL said LN S stated Oh sorry, I had to go pee. LEO LL stated the LN left the patient in order to pee. The resident did not have oxygen on and LN S said it was because LN S could not get an O2 saturation on R4. LEO LL then said the number LN S gave for R4's blood pressure was ,d+[DATE] mmHg (exacerbated sigh), there was no way, as EMS arrived within minutes and said R4's systolic was 44 mmHg and they could not get a diastolic on R4. LEO LL said R4 looked pale, with flushed cheeks, and was not moving, but you could tell R4 was struggling to breathe. LEO LL asked LN S if R4 aspirated on something and LN S said no, but said her lungs sounded wet and full of fluid, and R4 had not responded to sternal rub. LEO LL stated to me the LTC facility needed to increase patient check-just common sense and said the last time they checked on R4 was 11:38 PM ([DATE]) and EMS was not called until 01:23 AM ([DATE]), almost 2 hours with no check. LEO LL further stated the facility was better, but not what it could or should be. The facility did not provide a policy regarding UTI and hydration. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175450	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Anew Healthcare Oxford	200 S Ohio St Oxford, KS 67119

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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 0692 Level of Harm - Actual harm Residents Affected - Few	The facility failed to ensure staff provided adequate hydration to quadriplegic, dependent R4, who became unresponsive, displayed troubl[TRUNCATED]

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35717 The facility reported a census of 31 residents with 16 included in the sample. Based on observation, interview, and record review the facility failed to ensure staff provided feeding tube care in accordance with professional standards of practice. On 06/16/24, a Certified Nurse Aide (CNA) pulled out R3's feeding tube, which required emergency medical transportation to a local hospital for surgical replacement. Finding included: - The Electronic Health Record revealed Resident (R)3 was [AGE] years old and the 03/28/24 Physician Order revealed Physician U ordered R3's admission to the facility and noted his diagnoses included: cerebral palsy, down's syndrome, autism, congenital stricture of esophagus, and acute respiratory hypoxia. The 04/04/24 Annual Minimum Data Set (MDS) Assessment revealed the staff assessment of R3's mental status revealed he had short-term memory problems and severely impaired cognitive skills for daily decision making. The MDS indicated R3 had no functional range of motion impairment to his upper or lower extremities, and he did not use a mobility device. R3 required total dependence on staff for toileting hygiene, dressing, and personal hygiene. R3 had no falls, weighed 70 pounds, and was 52 inches tall. R3 had a feeding tube and received 51% of his total calories by artificial route and 501 cc/day or more of average fluid intake per day by tube feeding. The 06/24/24 Quarterly MDS Assessment revealed R3 had short and long-term memory problems and severely impaired (never/rarely made decisions) cognitive skills for daily decision making, with continuous inattention and disorganized thinking. The resident was completely dependent on staff for all the effort regarding oral hygiene, toileting hygiene, shower/bathing, dressing, and personal hygiene. The resident did use a manual wheelchair and/or scooter. The resident weighed 65 pounds and was 52 inches tall and had a feeding tube while a resident. The resident had mouth or facial pain, discomfort, or difficulty with chewing. The care plan special instructions sections at the top of the page, noted R3 was non-verbal. Review of R3's 04/22/24 Care Plan revealed no focus dedicated solely to his G-tube. The interventions lacked instructions for staff in preventing G-tube dislodgment/displacement and further lacked interventions for staff in case it became dislodged or pulled out. The Care Plan further lacked mention of the prior incident(s) where R3's G-tube was pulled out and that it required EMS transport and immediate treatment. Review of the Nurse Note dated 06/16/24 at 05:32 PM revealed staff called the nurse to R3's room because the CNA pulled the resident's G-tube out while changing his shirt. Res tolerated well. Pressure dressing applied. The 06/16/24 at 05:40 PM Nurse Note revealed a verbal order to send R3 out via Emergency Medical Services (EMS). (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 06/16/24 at 06:53 PM Nurse Note revealed the local hospital called to have the resident picked up after they completed placement of the G-tube (feeding tube). On 06/17/24 at 01:09 PM Nutrition/Dietary Note revealed R3 was NPO, continued on Jevity 1.5 (nutritional supplement provided via G-tube) and received 237 milliliters (ml) five times a day, and 30 cubic centimeters (cc) water flush before and after each feeding. R3 received 80 ml of water five times a day for additional 400 ml of fluid. The note included the current rate was meeting 100% of his estimated needs and noted R3 triggered for significant weight loss, and the RD had no new recommendations at this time. The 06/21/24 at 09:07 AM Nurse Note revealed R3 discharged from the local hospital because they were unable to insert a gastronomy tube, and would transfer R3 to another, larger area hospital. Review of the resident's nurse's notes from 06/16/24 at 06:53 PM to 06/21/24 lacked any monitoring related to replacement of the resident's feeding tube on 06/16/24 and/or documentation which identified why the resident had to have his G-tube replaced again on 06/21/24. The 06/21/24 at 02:21 PM Nurse Note revealed the resident returned from the emergency room via facility transportation with a gastronomy tube to the left side of his abdomen. The note included the resident continued one-on-one observation. The 06/27/24 at 03:21 PM IDT Meeting Notes included R3's care plan was reviewed and updated as needed. The resident was notified of the plan of care. Medical provider was notified of change in condition. The resident's care plan continued to lack further instruction to staff regarding R3's dislodged G-tube. Upon entrance on 07/31/24 at 08:55 AM, tour hallway at 09:26 AM revealed resident in his room on one-on-one observation. The resident remained on one-to-one observation during the duration of the onsite survey on 07/31/24, 08/01/24, 08/05/24, and 08/06/24. The resident was in his wheelchair, in his bedroom, in the main commons area, in the room across from the nurse's station, and he always had one staff with him, but did not have on shoes. The resident was non-verbal and did make some small noises but spent time playing on his electronic device and in his wheelchair as staff wheeled him around, inside, and outside, of the facility. On 08/01/24 at approximately 11:45 AM, the surveyor observed staff pushing R3 in his wheelchair while R3 played on his electronic device. R3 had his feet dangling down with no socks on and feet looked darkened and dirty. R3 had two of his fingers in his mouth with a band of darkly discolored, visibly dirty ring around the base of those two fingers, just below the area he had in his mouth on his fingers. The LN KK began looking for gloves, did not don gloves, and then just used a few wipes to clean R3's dirty fingers. During an interview with CNA II on 08/06/24 at 12:25 AM revealed R3 had some weight loss. CNA II had a tube feeding and stated she had no concern with him and said he does not pull on it. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Law Enforcement Officer (LEO) GG on 08/05/24 at 04:09 PM revealed he had been out to the facility on multiple staff to resident battery issues and neglect. LEO GG stated his office has received over 300 calls regarding the facility within the 2 years the facility has operated. LEO GG stated his staff were at the facility multiple times each week. LEO GG stated if the residents were ambulatory and able to do things, then they looked good; If they were not able to do anything for themselves or be vocal about it, then they were not getting the care from staff. During an interview with LEO LL on 08/07/24 at 04:09 PM revealed she had a healthcare background. LEO LL stated the LEO's were trying to do classes at the facility to break down the laws to get this under control. LEO LL stated as far are the training goes, she did her due diligence to look into the training records. According to one CNA training record she reviewed, she was trained on all the areas, now does that mean that they are actually doing the training? No. Maybe. Maybe Not. But they are documenting it. Interview with Administrative Nurse C on 08/06/24 at 03:43 AM revealed R3 had been on one-on-one with staff since the incident with R1 and said somebody always had an eye on him. Interview with Administrative Nurse B on 08/06/24 at 04:45 AM revealed he is one-on-one with staff, and they were looking to find him a better home. Administrative Nurse B said there just were not a lot of places for R3 and said it was not fair to him. Review of the unnamed, undated Change of Condition document provided by the facility revealed the DON/Designee would notify the MDS Nurse, Resident's Provider, Responsible Party, and Leadership with potential changes of condition when and if needed. A potential change of condition was identified in the document as a Gastrostomy tube displacement. The facility failed to ensure staff provided feeding tube care in accordance with professional standards of practice. On 06/16/24, a Certified Nurse Aide (CNA) pulled out R3's feeding tube, which required emergency medical transportation to a local hospital for surgical replacement.

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F 0695 Level of Harm - Actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35717 The facility reported a census of 31 residents, with 16 residents sampled. Based on observation, interview, and record review, the facility failed to ensure staff provided oxygen to quadriplegic, dependent Resident (R) 4, who became unresponsive and displayed trouble breathing. On [DATE] at around 01:15 AM, staff found the resident unresponsive, cyanotic, with wet lung sounds, and with no urinary output. The staff did not apply oxygen and did not ensure a staff member stayed with R4 during the critical incident. License Nurse (LN) S left the room and called the physician, discussed the situation, received an order to call 911, then she called 911, printed and filled out papers, then went to the bathroom. When emergency responders arrived, they found no staff in the hallway and found the resident alone in her room and with no oxygen applied, even though the staff noted R4 displayed obvious signs of airway distress. R4 required emergency medical services (EMS) response and treatment to include obtaining her oxygen saturation level of 77%, a systolic blood pressure of 44 millimeters of mercury (mmHg) and could not obtain her diastolic pressure. R4 required supplemental oxygen and EMS took R4 to the local hospital for treatment. The Emergency Department (ED) staff documented R4 appeared in poor health, appeared toxic, in severe distress, with flat jugular veins, cyanotic nail beds, lethargic, confused, only made sounds of moan/groans, and appeared poorly groomed, disheveled, malodorous. The ED placed a urinary catheter and noted 10 milliliters (ml) of dark orange/red urine with obvious pus and R4 required placement of an intraosseous to her right lower tibia (shinbone). The hospital admitted R4 with acute respiratory failure, pneumonia (inflammation of the lungs), sepsis (life threatening systemic reaction that develops due to infections which cause inflammation throughout the entire body), and comfort care with an onset date of [DATE]. R4 died at 09:08 AM on [DATE]. Findings included: - The EHR revealed Resident (R)4 was [AGE] years old and admitted to the facility on [DATE]. The signed [DATE] Medication Review Report in the Electronic Health Record (EHR) revealed R4 had diagnoses which included the following: dysphagia (swallowing difficulty), anemia (inadequate number of healthy red blood cells to carry adequate oxygen to body tissues), generalized anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), chronic pain due to trauma, chronic pain syndrome, hypertension (high blood pressure), hydronephrosis (swelling of kidneys due to build up of urine, when it cannot drain), chronic kidney disease stage 1 (mild kidney damage with normal kidney function), history of traumatic brain injury, personal history of urinary (tract) infection, hypocalcemia (abnormally low level of calcium in the blood), quadriplegia (inability to move the arms, legs and trunk of the body below the level of an associated injury to the spinal cord), muscle weakness, type 2 diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), dysphagia following other cerebrovascular disease. (continued on next page)

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F 0695 Level of Harm - Actual harm Residents Affected - Few	The [DATE] Annual Minimum Data Set (MDS) revealed R4 had a Brief Interview for Mental Status score of 9, indicating moderate cognitive impairment. The MDS noted R4 did not reject care but did have a worsening of verbal behavioral symptoms directed towards others which occurred one to three days of the seven-day observation period. R4 had impairment to both sides of her upper and lower extremity regarding functional limitation in range of motion and used a wheelchair for mobility. R4 required supervision or touching assistance with eating and was dependent on staff for oral hygiene, toileting, shower/bathing, dressing and personal hygiene, and was dependent on staff for mobility. R4 was always incontinent of bladder and occasionally incontinent of bowel. R4 weighed 264 pounds. R4 received daily injections of insulin and received antianxiety and hypoglycemic medications. The resident was not on oxygen therapy. The MDS noted R4's primary medical condition was quadriplegia. The MDS further indicated R4 had cerebrovascular accident (CVA/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), renal (pertaining to kidneys) insufficiency, renal failure, and End Stage Renal Disease (ESRD, a terminal disease of the kidneys) indicated. The [DATE] Urinary Incontinence/Indwelling Catheter Care Area Assessment revealed the resident was always incontinent, but the CAA was not completed. The [DATE] Quarterly MDS revealed she had a BIMS score of nine and no change in behavioral symptoms since the prior assessment. The resident continued to have functional range of motion impairment to both sides of her upper and lower extremity, used a wheelchair for mobility, required substantial/maximal assistance with eating, and was dependent on staff for her self-care and mobility. The MDS noted she was frequently incontinent of urine and bowel. R4 had no swallowing disorder noted and weighed 262 pounds. R4 received antianxiety and antidepressant medications. The resident did not receive oxygen or any special treatments, procedures, and programs. The [DATE] Care Plan included the following staff interventions/tasks regarding R4: [DATE] - Sometimes R4's response was not to actual pain, but an anticipation of pain, as R4 has been known to say that hurts ow or even curse at staff before they touch her. [DATE], revised [DATE] - Staff would remind R4 she needed to swallow an extra time after every ,d+[DATE] bites to make sure she removed any residual food from her mouth, to help with choking and aspiration risks. R4 required assistance with feeding, should sit upright for all meals and for 30 minutes afterward, and should take all meals in the dining hall for safety. The resident used a lidded cup with a built-in straw to protect from spilling and maintain her independence. [DATE], revised [DATE] - R4 had an ADL self-care performance deficit related to her diagnoses of CVA and quadriplegia and staff were to report any changes to the nurse. R4 required total assistance of two staff for transfers and use of a mechanical lift. [DATE], revised [DATE] - R4 was totally dependent on two staff for toilet use. [DATE], revised [DATE] - R4 had bowel incontinence r/t [related to] and did not finish the care plan focus. The following staff intervention to provide peri-care after each incontinent episode. A [DATE], revised [DATE], intervention included to check and change every two hours and PRN (as needed). (continued on next page)

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F 0695 Level of Harm - Actual harm Residents Affected - Few	A [DATE] Care Plan focus noted R4 had a urinary tract infection and included the staff interventions to check and change R4 every two hours for incontinence; wash, rinse, and dry soiled areas; give antibiotic therapy as ordered; Monitor/document for side effects and effectiveness and administer Macrobid (antibiotic) Oral Capsule 100 MG, give 1 capsule by mouth two times a day for UTI for 10 days. The staff were to obtain and monitor lab/diagnostic work as ordered and report the results to the physician and follow up as indicated. A [DATE] Care Plan focus noted R4 had a tooth infection and included staff to administer 1 tablet of Bactrim (antibiotic) DS Oral Tablet ,d+[DATE] MG, by mouth two times a day for R4's tooth infection for seven days. The [DATE] at 05:47 PM Health Status Note included R4 remained in bed the entire first shift. She was not feeling well, however, was not able to verbally convey what was not feeling well. She consumed 480 cubic centimeters (cc) of health shakes today at breakfast and lunch meals but otherwise was not eating today. Her vital signs remained within normal limits and staff placed her in the Provider Book for a full assessment. The [DATE] at 08:42 AM Nurse Note included R4 was not feeling well for the past couple of days. She remained without a fever; however, she declined getting up again this morning and on Wednesday. She was up in her chair yesterday (Thursday) morning; however, she did not eat, she only took fluids at breakfast and lunch. Labs were ordered yesterday, to be drawn today, and a urinalysis (UA) with culture and sensitivity (C&S) if indicated. This morning R4 began coughing and her chest was congested and had some Ronchi as evidenced by a rumbling (sound) upon expiration to her right (R) upper and mid lobe, and her R lower lobe was difficult to auscultate anteriorly. She was not able to cough hard enough to expectorate her phlegm at the time. The left (L) upper lobe presented with rales. R4 had no fever, but her face was very flushed. Her temperature measured 98.4 degrees Fahrenheit by noncontact thermometer to her forehead, pulse measured 102 beats per minute (bpm), Respirations were 19, blood pressure was ,d+[DATE] millimeters of mercury (mmHg). The staff made notifications and received an order for a chest X-ray and obtained a UA per straight catheterization with assistance of three staff. The [DATE] at 11:59 AM Nurse Note revealed R4's chest x-ray revealed no acute pulmonary or pleural abnormality is identified and noted the resident continued coughing with some mucous that she could not spit up. The [DATE] at 03:18 AM Order Note revealed the Macrobid Oral Capsule 100 MG, 1 capsule by mouth, two times a day for UTI for ten days, noted This dose fails a general dose range check based on drug inputs and/or the patient information provided. This drug's dose should be adjusted based on renal function. Manual screening is required. A secondary Order Note from [DATE] at 03:18 AM revealed a mild drug interaction: The antimicrobial effectiveness of Macrobid Oral Capsule 100 mg may be decreased by Milk of Magnesia Oral Suspension 400 mg per 5 ml. A Nurse Note dated [DATE] at 12:40 PM noted an order for Amoxicillin (antibiotic) 500 mg three times a day for 10 days and Ibuprofen 600 mg twice a day for 7 days. (continued on next page)

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F 0695 Level of Harm - Actual harm Residents Affected - Few	A [DATE] at 12:46 PM Order Note included the system has identified a possible drug allergy for the following order: Amoxicillin Oral Tablet 500 MG (Amoxicillin), give 1 tablet by mouth three times a day for tooth infection. Another [DATE] at 01:42 PM Order Note included a moderate severity drug interaction between Bactrim DS Oral Tablet ,d+[DATE] mg (sulfamethoxazole-trimethoprim) and Losartan Potassium tablet 50 MG and noted the coadministration of angiotensin II receptor antagonist and trimethoprim may increase the risk for hyperkalemia (higher than normal potassium levels in the blood) especially in the elderly. A [DATE] at 09:23 AM Nurse Note included the speech therapist changed R4's diet to puree diet due to her change in condition. The [DATE] at 10:19 PM Nurse Note documented the resident refused her shower today and stated she did not want one due to not getting up today and said, another day. The [DATE] at 08:21 AM Nurse Note documented the resident was up for breakfast this morning in good spirits, eating pureed diet and tolerating well, with no emesis (vomiting). The [DATE] at 10:37 PM Nurse Note documented the resident had an elevated temperature at 07:00 PM of 100.2 (degrees F) and received her scheduled ibuprofen prior, no complaints made by resident, alert in bed, with no nausea or vomiting noted. Temperature noted at 97.3 (degrees F). Review of an Alert Note dated [DATE] at 05:15 AM revealed Licensed Nurse (LN) S documented the following regarding R4: Resident at 0115 [01:15 AM] presented with lethargy unable to arouse, sternum rub attempted without success, all lung lobes crackles throughout O2 sat unable to obtain, R 28 BP ,d+[DATE] T 98 P 88 BS 167. Resident eyes fluttering very minimal urine output. LN contacted the physician, who contacted the LN writer and gave the order to send R4 to the ER. The LN contacted EMS, local law enforcement, and EMS arrived and transported the resident to the local hospital at 01:45 AM. The LN documented she sent the notification to Administrative Staff A, Administrative Nurse B, and Administrative Nurse C. Per a witness statement (which did not have a back page to identify name, date, or notarization) revealed a CNA documented the following regarding R4 on [DATE]: They got R4 up for breakfast, chatted with her and she acknowledge the CNA's presence. She was not feeling well but she wanted up for breakfast. She only ate a couple of bites of oatmeal but did eat her gelatin. The CNA statement noted they came around a few times to offer her water, which she took a few sips of. She refused lunch, and I got her more water. She did not look like she felt good any time I passed, so I informed the nurse that she didn't look very good. For dinner she stayed in bed and we gave her a chocolate shake and water. At dinner she was lightly wet so we changed her, but not much was on her. (continued on next page)

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F 0695 Level of Harm - Actual harm Residents Affected - Few	Per the signed and notarized witness statement dated [DATE], Certified Nurse Aide (CNA) R documented she started her shift on [DATE] at 06:00 PM and noted R4 did want to get up for breakfast, however, did not want to eat much. CNA R documented she provided R4 with some gelatin and a health shake, and R4 laid back down. CNA R and another CNA changed R4 and made sure she was dry and comfortable. CNA R documented they reported to LN G that R4 wasn't feeling well and really didn't want to get up for lunch! CNA R said we were told she was being treated for a UTI and to push fluids. She did drink water and shakes for us through out our shift at 6pm the night shift came in, we did rounds with them . we adjusted her in bed. We reported how she had been feeling. She was responding to us well at that time. Per the signed and notarized witness statement dated [DATE], CNA N documented on [DATE] at about 01:00 AM she and CNA P were starting rounds, beginning with R4. Upon entering the room R4 still seemed to not feel well as passed down from first shift staff. CNA P laid the bed flat to change R4's brief. CNA N documented that CNA P verbalized R4 barely had any output and how that was not normal. CNA N documented that after elevating the head of the bed, CNA N and CNA P both noticed a flushed look on R4's face, pale lips, wheezing in her lungs that sounded like phlegm, and her eyes were fluttering. CNA N documented that CNA P did a sternum rub on R4's chest and R4 did not respond, and CNA P went to the LN to inform her of R4's condition, while CNA N stayed in R4's room. CNA N documented the LN S arrived and took vitals and could not get an O2 reading on R4. CNA N documented the LN then decided to send R4 to the hospital and the nurse made the call, then waited in R4's room until EMS arrived, while CNA N and CNA P continued our rounds as the Nurse gave EMS & Cops info. The other aide went back to [R4's] room to relay her info as well while I finished with other resident. As I finished with other resident [R4] was wheeled out. Per the signed and notarized witness statement dated [DATE], CNA P documented on [DATE] she saw R4 about 11:40 PM and she seemed to be normal. She opened her eyes and was awake. Just seemed tired. CNA P noted R4 was dry and had been dry all night. On [DATE] CNA P noted she started her next rounds around 01:00 AM and she and CNA N went to R4's room to change her first. CNA P noted she and CNA N cleaned R4's room and her wheelchair, then went to change R4, and noted she looked find just seemed tired. CNA P noted when she laid R4's bed flat, so they could roll her to change her, she noticed R4 had very little pee in her brief. CNA P documented that as they set R4 back up, she noticed that her breathing was heavy in her stomach and sounded like phlegm possibly in her throat or lungs when she would breath (sic). Her lips were turning purple. Her eyes were rolling back in her head and wasn't responding to the sternal rub. CNA P documented she immediately went and told LN S, who gathered equipment and responded, obtained R4's blood sugar and vitals, listened to her lungs, but could not get R4's O2 saturation. CNA P documented the LN then went back to the nurse's station while CNA N stayed in the room with R4. The nurse then called the cops, and the physician and CNA P went back down to the room to tell CNA N R4 was being sent out. CNA P documented that she and CNA N then continued their rounds and went to the next room. CNA P further documented Not too long after going to our next room I went back down to the nurses station where I seen the nurse [LN S] and a female cop meet in the hallway right outside the nurse's station. The nurse [LN S] gave the cop paper work on [R4]. They then went down to [R4's] room. I then met the cop and [LN S] down in [R4's] room a few min. later. I gave the cop a run down of what happened when I was with [R4]. I then left the room and was walking down the hallways and seen a male EMT at the nurses station. I told the EMT that the cop and nurse [LN S] were in [R4's] room and where [R4's] room was. I then got back to doing my rounds. A little bit later I seen the EMT(s) wheeling [R4] out and the nurse [LN S] walking with them. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Anew Healthcare Oxford		STREET ADDRESS, CITY, STATE, ZIP CODE 200 S Ohio St Oxford, KS 67119	

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F 0695 Level of Harm - Actual harm Residents Affected - Few	Per the [DATE] signed and notarized Witness Statement by Licensed Nurse (LN) S revealed at 01:15 AM that morning Certified Nurse Aide (CNA) P came to the nurse's room and stated to her that R4 was not acting like herself and she'd tried sternum rub and [R4] would not wake up. LN S documented she then grabbed the stethoscope, blood pressure cuff, thermometer, glucometer, oxygen saturation (O2) monitor, and went to R4's room with the CNA. She documented she went to R4s room, turned the overhead light on and noted the resident was her WNL [Within Normal Limits] pale skin color no sweating noted eyes mostly closed fluttering. LN S noted she could hear liquid in R4's lungs and attempted but could not obtain R4's O2 saturation reading, attempting on two of R4's left fingers (the statement lacked evidence LN S provided oxygen to R4 at this time). LN S documented Labor breathing noted and said R4's vital signs measured as follows: blood pressure was ,d+[DATE] millimeters of mercury (mmHg), respirations were 28 (BPM - breaths per minute) (normal range for an adult female at rest is ,d+[DATE] BPM), pulse was 88 (beats per minute), and temperature was 98.0 (degrees Fahrenheit). LN S noted she then went to get glucometer strips and left the CNAs in R4's room and came right back to obtain R4's blood sugar, noted as167. LN S documented she used the stethoscope and could hear crackles throughout all lung lobes. LN S further documented that before she attempted to get an O2 sat, she tried sternum rub, shaking resident arms and hollering to her without response (the witness statement continued to lack evidence O2 was provided to R4). LN S documented that during report (coming onto her shift) she had received no information from any staff, prior to 01:15 AM, that anything was going on with R4. LN S documented she had not noticed any issues with R4 during her before bed treatment, when she gave her roommate her breathing treatment (11:30 PM), or removed the roommate's breathing treatment mask at 12:09 AM. LN S noted she went to call the physician at 01:13 AM according to her phone log (and she noted the facility clock showed it was at 01:20 AM) and LN S said she waited three minutes and received a call back from a physician. LN S stated she explained the situation and asked if she could send R4 to the ER, the physician and LN S had a discussion over R4's status, vitals, lung sounds, and breathing, and the physician gave the order to send R4 to the ER. LN S then said, while she was still at the nurse's station after she hung up with the physician, she then called 911, filled out all paperwork, and printed all papers, then ran to the restroom. LN S documented that when she came out of the restroom, she saw a law enforcement officer in the hallway and ran down to them with the printed papers. LN S documented she and the law enforcement officer then went to R4's room and found R4 alone in her room with no staff present. LN S documented that shortly after another responder appeared, they retrieved R4's vital signs, and after reading the resident's O2 saturation level, LN S then asked the responder do you want me to get O2? and the responder stated, yeah that probably be a good idea. LN S then left the room to get O2 tubing then headed to get an O2 tank as EMS arrived so she led EMS to R4's room. EMS assessed and transferred R4 to the gurney and left with R4 at approximately 01:45 AM. LN S documented she then texted the notification to Administrative Staff A, Administrative Nurse B, and Administrative Nurse C. Review of the [DATE] Emergency Department (ED) Nursing Documentation for R4 revealed the following: Physical Assessment as Appears in poor health, Appears toxic, Tense, Severe distress. Skin: Pale, Mottled Respiratory: Left Lung Sounds: Rales/Crackles, Right Lung Sounds: Rales/Crackles Cardiovascular: Edema: 3+ pitting: BLE Neurologic: Level of Consciousness: lethargic, confused; Verbal Response: only sounds/moan/groans (continued on next page)

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F 0695 Level of Harm - Actual harm Residents Affected - Few	Psychiatric: Appearance: Poorly groomed, Disheveled, Malodorous The Patient Progress Notes from the local hospital dated [DATE] at 02:18 AM revealed R4's blood pressure was ,d+[DATE] mmHg, and her pulse was 112 beats per minute. At 02:31 AM R4's blood pressure was , d+[DATE] mmHg, and her pulse was 113 beats per minute. The [DATE] ED Nursing Note regarding R4 on [DATE] included: At 05:17 AM, due to unsuccessful attempts to place a central line, the ED placed an intraosseous (IO, process of injecting medication/fluids/blood products directly into the bone marrow) to R4's right proximal tibia. Review of the labs collected by the local hospital on [DATE] at 02:39 AM revealed the resident had a platelet count of 67 (Low=130 and High=400). R4 had critically high Lactic Acid lab results which measured 3.7 millimoles per liter (mmol/L) (Low=0.70 and High=2.00). Review of the ED Provider Documentation Report for R4 from [DATE] revealed the following: Chief Complaint and Reason for Visit: Acute Respiratory Failure, pneumonia, sepsis, comfort care. Final Impression: Sepsis, left lower lobe pneumonia, pulmonary edema. Quadriplegic. Current Condition: Critical Per the Unites States Centers for Disease Control and Prevention website, dated [DATE], revealed Sepsis is listed as the body's extreme response to an infection. It is a life-threatening medical emergency. The website further stressed the importance of early recognition and timely treatment of sepsis, reassessment of antibiotic needs and prevention of infections. Review of the chest X-Ray Report on [DATE] at 03:06 AM revealed R4 had airspace infiltrate and atelectasis in the left lower lobe of her lung, with no heart failure present. The report noted the left lower lobe infiltrate and atelectasis was mostly new compared to the last exam on [DATE] (12 days prior). The hospital record review revealed R4 died at the hospital on [DATE] at 09:08 AM, approximately 8 hours after staff found her unresponsive. Interview with CNA N on [DATE] at 11:38 PM revealed the nurse's usually do the vital signs and stated she had only taken vitals once. Regarding the [DATE] incident with R4, CNA N stated that R4 did not respond to sternal rub, and she stayed in the room with R4 while CNA P told the nurse. Then, when the LN came back to the room, CNA N and CNA P continued their rounds with residents. CNA N stated by the time they finished the next room, they saw R4 going out with EMS. When asked about R4's earlier in her shift, CNA N stated R4 was actually a very heavy wetter but stated when she checked on R4 she was dry, then she was barely wet like a quarter sized spot in her brief when they changed her at approximately 01:00AM on [DATE]. CNA N confirmed she did not change R4's brief upon arrival on her shift and did not change her brief earlier in her shift because she was dry. CNA N stated she had received report that R4 was a little worse today and not active or talkative. (continued on next page)

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F 0695 Level of Harm - Actual harm Residents Affected - Few	Interview with CNA II on [DATE] at 12:25 AM revealed she received training about a week ago over R4, not outwardly about R4, but just about a lack of oxygen and to put oxygen on the resident if their O2 was down and to ensure things were done properly. CNA II stated she worked with R4 two days prior to the incident and said R4 seemed okay, but you never know. CNA II said CNAs are hands on and they know about changes in residents and to report any change to the nurse. CNA II stated she does take vitals and if a resident displayed abnormal breathing or too high or low of blood pressure, she would report that to the nurse. CNA II stated the CNAs report the color of urine, such as urine color of concern like red or orange, brown/black, orange or anything cloudy, need reported or if the urine is chunky, as she had seen chunky urine. CAN II stated if a resident had a UTI the nurses let the CNA staff know and the CNAs encourage fluids and keep the residents cleaned up. CNA II stated the electronic charting for CNAs only allowed for a checkmark on whether a resident was continent or incontinent. During an interview with Administrative Nurse C on [DATE] at 03:43 AM revealed she knew R4 was being treated for a UTI and tooth infection and stated they were monitoring signs and symptoms. Administrative Nurse C said she thought R4 was getting better, was up for a meal and she was doing okay, so when she found out about the outcome to R4, she was shocked. Administrative Nurse C was told they transferred R4 out to the ED. Administrative Nurse C stated she expected staff to report to a licensed nurse if a resident was not voiding within so many hours and further stated to be honest R4 was always wet no matter what, but sometimes she did not drink as much as other times. Administrative Nurse C expected staff to report any change in condition. Administrative Nurse C stated the CNAs task charting included checkmarks to indicate if a resident voided or not but verified it did not allow for an amount or urine description. Administrative Nurse C said they were pushing fluids for R4, would encourage fluids, expected staff to report if a resident had no output and for staff to follow up. When asked about the lack of output for R4 and EMS transport, Administrative Nurse C stated she was probably dehydrated and not doing too hot, but if a resident was not voiding the staff should have reported that and then said, poor communications. During an interview with Administrative Nurse B on [DATE] at 04:45 AM, revealed R4 was able to get up that morning and barely ate breakfast, but that night Administrative Nurse B received a text stating that R4 was at the hospital with an O2 saturation level of 77%, and the nurse did not call to notify her. Administrative Nurse B said when she came in that morning ([DATE]) she did not even know what happened, had the police not called and told the facility that the vital signs the nurse obtained did not align with what EMS reported or else she would not know that. Administrative Nurse B said if the staff could not get the O2 saturation level on a resident, she expected the staff to put oxygen therapy on, but then said the LN failed to administer O2 to R4. Administrative Nurse B stated she heard that the nurses were not in the room with R4 the whole time and further said she expected the staff to stay in the room with residents in distress. Administrative Nurse B stated she did call the nurse in as the police officer said he was going to press charges. The nurse stated she needed to go to the bathroom real bad, she confirmed she could not get the resident's O2 saturation level, she said she did not put oxygen on the resident, and then confirmed she asked the officer if she should put the oxygen on R4. Administrative Nurse B stated some CNAs had training, and others were not supposed to do sternal rubs on residents. (continued on next page)

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F 0695 Level of Harm - Actual harm Residents Affected - Few	During a telephone interview with Law Enforcement Officer (LEO) GG on [DATE] at 12:44 PM revealed LEO's have responded to lots of calls to the facility over the past almost two years and estimated that number to be over 300 calls. LEO GG noted he was just in the facility recently to address a resident (R4) with difficulty breathing and with wet lungs that you could hear without a stethoscope. LEO GG said the nurse did not remain in R4's room, she left the room and when one of his officers arrived the resident was in her room alone. LEO GG stated he responded to the call as an EMT and said when he arrived CNA P was walking down the hall towards him and he yelled which room? and CNA P continued to walk down the hallway in no hurry, probably about 1 to 3 minutes to wait, and then stated the room, and it was the room she had just come out of. LEO GG stated that was very frustrating as time counts in emergency response situations. LEO GG stated that is a problem and R4 needed positive pressure ventilation to get the water out of her lungs and he could not believe she did not have oxygen on her. LEO GG said after he arrived to the resident's room and they got an oxygen saturation level on her of 77% the LN then asked if she should put oxygen on R4 and he said yes, that is probably a good idea and further stated she should have put that on first thing that is why they do the ABC's, A is Airway. LEO GG said in a very exacerbated tone, to have a nurse look at me and say, 'do you want me to get oxygen?' and to look at R4 I am thinking why are you not bagging her or something? To have the nurse just say she had to pee, I just can't believe it. LEO GG further stated the LN gave him a blood pressure number for R4 that was impossible to be accurate (,d+[DATE]), considering that when they arrived to get the blood pressure, they could not even get a diastolic number and her systolic was in the 60's. LEO GG said it was accurate to say that R4 looked disheveled and was malodorous. LEO GG said if the residents were able to be ambulatory and able to do things, they look good, if they are not and not able to do anything and be vocal, then they were not getting the care. LEO GG said day shift and night shift are not the same and stated night shift were never in the resident's rooms and every time LEO GG went into the facility at night, they were not providing cares. Interview with LEO LL on [DATE] at 04:09 PM revealed she was the responding officer to the [DATE] incident regarding R4. LEO LL stated she had a healthcare background (prior CNA/EMT) and stated she did not agree with how the facility staff handled the incident involving R4, in any way. She stated in any kind of healthcare, if the person is struggling to breathe, you get oxygen on them and it did not even matter what their O2 saturation is, you put oxygen on a person when they are struggling like R4. LEO LL stated when she arrived at the facility the dispatch had told her the room number, but when LEO LL walked in there were not staff in the commons area, no staff in the nurse's station, no staff in the hallway. When LEO LL walked by the room number given to her by dispatch, she thought it was the wrong number since no staff were in the room and the lights were mostly off, so she walked back to the nurse's station and ran into LN S. LEO LL said LN S stated Oh sorry, I had to go pee. LEO LL stated the LN left the patient in order to pee. The resident did not have oxygen on and LN S said it was because LN S could not get an O2 saturation on R4. LEO LL then said the number LN S gave for R4's blood pressure was ,d+[DATE] mmHg (exacerbated sigh), there was no way, as EMS arrived within minutes and said R4's systolic was 44 mmHg and they could not get a diastolic on R4. LEO LL said R4 looked pale, with flushed cheeks, and was not moving, but you could tell R4 was struggling to breathe. LEO LL asked LN S if R4 aspirated on something and LN S said no, but said her lungs sounded wet and full of fluid, and R4 had not responded to sternal rub. LEO LL stated to me the LTC facility needed to increase patient check-just common sense and said the last time they checked on R4 was 11:38 PM

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F 0699 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. 37026 The facility census totaled 31, with 16 included in the sample, and three residents reviewed for Trauma Informed Care. Based on observation, interview, and record review the facility failed to ensure Resident (R) 1 received trauma informed care in accordance with professional standards of practice, accounting for her experiences and preferences, and eliminating or mitigating triggers that could cause re-traumatization when the facility failed to implement person centered interventions for R1 after R3 entered her room, uninvited, attempted to get in her bed, touched her private parts, and the facility failed to recognize the impact to R1's psychosocial wellbeing. Since the incident with R3, facility staff reported R1 has isolated herself more and had changed in her day-to-day behavior and R1 reported she felt punished by the facility, embarrassed at multiple requests for skin checks of her private parts, and had to minimize her existence in her daily life. Findings included: - Review of R1's Electronic Health Record (EHR) revealed the resident had the following diagnoses: paranoid schizophrenia (mental disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought), major depressive disorder (major mood disorder which causes persistent feelings pf sadness), need for assistance with personal care, post-traumatic stress disorder (PTSD- mental disorder characterized by an acute emotional response to a traumatic event or situation involving severe environmental stress), problems related to living in a residential institution, and suicidal ideations. Review of the 01/26/24 Annual Minimum Data Set [MDS] Assessment revealed the resident had a Brief Interview for Mental Status score of 15, which indicated intact cognition. The resident had a total mood severity score of zero, which indicated no depression. The resident reported never feeling lonely or isolated from those around her. The resident had no behaviors present during the observation period. Review of the 04/26/24 Quarterly MDS Assessment revealed the resident had no changes in BIMS or Mood Severity Scores but reported rarely feeling isolated from those around her. The resident used a walker and wheelchair for mobility. Review of the resident's Care Plan revealed the following: 05/20/24 - Stop sign banner applied to the door to prevent unwanted entry. 06/05/24 - Staff would know the resident accused people of doing things at times that could not be possible due to her hallucinations and delusions. Staff would investigate allegations the resident voiced. 06/05/24 - Staff would know the resident had attention seeking behaviors at times and would often report items as missing that were found later, hidden in other areas. She often made false accusations related to her paranoid schizophrenia diagnosis. The resident would become paranoid that her medication had been tampered with or her water was being poisoned. At times she would choose to sit herself on the floor. (continued on next page)

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F 0699 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	06/05/24 - Staff would know the resident had a long-standing belief that a people were following her and had lived in the walls of a facility she lived in prior. The resident further believed the people hurt her neighbors when she lived in the community. The resident did not like to talk about the situation and would have staff check her room to ensure they were not there. Staff were to reassure her that the people were not at the facility if they saw her becoming upset. 06/20/24 - Staff would know the resident had depression, PTSD, and schizoaffective disorder. 07/24/24 - Staff were to know the resident had paranoid delusions and hallucinations starting on 6/19/24, evidenced by frequent false 911 calls, denying staff to provide cares, and fixating on management. 06/20/24 - Staff were to assist the resident with placement to a facility that can meet her psych needs. 06/20/24 - Staff would know the resident did not accept her mental health diagnosis and would become upset if discussed in front of her. Staff were to reassure the resident. 06/20/24 - Staff would know the resident had a geriatric psychiatric practitioner to help with her depression. 06/20/24 - Staff would educate the resident about making unnecessary calls to 911 and how it causes those with legit emergency from being seen in a timely matter. 06/20/24 - Staff were to determine reason for refusal (of cares), document, and return later and try again. The resident's care plan lacked any interventions, which recognized the widespread impact of trauma, signs and symptoms of trauma and/or knowledge of the resident's trauma related to an incident on 05/19/24, the resident voiced as traumatic to her, when R3 entered the resident's room, took R1's belongings, tried to lay in her bed, touched her private parts, and staff assisted the resident out of her room. The care plan further lacked specific staff interventions related to her PTSD diagnosis and possible triggers for re-traumatizing the resident. Review of the 05/19/24 at 05:13 PM Nurse Note revealed the resident reported R3 entered her room, took her belonging, stated R3 tried to lay in her bed, touched her, and was assisted out of her room at the time. The facility notified the resident's provider and family. Review of the 05/19/24 at 07:49 PM Nurse Note revealed staff assessed the resident's skin with no skin issues noted and the resident denied pain. The facility educated staff on the importance of staying one-on-one with R3. The note lacked any evidence the facility assessed the resident's psychosocial wellbeing at the time and/or implemented interventions related to the resident's feeling about the incident with R3. Review of the 05/19/24 at 07:53 PM revealed later R1 reported the resident touched her in her private area while sleeping, but did not say anything till supper time. The note lacked any follow up or assessment of the resident's psychosocial wellbeing. The resident's care plan further lacked any direction to staff related to the incident, which occurred earlier in the day other than putting a stop sign on the resident's door to prevent unwanted entry. (continued on next page)

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F 0699 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the 05/19/24 at 11:04 PM Nurse Note revealed the resident declined a skin assessment at this time. The note lacked any interventions related to assessing the resident's psychosocial wellbeing after the incident with R3. Review of the 05/20/24 at 09:10 AM Administrator Note revealed facility staff offered to send the resident to the emergency room for further treatment and stated she would make an appointment at her primary care provider. The Director of Nursing completed a skin assessment at this time with no new findings. Review of the Social Services Progress Note dated 05/21/24 at 11:39 AM revealed due to R1's allegations against R3 the Social Service Designee (SSD) reached out to the resident's mental health provider to schedule a zoom call for Thursday (05/23/24, five days after R1 reported being touched by R3). The SSD also reached out to Social Worker (SW) HH to see if she would see if it would be possible for her to see R1 twice a week for three weeks. SW HH did not know if time would allow for her visits but would let the facility know. The resident's care plan lacked any evidence the SSD, put any further interventions related to R1's psychosocial wellbeing in place during the time she was waiting to be seen by her mental health practitioner and/or social worker. Review of the 05/21/24 at 01:44 PM Social Service Progress Note revealed the SSD reached out, through email, to the resident's Guardian to get permission for the resident's mental health practitioner to do a Zoom call on Thursday, the facility would wait for the Guardian's response. Review of the 05/21/24 at 03:15 PM Nurse's Note revealed staff attempted to do a skin assessment on the resident twice. The resident voiced she had no skin problem and did not need a skin check. Review of the 05/23/24 at 10:02 AM Social Service Progress Note revealed the SSD set up a Zoom call for the resident with her mental health provider just to make sure she is stable after the incident that occurred earlier in the week. The SSD noted she reached out to the resident's Guardian on 05/21/24 to get permission to have R1 seen, but she never responded to email. The SSD stated the Zoom appointment would stay open until noon incase R1's Guardian responded to the e-mail. The note lacked evidence the facility made any attempt since 05/21/24 to contact R1's Guardian or attempted any other means of communication since the original e-mail, two days prior. The facility further failed to document any attempts to ask the resident how she felt about talking to her mental health provider about the incident that occurred earlier in the week. Review of the 05/27/24 at 01:16 AM Nurse Note revealed the resident's Guardian called the facility to inquire about staff in the resident's room looking at her skin. She asked the staff to leave the resident's room at that time stating she had been traumatized enough. She then asked the staff if they took R1's clothes off to look at her skin or her private parts. The nurse assured the Guardian staff completed the resident's skin assessment earlier in the day and that no one had taken resident' clothes off to look at her private parts. The guardian stated to facility staff I don't want no one talking to her or going in her room unless they get permission from me first. The guardian asked staff to leave the resident alone and stated the staff present just did not listen. The guardian then asked staff again to be called before speaking to R1 and/or performing any cares on the resident. The EHR lacked evidence the facility followed up with R1 about her wishes regarding the guardian's request. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Anew Healthcare Oxford		STREET ADDRESS, CITY, STATE, ZIP CODE: 200 S Ohio St Oxford, KS 67119	

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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 0699 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the 06/07/24 at 11:32 AM Social Service Progress Note revealed the SSD received a call from R1's Guardian stating the resident had some missing items. The SSD and Director of Nursing asked the resident about the missing items with the resident's Guardian on the phone. The resident's Guardian stated she was going to document the conversation as the facility asked the resident what was missing. The resident opened up a box with a lot of tea bags noting some of them were missing. The SSD asked the resident how she kept track of her teas and the resident reported one specific flavor was missing. The SSD pointed out inconsistencies in the resident's report. The writer stated the Guardian interrupted past allegations that the facility felt was resolved. The SSD called the conversation contradicting. The writer asked R1 if she felt safe, and the resident's Guardian told the resident not to answer the question. The facility offered to replace the tea and left the room. The facility further failed to follow up on the resident's concerns of someone being in her room uninvited, unsupervised. Review of the 06/07/24 at 12:07 PM Social Service Progress Note revealed the resident's Guardian never responded to requests to give permission to do a Zoom call with the resident. The 06/07/24 at 11:32 AM (approximately 35 minutes earlier) Social Service Progress Note indicated the SSD spoke to the resident's Guardian on the phone and in the presence of the resident but failed to ask about the Zoom call for the resident. Review of the 06/16/24 at 04:00 AM Incident Note revealed R1 requested for the nurse to check on a rash located under her breast. A Certified Nurse Aide (CNA) accompanied the nurse to the resident's room, but the resident requested the aide (who is also female) to step outside. The CNA explained to the resident that they were informed by management to have two people in her room at all resident visit for safety concerns. The resident was on the phone at the time of the incident and the resident declined the nurse's cares stating she did not need her anymore and further stated her guardian would check on her, so the nurse and CNA left her room. EMS arrived at the facility at 03:35 AM stating the resident called them. EMS later left the facility without the resident when they reported the resident did not want to go to the hospital. Review of the resident's EHR and plan of care lacked any evidence/justification R1 required two staff present during her cares. Review of the 06/19/24 at 01:34 PM Nurse Note revealed the writer went to the resident's room with another staff member to do a skin assessment and the resident refused. Review of the resident's EHR and plan of care lacked any evidence/justification R1 required two staff present during her cares. Review of the 06/26/24 at 10:05 AM Plan of Care Note revealed the resident declined to attend the care plan meeting and her representatives attended via Zoom. One of the resident's representatives asked the facility about the process of discharging the resident and they were told they would have to transfer the resident to the receiving facility and let them know the discharge date once it was decided. The representatives stated they did not receive the thirty-day discharge notice the facility issued until 06/24/24. The Administrator informed the resident's guardian the facility sent it on 06/21/24. The representatives asked the facility about the appeal date and the Administrator stated she would send the appeals process through electronic mail. (continued on next page)

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F 0699 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the 06/26/24 at 01:04 PM Late Entry Administrator Note revealed the facility resent a thirty-day discharge notice and a process to appeal the thirty-day notice. The facility would continue to monitor and support. The resident's care plan lacked any evidence the facility put in interventions related to the resident's involuntary discharge from the facility and/or her psychosocial wellbeing after being told she would have to relocate from her home of five, almost six, years. The resident's care plan continued to lack rationale or direction for the use of two staff when interacting with the resident and continued to lack trauma informed care related to R3 entering R1's room and touching her private parts. Review of 06/29/24 at 09:44 PM Nurse Note revealed the resident refused to allow two staff to monitor her during her shower and only allowed one staff member. Staff notified the administrator. The resident's record and care plan continued to lack a rationale for the use of two staff for cares of the resident, when the resident continued to voice concerns with two staff present for cares. An observation of the resident on 07/31/24 at 04:09 PM during an interview at the same time revealed the resident sat on her bed with her telephone propped on the bed next to her and her Guardian on the line. The resident appeared clean and well groomed. She originally presented with combed hair, was well dressed, and had an overall pleasant affect and offered the surveyors a place to sit in her room. Once the resident began talking about her feelings related to past events, which occurred at the facility her mood became more somber and timid, and her body language began to change. The resident began to have furrowed brows, became teary eyed at times, and her voice fluctuated with frustration/defeat over how the facility handled the incidents with R3. Over the course of the conversation the resident reported she felt she had to diminish her presence for fear of retribution and the surveyor noted the resident's shoulders started to fold toward each other and her hands folded into her lap as she made her size smaller throughout the course of the conversation without realizing it. R1 mentioned there were two staff whom she considered close to her before but were treating me bad because they wanted to be in [Administrative Staff A's] good graces, and that was upsetting. When R1 stated this her eyes welled with tears, and she then looked down toward the floor and was silent. (continued on next page)

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F 0699 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An Interview with R1 and her representative at 04:09 PM on 07/31/24 revealed one day she was not feeling great due to her back pain. She was sleeping and felt a hit in her private parts and described R3 was in her room again. R1 stated R3 would come into the room at times when she was changing her bra and panties. R1 stated at one time R3 was in her room playing in water in her bathroom, she pulled her call light, and when staff responded they could not handle him or get him out. R1 reported at one point staff had to pick R3 up and put him in his chair to get him out of her room. R1 stated she was not going to say anything originally but was upset and wanted the facility to know about it, and it was embarrassing. R1 felt staff were vindictive toward her since the incident occurred and she reported it. She further reported staff told her R3 just climbed in most resident's beds and that he had the mentality of a five-year-old. The resident's representative said she asked the facility what do you mean, he touched my [relationship to the resident] and the facility responded that R3's arm slipped and probably hit the top of R1's thigh. R1 stated she had multiple missing items and felt R3 was responsible for taking the items out of her room. R1 reported after the incident with R3 many staff, at various times asked to do skin checks on the resident (private area) and insisted that she should be seen the hospital. The resident told the nurses and administrative staff she did not need to go to the hospital. She said she was sleeping with covers on at the time of the contact and was sure there was no injury such as bruising or scratching. R1 reported just because there were not bruises or scratches does not mean R3 did not attempt to get into bed with her and did not hit her private areas. (The resident re-enacted how she was laying in her bed at the time of the contact). R1 stated she knew if she went to the hospital with no bruises or scratches it was going to make her look bad. After the incident with R3, R1 stated the facility took all rights away from her. She could no longer have one staff performing cares and even housekeeping staff were required to have two people in the room and she could no longer leave the room if housekeeping was in the room. Two staff now had to watch her shower and it was very upsetting to her. R1 reported she bathed herself in her sink at times because she did not want so many staff watching her shower. R1 reported the floor of the bathroom became slippery when bathing herself and further reported being fearful of a fall as her balance and stamina were not always the best. R1 reported if the facility had been supervising R3, she would not have had to go through this and felt like the facility treated her like she did something wrong. She reported being at the facility for the last five years with no concerns and now she has been issued a discharge notice from the facility. R1 stated she called her Guardian when staff were in the room for her protection and was glad the Guardian was involved in her care. The Guardian expressed she told staff to leave the resident alone unless they called her because of the frequent requests to do skin checks after the incident with R3. The resident reported the facility has further filed an Adult Protective Services report against her Guardian for speaking up for her. The resident voiced fears a new facility might persecute her based on what this facility told them about her. During a phone interview on 08/05/24 at 12:44 PM with Law Enforcement Officer (LEO) GG he reported R1 had an iPad stolen at one time and the facility did replace it, but never did prove who took it from her room. LEO GG reported R3 was not appropriately placed at the facility and noted the facility could not meet his needs. Regarding the battery incident between R1 and R3 he stated staff talked about R3's rights, but LEO GG then stated, what about [R1's] rights?. LEO GG further stated the facility treated R1 like she was the one at fault for the encounter. LEO GG stated the police department was called many times over the last year, they respond to calls at the facility approximately two to three times a week, and approximately only two were not legitimate out of all of the calls for the year. (continued on next page)

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F 0699 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with CNA N on 08/05/24 at 11:38 PM revealed she knew what cares to provide residents by looking at their plans of care. CNA N reported she gave the resident showers, did not have two people present every time and the resident did fine. CNA N reported she has had no concerns with the resident since she started working at the facility. The incident with R3 happened before she started but heard that is why R3 required one-on-one supervision. CNA N reported the resident had no behaviors, delusions, hallucinations, and remembered things they talked about during showers from week to week. CNA N reported having no trauma informed care training and being unaware of any interventions related to trauma for R1. During an interview on 08/06/24 at 12:24 AM with CNA II revealed she heard the resident had called the cops but was not there for the calls. CNA II reported the resident isolates herself. CNA II reported staff were not allowed to go in the resident's room and could only talk to her through the door. She reported she did not try to go in the resident's room too much but did pick up her trash and give her water. CNA II stated she heard the resident's Guardian would incite behaviors from the resident, but she was not there for it and thought it might just be hearsay. CNA II reported having no trauma informed care training and being unaware of any interventions related to trauma for R1. During an interview on 08/06/24 at 03:42 AM with Administrative Staff C revealed the resident kept to herself and did not want staff in her room. Administrative Staff C reported the resident's outlook at the facility had changed over the last year and she had a different outlook, behavior wise. She reported the resident did not seem to be happy at the facility and she tried hard to fix the problem and accommodate resident needs. Administrative Staff C reported she heard the resident's story about R3 changed three times, but the Director of Nursing and Administrator were handling that situation. She reported R1 as more secluded since the incident with R3. Staff offered skin assessments, but R1 refused. Administrative Staff C said R1 was very different than when she started a few years ago and noted the resident has not called 911 recently. During an interview at 04:43 AM on 08/06/24 with Administrative Staff B revealed R3 used to walk around until after the incident with R1. Administrative Staff B reported the resident originally reported R3 tried to get into bed with her but then told her Guardian that R3 touched her private parts. Administrative Staff B reported the resident refused to have skin checks of her private parts. She stated the resident and Guardian wanted to file charges against R3 and since she was not happy corporate said they could help R1 find another facility. R1 reported being happy at the facility until R3 came and Administrative Staff B stated R3 was still a human too. When asked about how the facility handled R1's psychosocial wellbeing and/or history of trauma Administrative Staff B reported they offered for her to go to the ER, but she refused. Administrative Staff B confirmed the facility had not addressed R1's psychosocial impact from the incident with R3, had not addressed potential past trauma's R1 may have had, and not viewed the incident with R3 as traumatic to R1. During an electronic mail interview with R1's Guardian dated 08/07/24 at 10:52 AM revealed the facility had not assessed R1 for any past trauma that she was aware of. R1's Guardian stated the facility listed information that was not correct concerning R1's history in the care plan and noted they did not reach out to her or the resident's other family members for further information. R1's Guardian stated she did not believe that R1 received any visits from SSD L, when R1 was assaulted by a male resident that was uninvited to her room. The Guardian stated she asked the facility to call her when they talked to the resident about the incident with R3 because a major trust factor has been broken. (continued on next page)

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F 0699 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the undated Trauma Informed Care policy revealed the facility would provide care and services which, in addition to meeting professional standards were delivered using approaches which were culturally competent, accounted for experiences and preferences and addressed the needs of trauma survivors by minimizing triggers and/or re-traumatization. The word trauma would be defined as resulting from an event, series of events, or set of circumstances that was experienced by an individual as physically or emotionally harmful or life threatening and that had lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being. A common source of trauma included physical, sexual, mental, and/or emotional abuse (past or present). The facility failed to ensure R1 had trauma informed care in accordance with professional standards of practice, accounting for her experiences and preferences, and eliminating or mitigating triggers that could cause re-traumatization when the facility failed to implement person centered interventions for R1 after R3 entered her room, uninvited, attempted to get in her bed, touched her private parts, and the facility failed to recognize the impact to R1's psychosocial wellbeing. Since the incident with R3, facility staff reported R1 has isolated herself more and had changed in her day-to-day behavior and R1 reported she felt punished by the facility, embarrassed at multiple requests for skin checks of her private parts, and had to minimize her existence in her daily life. On 08/12/24 at 12:20 PM Administrative Staff A was provided the IJ template and notified the facility failed to ensure Resident (R) 1 received trauma informed care in accordance with professional standards of practice, accounting for her experiences and preferences, and eliminating or mitigating triggers that could cause re-traumatization when the facility failed to implement person centered interventions for R1 after R3 entered her room, uninvited, attempted to get in her bed, touched her private parts, and the facility failed to recognize the impact to R1's psychosocial wellbeing, which placed the resident in immediate jeopardy. On 08/12/24 at 03:36 PM the facility provided an acceptable plan for removal of the immediacy, which included the following actions: 1. Staff provided education to all current staff on Trauma Informed Care starting at 01:00 PM on 08/12/24 and all staff would be educated prior to next worked shift. 2. All current staff were educated on how to know preferences utilizing the resident's care plan starting at 01:00 PM on 08/12/24 and all staff would be educated prior to next worked shift. 3. The Care Plan for R1 was updated to identify resident standards/preferences on 08/09/24. 4. Staff would meet with the resident for preferences on how often she would like the facility to check in including date, time and personnel on 08/12/24 5. R1 would be offered to have new trauma informed care assessment and will be completed on 08/12/24, if agreed upon by resident. After verification of the removal of the immediacy on-site on 08/13/24 the deficiency remained at a scope and severity of a G.

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F 0741

Level of Harm - Actual harm

Residents Affected - Few

Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents.

37026

The facility census totaled 31 with 16 included in the sample. Based on observation, interview, and record review the facility failed to ensure sufficient staff who provided direct services to residents with the appropriate competencies and skill sets to provide nursing and related services for Resident (R) 11, who was diagnosed with a mental disorder, and ensure he received the appropriate treatment and services to attain the highest practicable mental and psychosocial well-being, when the resident became notably more tearful over a few weeks, voiced auditory and visual hallucinations, and reported he had voices telling him to doing something naughty to other residents.

Findings included:

- Review of the resident's Electronic Health Record (EHR) revealed the resident had major depressive disorder (major mood disorder which causes persistent feelings pf sadness) and mood disorder (category of mental health problems, feelings of sadness, helplessness, guilt, wanting to die were more intense and persistent than what may normally be felt from time to time).

Review of the 05/17/24 Modification of Quarterly Minimum Data Set Assessment revealed the resident had a Brief Interview for Mental Status score of 15, which indicated intact cognition. The resident had a Total Mood Severity Score of 00, which indicated no depression. The resident reported he felt isolated, rarely. The resident had no behaviors at the time of the assessment. The resident required antipsychotic, antidepressant, and diuretic medications. The resident required antipsychotic medication on a routine basis and the facility did not attempt a gradual dose reduction of the resident's antipsychotic.

Review of the resident's Care Plan revealed:

08/05/22 - Staff would know the resident had a long history of severe depression with psychosis, anxiety, history of drug and alcohol abuse, history of suicidal ideations and history of suicide attempts. The resident had multiple inpatient psychiatric stays. The resident had episodes of being manipulative and non-compliant.

08/02/22 - Staff would administer medications as ordered and monitor/document for side effects and effectiveness.

08/05/22 - Staff would discuss the resident's behavior with him, as it occurred, to help redirect him if needed, explain outcomes that may occur due to his behaviors, and re-educate as needed (such as: educating about noncompliance with doctor/cardiology orders or recommendations).

08/05/22 - Staff would encourage the resident to talk about his feelings if he was upset or mad about something.

08/05/22 - Staff would know the resident may manipulate verbiage to what he felt would best benefit him at times.

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F 0741 Level of Harm - Actual harm Residents Affected - Few	11/15/2023 - Psychiatry services were in place as needed/ordered. The resident was seen by a mental health provider and attended talk therapy. 11/15/2023 - Staff would encourage the use of non-pharmacological interventions to decrease symptoms of depression such as: encourage the resident to participate in group activities that he enjoys (bingo, karaoke, watching tv, movies, sports with peers), listening to music on his phone, and sharing his music with others. Staff would encourage the resident to talk about his feelings and let him express feelings of paranoia while reassuring him that his feelings are important while trying to identify triggers and remove them or assist the resident with avoiding them if able. The resident's care plan lacked any updates as of 08/07/24 related to the resident having increased tearfulness and statements indicating he felt more depressed. The care plan lacked any direction to staff to monitor the resident for increased auditory and visual hallucinations, which included expressions he had thoughts to do naughty things with other residents per R11 on 07/14/24. R11's care plan further lacked any instruction to staff to assist the resident to go outside more per his request and/or encouraging the resident to walk to dine per his desire to ambulate more. Review of the Orders tab in the EHR revealed the resident had the following physician's orders: 05/25/24 - Risperidone (antipsychotic medication) oral tablet 1 mg - staff would give 1 tablet by mouth two times a day related to major depressive disorder, severe with psychotic features. 06/25/24 - Cymbalta (antidepressant medication) oral capsule delayed release particles 60 milligrams (mg) - staff would give the resident one capsule by mouth one time a day for mood disorder. 05/25/24 - Staff were to monitor the resident for the following behaviors: itching, picking at skin, restlessness, agitation, hitting, increase in complaints, biting, kicking, spitting, foul language, elopement, stealing, delusions, hallucinations, psychosis, aggression, refusal of care every shift. The monitoring lacked increased tearfulness and thoughts of doing something naughty to other residents. The resident's orders lacked monitoring for increased symptoms of depression. Review of Behaviors under the Task lacked any documentation of the resident's tearfulness, reports of depression, reports of auditory and visual hallucinations, and having thoughts of doing something naughty with other residents. Review of the 06/25/24 at 12:31 AM Nurse Note revealed the resident's physician increased his Cymbalta to 60 mg daily. Review of the 07/12/24 at 12:15 PM Social Service Progress Note revealed Gero-psych saw the resident on 07/07/24. Review of the 07/12/24 at 12:51PM Social Service Progress Note revealed the resident refused to go to an alcoholic anonymous (AA) meeting, he said he was going to go then changed his mind. The note lacked any follow up or education of outcomes related to missing the meeting and/or re-education on the importance of the meetings. (continued on next page)

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F 0741 Level of Harm - Actual harm Residents Affected - Few	Review of the 07/14/24 at 02:41 PM Nurse Note revealed a visiting social worker talked to the resident and the social worker expressed concerns for the resident's mental health. The resident admitted to hearing loud voices in his head as the resident cried. The resident expressed that he was not sleeping well, and it appeared to be worse on sleepless nights. The voices told the resident to do naughty things with other residents, but he voiced strongly that he would not and had no plans or actions to do such things. The resident had no active verbalization of suicidal or homicidal thoughts but did have indoor auditory and visual hallucinations at the time. The resident spent a majority of his day at the kitchen table watching his phone. The resident verbally stated spending more time outside as something he really wanted to do and noted that helped with his depression. The nurse and social worker validated all of the resident's concerns and went over the next steps of getting ahold of the resident's mental health provider to see him next week and educated the resident to try to remember that the voices/visual auditory symptoms were not real and if he needed to talk to someone to get a nurse for any kind of support needed. Nursing staff were educated to closely monitor the resident. The resident remained very tearful but went outside for a cigarette and to get some fresh air. The resident stated the concerns he reported had been going on for a few weeks, but he stated he had not voiced any concerns to any of the nursing staff at the facility and had appeared cheerful and laughing with jokes. The note lacked evidence staff notified the resident's physician or mental health provider of his increased tearfulness, expressions of doing naughty things, and/or auditory and visual hallucinations. Review of the Nurse Notes from 07/14/24 at 02:41 PM to 07/15/24 at 09:17 PM (late entry note) lacked any documentation that facility staff monitored the resident more closely for auditory and visual hallucinations, increased tearfulness, or expressions of doing naughty things. Review of the 07/15/24 at 09:17 AM (entered three days later on 07/18/24 at 09:19 AM) Social Services Progress Note revealed the Social Services Designee (SSD) sent an e-mail to the resident's mental health provider to request a medication review since he told a nurse he was hearing voices that were telling him to do naughty things. Review of the Nurse Notes from 07/15/24 to 07/18/24 lacked any documentation that facility staff monitored the resident more closely for auditory and visual hallucinations, increased tearfulness, or expressions of doing naughty things to other residents. The record further lacked evidence the resident's mental health provider responded to do a medication review or assess the resident's recently voiced concerns related to his mental health. Review of the 07/18/24 Physician Extender Progress Note revealed the Physician Extender saw the resident regarding weight gain and a refill of his pain medications. The note lacked documentation the Physician Extender saw the resident for his new onset auditory and visual hallucinations and/or increased tearfulness. Review of the 07/19/24 at 08:58 AM Inter-Disciplinary Team Meeting Notes revealed the resident had new or worsening behaviors since the last review. Staff reviewed the resident's care plan and updated it as needed. The facility notified the resident's medical provider of his change in condition. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Anew Healthcare Oxford		STREET ADDRESS, CITY, STATE, ZIP CODE 200 S Ohio St Oxford, KS 67119	

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 0741 Level of Harm - Actual harm Residents Affected - Few	Review of the 07/19/24 at 02:41 PM Social Service Progress Note revealed R11 agreed to do an AA meeting via virtual meeting platform and was going to attend this day, but there was a miscommunication about the time. R11 thought he could log on to the meeting at any time. The writer informed the resident of the times and days the meetings were held. The SSD would make sure the resident had a schedule and times of meetings, along with providing the resident with the virtual meeting platform ID, if he wanted to get into the meeting on his phone. Review of the resident's nurse's notes for 07/20/24, 07/21/24, 07/22/24, 07/23/24, and 07/24/24 lacked any documentation that facility staff monitored the resident more closely for auditory and visual hallucinations, increased tearfulness, or expressions of doing naughty things. Review of the 07/25/24 at 08:50 AM Late Entry Social Service Progress Note revealed the resident preferred not to attend AA meetings outside of the facility. The SSD asked R11 if he wanted to attend meetings on virtual meeting platform, and he stated yes (after agreeing to do the meetings via virtual meeting platform on 07/19/24). The resident downloaded virtual meeting platform in front of SSD (6 days after the original note saying the SSD would assist the resident getting an AA meeting on the phone). The writer stated the resident had a copy of the virtual meeting ID, password, and times of meetings for future references. The note lacked any documentation that facility staff monitored the resident more closely for auditory and visual hallucinations, increased tearfulness, or expressions of doing naughty things. The note further lacked any follow up with the resident's mental health provider. Review of the 07/25/24 at 03:39 PM Social Service Progress Note revealed staff informed the writer R11 was crying and stated he felt depressed. The writer called the resident's mental health provider and left a voicemail letting her know she emailed R11's medication list last week and the facility tried to get hold of her. Review of the resident's nurse's notes for 07/26/24, 07/27/24, 07/28/24, 07/29/24, 07/30/24, 07/31/24, 08/01/24, and 08/02/24 lacked any documentation that facility staff monitored the resident more closely for auditory and visual hallucinations, increased tearfulness, or expressions of doing naughty things to other residents. Review of the 08/03/24 at 05:09 PM Nurse Note revealed the resident was tearful during the shift. The resident stated he felt depressed and voiced his ex-wife has not been talking with him and he missed his family. Staff encouraged the resident to keep himself positive and educated him to speak to any nursing staff at any time if he needed to and noted they would be happy to sit and speak with him about his feelings. The resident stated he felt better. The nurse writer educated staff to monitor the resident frequently for any more depressive episodes. The resident denied any self-harm or feelings/thoughts of suicide and/or of hurting others. Review of the resident's nurse's notes for 08/04/24, 08/05/24, 08/06/24, and 08/07/24 lacked any documentation that facility staff monitored the resident more closely for auditory and visual hallucinations, increased tearfulness, or expressions of doing naughty things. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175450	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/13/2024
NAME OF PROVIDER OR SUPPLIER Anew Healthcare Oxford		STREET ADDRESS, CITY, STATE, ZIP CODE 200 S Ohio St Oxford, KS 67119	

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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 0741 Level of Harm - Actual harm Residents Affected - Few	Observations of the resident at various times on 08/05/24 from 11:17 PM to 08/06/24 after 06:00 AM revealed the resident sat in the dining area of the facility and slept off and on with his head extended back, headphones in place, and phone in hand or placed on the dining table. During an interview with the resident as the surveyors walked through the building, he reported he had children and a grandchild who lived in the state and an adult child who moved to another state, that he missed. The resident was pleasant and had a proud disposition while talking about his children and grandchild, but appeared sad as he said he missed them. During an interview with Certified Nurse Aide (CNA) N on 08/05/24 at 11:38 PM revealed the resident was more tearful recently. CNA N stated she prompted him to go to bed and put his feet up and yesterday he immediately started crying. CNA N stated the resident saw his family yesterday and she reported she felt sad for him and did not mean to make him sad when he became tearful. Yesterday she stated the resident talked to her and they kind of cried it out. If a resident was more tearful or showing signs of depression, she would offer support to the resident and comfort them. CNA N would also report it to the nurse. Review of the resident's record for 08/04/24 and 08/05/24 lacked any documentation regarding the resident's tearfulness CNA N reported. During an interview on 08/06/24 at 12:24 AM with CNA II revealed she talked to the resident for an hour every night she worked. CNA II stated the resident was more tearful lately and had more signs of depression for the last month or two months. CNA II reported she asked the resident about talking to a therapist and he said he talked to his therapist a few days ago and was able to see his family so was starting to feel better. During an interview on 08/06/24 at 03:42 AM with LN C revealed for R11's mental health concerns he has a therapist that he enjoys as he gets his one-on-one time with her. He has a mental health provider, but she only gets to come twice a month and they are monitoring his mental health. LN C further reported the resident is depressed and he is not walking as much as he would like to be, so they try to do a walk to dine program with the resident. LN C expected the resident's care plan to be updated with the types of symptoms the resident was having. During an interview at 04:43 AM on 08/06/24 with Administrative Nurse D revealed the resident had increased tearfulness. She expected staff to do one-on-one with a resident having mental health concerns and staff were to call her right away. She reported the resident saw his mental health provider about a month ago. Administrative Nurse D expected staff to offer psychosocial support to residents and offer AA or NA, especially during a mental health crisis. Review of the undated facility policy Social Services, Provision of . revealed the facility provided medically related social services to assist each resident to attain or maintain he/her highest practicable physical, mental, or psychosocial well-being. The facility failed to ensure sufficient staff who provided direct services to residents with the appropriate competencies and skill sets to provide nursing and related services for R 11, who was diagnosed with a mental disorder, and failed to ensure he received the appropriate treatment and services to attain the highest practicable mental and psychosocial well-being, when the resident became notably more tearful over a few weeks, voiced auditory and visual hallucinations, and reported he had voices telling him to doing something naughty to other residents.

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	175450	A. Building B. Wing	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Anew Healthcare Oxford	200 S Ohio St Oxford, KS 67119

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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 0742 Level of Harm - Actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. 37026 The facility census totaled 31 with 16 included in the sample. Based on observation, interview, and record review the facility failed to ensure Resident (R) 11, who was diagnosed with a mental disorder, received the appropriate treatment and services to attain the highest practicable mental and psychosocial well-being, when the resident became notably more tearful over a few weeks, voiced auditory and visual hallucinations, and reported he had voices telling him to doing something naughty to other residents. Findings included: - Review of the resident's Electronic Health Record (EHR) revealed the resident had major depressive disorder (major mood disorder which causes persistent feelings pf sadness) and mood disorder (category of mental health problems, feelings of sadness, helplessness, guilt, wanting to die were more intense and persistent than what may normally be felt from time to time). Review of the 05/17/24 Modification of Quarterly Minimum Data Set Assessment revealed the resident had a Brief Interview for Mental Status score of 15, which indicated intact cognition. The resident had a Total Mood Severity Score of 00, which indicated no depression. The resident reported he felt isolated, rarely. The resident had no behaviors at the time of the assessment. The resident required antipsychotic, antidepressant, and diuretic medications. The resident required antipsychotic medication on a routine basis and the facility did not attempt a gradual dose reduction of the resident's antipsychotic. Review of the resident's Care Plan revealed: 08/05/22 - Staff would know the resident had a long history of severe depression with psychosis, anxiety, history of drug and alcohol abuse, history of suicidal ideations and history of suicide attempts. The resident had multiple inpatient psychiatric stays. The resident had episodes of being manipulative and non-compliant. 08/02/22 - Staff would administer medications as ordered and monitor/document for side effects and effectiveness. 08/05/22 - Staff would discuss the resident's behavior with him, as it occurred, to help redirect him if needed, explain outcomes that may occur due to his behaviors, and re-educate as needed (such as: educating about noncompliance with doctor/cardiology orders or recommendations). 08/05/22 - Staff would encourage the resident to talk about his feelings if he was upset or mad about something. 08/05/22 - Staff would know the resident may manipulate verbiage to what he felt would best benefit him at times. (continued on next page)

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F 0742 Level of Harm - Actual harm Residents Affected - Few	11/15/2023 - Psychiatry services were in place as needed/ordered. The resident was seen by a mental health provider and attended talk therapy. 11/15/2023 - Staff would encourage the use of non-pharmacological interventions to decrease symptoms of depression such as: encourage the resident to participate in group activities that he enjoys (bingo, karaoke, watching tv, movies, sports with peers), listening to music on his phone, and sharing his music with others. Staff would encourage the resident to talk about his feelings and let him express feelings of paranoia while reassuring him that his feelings are important while trying to identify triggers and remove them or assist the resident with avoiding them if able. The resident's care plan lacked any updates as of 08/07/24 related to the resident having increased tearfulness and statements indicating he felt more depressed. The care plan lacked any direction to staff to monitor the resident for increased auditory and visual hallucinations, which included expressions he had thoughts to do naughty things with other residents per R11 on 07/14/24. R11's care plan further lacked any instruction to staff to assist the resident to go outside more per his request and/or encouraging the resident to walk to dine per his desire to ambulate more. Review of the Orders tab in the EHR revealed the resident had the following physician's orders: 05/25/24 - Risperidone (antipsychotic medication) oral tablet 1 mg - staff would give 1 tablet by mouth two times a day related to major depressive disorder, severe with psychotic features. 06/25/24 - Cymbalta (antidepressant medication) oral capsule delayed release particles 60 milligrams (mg) - staff would give the resident one capsule by mouth one time a day for mood disorder. 05/25/24 - Staff were to monitor the resident for the following behaviors: itching, picking at skin, restlessness, agitation, hitting, increase in complaints, biting, kicking, spitting, foul language, elopement, stealing, delusions, hallucinations, psychosis, aggression, refusal of care every shift. The monitoring lacked increased tearfulness and thoughts of doing something naughty to other residents. The resident's orders lacked monitoring for increased symptoms of depression. Review of Behaviors under the Task lacked any documentation of the resident's tearfulness, reports of depression, reports of auditory and visual hallucinations, and having thoughts of doing something naughty with other residents. Review of the 06/25/24 at 12:31 AM Nurse Note revealed the resident's physician increased his Cymbalta to 60 mg daily. Review of the 07/12/24 at 12:15 PM Social Service Progress Note revealed Gero-psych saw the resident on 07/07/24. Review of the 07/12/24 at 12:51PM Social Service Progress Note revealed the resident refused to go to an alcoholic anonymous (AA) meeting, he said he was going to go then changed his mind. The note lacked any follow up or education of outcomes related to missing the meeting and/or re-education on the importance of the meetings. (continued on next page)

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F 0742

Level of Harm - Actual harm

Residents Affected - Few

Review of the 07/14/24 at 02:41 PM Nurse Note revealed a visiting social worker talked to the resident and the social worker expressed concerns for the resident's mental health. The resident admitted to hearing loud voices in his head as the resident cried. The resident expressed that he was not sleeping well, and it appeared to be worse on sleepless nights. The voices told the resident to do naughty things with other residents, but he voiced strongly that he would not and had no plans or actions to do such things. The resident had no active verbalization of suicidal or homicidal thoughts but did have indoor auditory and visual hallucinations at the time. The resident spent a majority of his day at the kitchen table watching his phone. The resident verbally stated spending more time outside as something he really wanted to do and noted that helped with his depression. The nurse and social worker validated all of the resident's concerns and went over the next steps of getting ahold of the resident's mental health provider to see him next week and educated the resident to try to remember that the voices/visual auditory symptoms were not real and if he needed to talk to someone to get a nurse for any kind of support needed. Nursing staff were educated to closely monitor the resident. The resident remained very tearful but went outside for a cigarette and to get some fresh air. The resident stated the concerns he reported had been going on for a few weeks, but he stated he had not voiced any concerns to any of the nursing staff at the facility and had appeared cheerful and laughing with jokes. The note lacked evidence staff notified the resident's physician or mental health provider of his increased tearfulness, expressions of doing naughty things, and/or auditory and visual hallucinations.

Review of the Nurse Notes from 07/14/24 at 02:41 PM to 07/15/24 at 09:17 PM (late entry note) lacked any documentation that facility staff monitored the resident more closely for auditory and visual hallucinations, increased tearfulness, or expressions of doing naughty things.

Review of the 07/15/24 at 09:17 AM (entered three days later on 07/18/24 at 09:19 AM) Social Services Progress Note revealed the Social Services Designee (SSD) sent an e-mail to the resident's mental health provider to request a medication review since he told a nurse he was hearing voices that were telling him to do naughty things.

Review of the Nurse Notes from 07/15/24 to 07/18/24 lacked any documentation that facility staff monitored the resident more closely for auditory and visual hallucinations, increased tearfulness, or expressions of doing naughty things to other residents. The record further lacked evidence the resident's mental health provider responded to do a medication review or assess the resident's recently voiced concerns related to his mental health.

Review of the 07/18/24 Physician Extender Progress Note revealed the Physician Extender saw the resident regarding weight gain and a refill of his pain medications. The note lacked documentation the Physician Extender saw the resident for his new onset auditory and visual hallucinations and/or increased tearfulness.

Review of the 07/19/24 at 08:58 AM Inter-Disciplinary Team Meeting Notes revealed the resident had new or worsening behaviors since the last review. Staff reviewed the resident's care plan and updated it as needed. The facility notified the resident's medical provider of his change in condition.

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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 0742 Level of Harm - Actual harm Residents Affected - Few	Review of the 07/19/24 at 02:41 PM Social Service Progress Note revealed R11 agreed to do an AA meeting via virtual meeting platform and was going to attend this day, but there was a miscommunication about the time. R11 thought he could log on to the meeting at any time. The writer informed the resident of the times and days the meetings were held. The SSD would make sure the resident had a schedule and times of meetings, along with providing the resident with the virtual meeting platform ID, if he wanted to get into the meeting on his phone. Review of the resident's nurse's notes for 07/20/24, 07/21/24, 07/22/24, 07/23/24, and 07/24/24 lacked any documentation that facility staff monitored the resident more closely for auditory and visual hallucinations, increased tearfulness, or expressions of doing naughty things. Review of the 07/25/24 at 08:50 AM Late Entry Social Service Progress Note revealed the resident preferred not to attend AA meetings outside of the facility. The SSD asked R11 if he wanted to attend meetings on virtual meeting platform, and he stated yes (after agreeing to do the meetings via virtual meeting platform on 07/19/24). The resident downloaded virtual meeting platform in front of SSD (6 days after the original note saying the SSD would assist the resident getting an AA meeting on the phone). The writer stated the resident had a copy of the virtual meeting ID, password, and times of meetings for future references. The note lacked any documentation that facility staff monitored the resident more closely for auditory and visual hallucinations, increased tearfulness, or expressions of doing naughty things. The note further lacked any follow up with the resident's mental health provider. Review of the 07/25/24 at 03:39 PM Social Service Progress Note revealed staff informed the writer R11 was crying and stated he felt depressed. The writer called the resident's mental health provider and left a voicemail letting her know she emailed R11's medication list last week and the facility tried to get hold of her. Review of the resident's nurse's notes for 07/26/24, 07/27/24, 07/28/24, 07/29/24, 07/30/24, 07/31/24, 08/01/24, and 08/02/24 lacked any documentation that facility staff monitored the resident more closely for auditory and visual hallucinations, increased tearfulness, or expressions of doing naughty things to other residents. Review of the 08/03/24 at 05:09 PM Nurse Note revealed the resident was tearful during the shift. The resident stated he felt depressed and voiced his ex-wife has not been talking with him and he missed his family. Staff encouraged the resident to keep himself positive and educated him to speak to any nursing staff at any time if he needed to and noted they would be happy to sit and speak with him about his feelings. The resident stated he felt better. The nurse writer educated staff to monitor the resident frequently for any more depressive episodes. The resident denied any self-harm or feelings/thoughts of suicide and/or of hurting others. Review of the resident's nurse's notes for 08/04/24, 08/05/24, 08/06/24, and 08/07/24 lacked any documentation that facility staff monitored the resident more closely for auditory and visual hallucinations, increased tearfulness, or expressions of doing naughty things. (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 0742 Level of Harm - Actual harm Residents Affected - Few	Observations of the resident at various times on 08/05/24 from 11:17 PM to 08/06/24 after 06:00 AM revealed the resident sat in the dining area of the facility and slept off and on with his head extended back, headphones in place, and phone in hand or placed on the dining table. During an interview with the resident as the surveyors walked through the building, he reported he had children and a grandchild who lived in the state and an adult child who moved to another state, that he missed. The resident was pleasant and had a proud disposition while talking about his children and grandchild, but appeared sad as he said he missed them. During an interview with Certified Nurse Aide (CNA) N on 08/05/24 at 11:38 PM revealed the resident was more tearful recently. CNA N stated she prompted him to go to bed and put his feet up and yesterday he immediately started crying. CNA N stated the resident saw his family yesterday and she reported she felt sad for him and did not mean to make him sad when he became tearful. Yesterday she stated the resident talked to her and they kind of cried it out. If a resident was more tearful or showing signs of depression, she would offer support to the resident and comfort them. CNA N would also report it to the nurse. Review of the resident's record for 08/04/24 and 08/05/24 lacked any documentation regarding the resident's tearfulness CNA N reported. During an interview on 08/06/24 at 12:24 AM with CNA II revealed she talked to the resident for an hour every night she worked. CNA II stated the resident was more tearful lately and had more signs of depression for the last month or two months. CNA II reported she asked the resident about talking to a therapist and he said he talked to his therapist a few days ago and was able to see his family so was starting to feel better. During an interview on 08/06/24 at 03:42 AM with LN C revealed for R11's mental health concerns he has a therapist that he enjoys as he gets his one-on-one time with her. He has a mental health provider, but she only gets to come twice a month and they are monitoring his mental health. LN C further reported the resident is depressed and he is not walking as much as he would like to be, so they try to do a walk to dine program with the resident. LN C expected the resident's care plan to be updated with the types of symptoms the resident was having. During an interview at 04:43 AM on 08/06/24 with Administrative Nurse D revealed the resident had increased tearfulness. She expected staff to do one-on-one with a resident having mental health concerns and staff were to call her right away. She reported the resident saw his mental health provider about a month ago. Administrative Nurse D expected staff to offer psychosocial support to residents and offer AA or NA, especially during a mental health crisis. Review of the undated facility policy Social Services, Provision of . revealed the facility provided medically related social services to assist each resident to attain or maintain he/her highest practicable physical, mental, or psychosocial well-being. The facility failed to ensure R11, who was diagnosed with a mental disorder, received the appropriate treatment and services to attain the highest practicable mental and psychosocial well-being when the resident became more tearful over a few weeks, voiced auditory and visual hallucinations, and told staff he had voices telling him to doing something naughty to other residents.

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NAME OF PROVIDER OR SUPPLIER: Anew Healthcare Oxford		STREET ADDRESS, CITY, STATE, ZIP CODE: 200 S Ohio St Oxford, KS 67119	

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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 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. 37026 The facility census totaled 31 with 16 residents included in the sample. Based on observation, interview and record review the facility failed to provide medically related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. The facility failed to provide medically-related social services to serve as an advocate in asserting Resident (R)1's rights as a resident and further failed to meet the needs of R1 when she began showing signs of distress after a traumatic event and through the transition process with her. Findings included: - Review of R1's Electronic Health Record (EHR) revealed the resident had the following diagnoses: paranoid schizophrenia (mental disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought), major depressive disorder (major mood disorder which causes persistent feelings of sadness), need for assistance with personal care, post-traumatic stress disorder (PTSD- mental disorder characterized by an acute emotional response to a traumatic event or situation involving severe environmental stress), problems related to living in a residential institution, and suicidal ideations. Review of the 01/26/24 Annual Minimum Data Set [MDS] Assessment revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The resident had a total mood severity score of zero, which indicated no depression. The resident reported never feeling lonely or isolated from those around her. The resident had no behaviors present during the observation period. Review of the 04/26/24 Quarterly MDS Assessment revealed the resident had no changes in BIMS or Mood Severity Scores but reported rarely feeling isolated from those around her. The resident used a walker and wheelchair for mobility. The resident's care plan lacked evidence of R1's wishes related to the representative/guardian being present during some interactions with staff. The resident's care plan lacked evidence of an individualized discharge plan with the resident after the facility initiated an involuntary transfer of the resident. The resident's care plan lacked evidence the facility provided medically related social services to develop a person-centered care plan for R1 when R3 came into her room, touched her private areas and R1 had a change in behaviors after the stressful event. Review of the 05/19/24 Nurse Notes revealed R1 reported R3 entered her room and touched her private area. Review of the resident's record lacked evidence the facility provided R1 with medically related social services to help meet the needs of the resident who was coping with a stressful/traumatic event. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Social Services Progress Note dated 05/21/24 at 11:39 AM revealed, due to R1's allegations against R3, the Social Service Designee (SSD) reached out to the resident's mental health provider to schedule a zoom call for Thursday (05/23/24, five days after R1 reported being touched by R3). The SSD also reached out to Social Worker (SW) HH to see if it would be possible for her to meet with R1 twice a week for three weeks. SW HH did not know if time would allow for her visits but would let the facility know. The resident's care plan/EHR lacked any evidence the facility's SSD, put any further person-centered interventions in place related to R1's psychosocial wellbeing during the time she was waiting to be seen by her mental health practitioner and/or social worker regarding the incident with R3 or as she coped with the feelings related to the incident with R3. Review of the 05/23/24 at 10:02 AM Social Service Progress Note revealed the SSD set up a Zoom call for the resident with her mental health provider just to make sure she is stable after the incident that occurred earlier in the week. The SSD noted she reached out to the resident's Guardian on 05/21/24 to get permission to have R1 seen, but she never responded to email (the note lacked evidence the SSD spoke to the resident at the time). The SSD stated the Zoom appointment would stay open until noon incase R1's Guardian responded to the e-mail. The note lacked evidence the facility made any attempt since 05/21/24 to contact R1's Guardian or attempted any other means of communication since the original e-mail, two days prior. The resident's care plan/EHR lacked any evidence the facility's SSD, put any further person-centered interventions in place related to R1's psychosocial wellbeing during the time she was waiting to be seen by her mental health practitioner and/or social worker regarding the incident with R3. Review of the 05/27/24 at 01:16 AM Nurse Note revealed the resident's Guardian asked staff to be call her (the Guardian) before speaking to R1 and/or performing any cares on the resident. The EHR lacked evidence the facility followed up with R1 about her wishes regarding the Guardian's request and or documentation noting the facility offered medically related social services to the resident by advocating for her wishes. Review of the 06/07/24 at 11:32 AM Social Service Progress Note revealed the SSD received a call from R1's Guardian stating the resident had some missing items. The SSD and Director of Nursing asked the resident about the missing items with the resident's Guardian on the phone. The resident's Guardian stated she was going to document the conversation as the facility asked the resident what was missing. The resident opened up a box with a lot of tea bags noting some of them were missing. The SSD asked the resident how she kept track of her teas and the resident reported one specific flavor was missing. The SSD pointed out inconsistencies in the resident's report. The writer stated the Guardian interrupted with past allegations that the facility felt was resolved. The SSD called the conversation contradicting. The writer asked R1 if she felt safe and the resident's Guardian told the resident not to answer the question. The facility offered to replace the tea and left the room. Review of the facility Grievance Log for 06/07/24 lacked evidence the SSD documented R1's grievance about missing teas although the facility reported the incident to the State Agency Abuse, Neglect, and Exploitation hotline. Review of the 06/07/24 at 12:07 PM Social Service Progress Note revealed the resident's Guardian never responded to requests to give permission to do a Zoom call with the resident. The 06/07/24 at 11:32 AM (approximately 35 minutes earlier) Social Service Progress Note indicated the SSD spoke to the resident's Guardian on the phone and in the presence of the resident but failed to ask about the Zoom call for the resident. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Anew Healthcare Oxford		STREET ADDRESS, CITY, STATE, ZIP CODE: 200 S Ohio St Oxford, KS 67119	

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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 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the 06/16/24 at 04:00 AM Incident Note revealed R1 requested for the nurse to check on a rash located under her breast. A Certified Nurse Aide (CNA) accompanied the nurse to the resident's room, but the resident requested the aide (who is also female) to step outside. The CNA explained to the resident that they were informed by management to have two people in her room at all resident visit for safety concerns. Review of the resident's EHR and plan of care lacked any evidence R1 required two staff present during her cares or follow up with the resident and/or guardian about the change in the resident's care. The resident's record further lacked evidence the facility provided medically related social services to assist the resident to advocate for her right to have one staff providing cares per her wishes. Review of the 06/19/24 at 01:34 PM Nurse Note revealed the writer went to the resident's room with another staff member to do a skin assessment and the resident refused. Review of the resident's EHR and plan of care lacked any evidence R1 required two staff present during her cares or follow up with the resident and/or guardian about the change in the resident's care. The resident's record further lacked evidence the facility provided medically related social services to assist the resident to advocate for her right to have one staff providing cares per her wishes. Review of the 06/26/24 at 10:05 AM Plan of Care Note revealed the resident declined to attend the care plan meeting and her representatives attended via Zoom. One of the resident's representatives asked the facility about the process of discharging the resident and they were told they would have to transfer the resident to the receiving facility and let them know the discharge date once it was decided. The representatives stated they did not receive the thirty-day discharge notice the facility issued until 06/24/24 (two days prior). The Administrator informed the resident's guardian the facility sent it on 06/21/24. The representatives asked the facility about the appeal date and the Administrator stated she would send the appeals process through electronic mail. The note lacked evidence the facility offered the assistance of their SSD through the transition process for R1. Review of the facility provided Discharge Letter for R1 dated 06/21/24 revealed the facility would discharge the resident thirty days from the date of the letter as necessary for the resident's welfare and noted the resident's needs could not be met in the home because of the action and inaction of the resident's guardian. The letter stated the facility was unable to communicate with the resident without guardian present per guardians request. The letter further stated the resident's guardian is not available by phone 24/7. The letter stated the resident's guardian called the local police on facility administration and wanted to press harassment charges for an unknown reason to the facility and law enforcement. Review of the resident's care plan and EHR lacked evidence the facility provided social services to assist the resident through her transition of care after they issued the 06/21/24 discharge letter to R1. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of 06/29/24 at 09:44 PM Nurse Note revealed the resident refused to allow two staff to monitor her during her shower and only allowed one staff member. Staff notified the administrator. The resident's EHR and care plan continued to lack person centered interventions related to the use of two staff for cares for R1. The resident's record lacked evidence the SSD assisted the resident in assertion of her right to only have one staff present for cares. Review of the facility provided Discharge Letter for R1 dated 07/12/24 revealed the facility would discharge the resident thirty days from the date of the letter as necessary for the resident's welfare and noted the resident's needs could not be met in the home because of the action and inaction of the resident's guardian. The letter lacked any further documentation regarding the guardian as identified in the 06/21/24 letter. Review of the resident's care plan and EHR lacked evidence the facility provided social services to assist the resident through her transition of care after they issued 07/12/24 discharge letter to R1. An observation of the resident on 07/31/24 at 04:09 PM during an interview at the same time revealed the resident became teary eyed at times, and her voice fluctuated with frustration/defeat over how the facility handled the incidents with R3. Over the course of the conversation the resident reported she felt she had to diminish her presence for fear of retribution. R1 mentioned there were two staff whom she considered close to her before but were treating me bad because they wanted to be in [Administrative Staff A's] good graces, and that was upsetting. When R1 stated this her eyes welled with tears, and she then looked down toward the floor and was silent. An Interview with R1 and her representative at 04:09 PM on 07/31/24 revealed R1 stated she was not going to say anything about R3 entering her room originally but was upset and wanted the facility to know about it, and stated it was embarrassing. R1 felt staff were vindictive toward her since the incident occurred and she reported it. She further reported staff told her R3 just climbed in most resident's beds and that he had the mentality of a five-year-old. After the incident with R3, R1 stated the facility took all rights away from her. She could no longer have one staff performing cares and even housekeeping staff were required to have two people in the room and she could no longer leave the room if housekeeping were in the room. Two staff now had to watch her shower and it was very upsetting to her. R1 reported she bathed herself in her sink at times because she did not want so many staff watching her shower. R1 reported the floor of the bathroom became slippery when bathing herself and further reported being fearful of a fall as her balance and stamina were not always the best. She reported being at the facility for the last five years with no concerns and now she has been issued a discharge notice from the facility. R1 stated she called her Guardian when staff were in the room for her protection and was glad the Guardian was involved in her care. The Guardian expressed she told staff to leave the resident alone unless they called her because of the frequent requests to do skin checks after the incident with R3. The resident reported the facility has further filed an Adult Protective Services report against her Guardian for speaking up for her. The resident voiced fears a new facility might persecute her based on what this facility told them about her. During a phone interview on 08/05/24 at 12:44 PM with Law Enforcement Officer (LEO) GG he reported the facility treated R1 like she was the one at fault for the encounter with R3. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/06/24 at 03:42 AM with Administrative Staff C revealed the resident kept to herself and did not want staff in her room. Administrative Staff C reported the resident's outlook at the facility had changed over the last year and she had a different outlook, behavior wise. She reported the resident did not seem to be happy at the facility and she tried hard to fix the problem and accommodate resident needs. Administrative Staff C reported she heard the resident's story about R3 changed three times, but the Director of Nursing and Administrator were handling that situation. She reported R1 as more secluded since the incident with R3. Staff offered skin assessments, but R1 refused. Administrative Staff C said R1 was very different than when she started a few years ago and noted the resident has not called 911 recently. Administrative Staff C reported the SSD updated resident care plans at times. During an interview at 04:43 AM on 08/06/24 with Administrative Staff B revealed R3 used to walk around until after the incident with R1. Administrative Staff B reported the resident originally reported R3 tried to get into bed with her but then told her Guardian that R3 touched her private parts. Administrative Staff B reported the resident refused to have skin checks of her private parts. She stated the resident and Guardian wanted to file charges against R3 and since she was not happy corporate said they could help R1 find another facility. R1 reported being happy at the facility until R3 came and Administrative Staff B stated R3 was still a human too. When asked about how the facility handled R1's psychosocial wellbeing and/or history of trauma Administrative Staff B reported they offered for her to go to the ER, but she refused. Administrative Staff B confirmed the facility had not addressed R1's psychosocial impact from the incident with R3, had not addressed potential past trauma's R1 may have had, and not viewed the incident with R3 as traumatic to R1. During an electronic mail interview with R1's Guardian dated 08/07/24 at 10:52 AM revealed the facility had not assessed R1 for any past trauma that she was aware of. R1's Guardian stated the facility listed information that was not correct concerning R1's history in the care plan and noted they did not reach out to her or the resident's other family members for further information. R1's Guardian stated she did not believe that R1 received any individualized visits from SSD L, when R1 was assaulted by a male resident that was uninvited to her room. The Guardian stated she asked the facility to call her when they talked to the resident about the incident with R3 because a major trust factor has been broken. During an electronic mail interview with SSD L on 08/09/24 at 01:29 PM she reported the SSD and Activities Director assessed residents for their preferences. SSD L stated the resident's preferences were on the resident's care plan and Kardex. If the situation was critical, they would meet with staff to inform them of the resident's preferences. The SSD reported the facility had a communication book they kept resident preferences in. The SSD reported all grievances were listed on the facility grievance forms. The SSD reported the facility interdisciplinary team were to support residents through the discharge process. The facility failed to provide medically related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. The facility failed to provide medically-related social services to serve as an advocate in asserting R1's rights as a resident and further failed to meet the needs of R1 when she began showing signs of distress after a traumatic event and through the discharge/transition process with her.

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	175450	A. Building B. Wing	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Anew Healthcare Oxford	200 S Ohio St Oxford, KS 67119

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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 0835 Level of Harm - Actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37026 The facility census totaled 31 with 16 included in the sample. Based on observation, interview, and record review facility administration failed to ensure the facility was ran in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. The outcome of these failures placed Resident (R)1 and R4 in immediate jeopardy. The failures further caused harm to R2, R11, R3, and R5. Findings included: - The facility administration failed to ensure Resident (R)1 had a right to designate a representative of her choice who could exercise her rights as she delegated to the representative without fear of reprisal and/or honoring the resident's right to have her representative present during interactions with facility staff. The facility administration failed to ensure R1 had a right to make choices about her life in the facility that were significant to her, which included the right to have only one staff present during cares as requested by the R1 when the facility failed to provide a valid rationale to the resident for the use of two staff for cares and interactions with the resident. The facility administration failed to provide a safe, clean, and homelike environment when observations revealed dirty and scuffed floors, brown liquid down the hallway, and staff served the residents their meals on Styrofoam plates. This failure had the potential to affect all residents. (continued on next page)

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F 0835 Level of Harm - Actual harm Residents Affected - Many	Facility administration failed to the prevent the neglect of quadriplegic, dependent Resident (R)4, when facility nursing staff did not adequately monitor or follow up on the decreased urinary output and decline experienced on [DATE], just one day after R4 completed antibiotic treatment for a Urinary Tract Infection (UTI). On [DATE] at around 01:15 AM, staff found the resident unresponsive, cyanotic, with wet lung sounds, and with no urinary output. The staff did not apply oxygen and did not ensure a staff member stayed with R4 during the critical incident. When emergency staff responded they found no staff in the hallway and found the resident was alone in her room and with no oxygen applied, even though the staff noted R4 displayed obvious signs of airway distress. R4 required emergency medical services (EMS) response and treatment to include obtaining her oxygen saturation level of 77%, a systolic blood pressure of 44 millimeters of mercury (mmHg) and could not obtain her diastolic pressure. R4 required supplemental oxygen and EMS took R4 to the local hospital for treatment. The Emergency Department (ED) staff documented R4 appeared in poor health, appeared toxic, in severe distress, with flat jugular veins, cyanotic nail beds, lethargic, confused, only made sounds of moan/groans, and appeared poorly groomed, disheveled, malodorous. The ED placed a urinary catheter and noted 10 milliliters (ml) of dark orange/red urine with obvious pus and R4 required placement of an intraosseous to her right lower tibia (shinbone). The hospital admitted R4 with acute respiratory failure, pneumonia (inflammation of the lungs), sepsis (life threatening systemic reaction that develops due to infections which cause inflammation throughout the entire body), and comfort care with an onset date of [DATE]. Hospital staff noticed 25 ml of a creamy white/green substance in R4's urinary catheter tube and R4 died at 09:08 AM on [DATE]. The failure of facility staff to adequately follow up on the decreased urinary output and decline, placed R4 in immediate jeopardy. The facility administration failed to ensure facility staff assessed for the preferences of Resident (R) 5, to prevent the potential involuntary seclusion of R5. Facility staff did not know why they continued to place R5 into the same spot of the facility each day, taking all meals in this same spot removed from the dining area and other residents, and spending much of R5's day in this same spot, without staff offering to include him in the main dining or into another area. The facility further failed to ensure they did not involuntarily seclude R5 to his room at night, when surveyors entered the facility (at approximately 11:17 PM) and found R5's wheelchair, his only mode of transportation, to be in the hallway outside of R5's room, with his room door closed. These failures, using reasonable person concept, involuntarily secluded R5 to his room. The facility administration failed to provide evidence R1 met discharge requirement as outlined in the State Operations Manual, Appendix PP when administrative staff issued an involuntary discharge notice to R1, but failed to recognize the impact to R1 after R3 entered her room, uninvited, attempted to get in her bed, touched her private parts, and the facility failed to recognize the impact to R1's psychosocial wellbeing. Since the incident with R3, facility staff reported R1 isolated herself more, changed in her day-to-day behavior, and R1 reported she felt punished by the facility, embarrassed at multiple requests for skin checks of her private parts, and had to minimize her existence in her daily life. The facility administration failed to ensure the contents of an involuntary, facility-initiated discharge included all required elements at the time they provided the notice to R1. The facility administration failed to ensure qualified staff performed a medical technique to assess for a resident's level of consciousness, when two Certified Nurse Aides (CNA) performed a sternal rub on an unresponsive resident prior to notifying the Licensed Nurse (LN). (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Anew Healthcare Oxford	200 S Ohio St Oxford, KS 67119

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F 0835 Level of Harm - Actual harm Residents Affected - Many	The facility administration failed to ensure staff provided Activities of Daily Living (ADL) care to dependent residents to ensure their highest physical, mental, and psychosocial well-being and to decrease the risk of infection. On [DATE] when Emergency Medical Services (EMS) transferred Resident (R) 4 they noted her brief needed changed and she had odor; the local hospital further described R4 as looking disheveled and malodorous. The facility administration failed to ensure staff would properly identify and monitor R2 when he received blood/blood products at the hospital on [DATE] between 10:55 AM and 07:27 PM. Upon the resident's return from the hospital, the facility failed to monitor the resident for signs of adverse reaction, which included respiratory distress or bronchospasm. At approximately 11:13 PM the resident used his emergency call light to inform staff he was having a hard time breathing. After 10 to 15 minutes of waiting on the nurse with no response the resident called EMS himself and his roommate assisted in reporting concerns to EMS. When the nurse entered the resident's room, she failed to obtain the resident's vital signs even after the resident reported respiratory distress and being scared. The nurse scolded the resident for not waiting on nursing staff response before calling EMS himself and documented the resident's actions as being rude. The resident was sent back to the hospital due to low oxygen levels and exacerbation of chronic obstructive pulmonary disease with (acute) exacerbation (COPD - progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing). The facility administration failed to ensure staff had the appropriate competencies and training when they failed to transfer R16 according to her plan of care, which resulted in a fall. The facility further failed to ensure staff provided adequate supervision, while providing one-on-one supervision to the R3, and the resident fell out of bed and sustained a laceration to the back of his head. The facility administration failed to ensure adequate hydration for quadriplegic, dependent Resident (R) 4, who experienced decreased urinary output and decline R4 on [DATE], just one day after she completed antibiotic treatment for a Urinary Tract Infection (UTI). On [DATE] at around 01:15 AM, staff found the resident unresponsive, cyanotic, with wet lung sounds, and with no urinary output. R4 required emergency medical services (EMS) response and treatment to include a systolic blood pressure of 44 millimeters of mercury (mmHg) and could not obtain her diastolic pressure. EMS took R4 to the local hospital for treatment. The Emergency Department (ED) staff documented R4 appeared in poor health, appeared toxic, in severe distress, with flat jugular veins, cyanotic nail beds, lethargic, confused, only made sounds of moan/groans, and appeared poorly groomed, disheveled, malodorous. The ED placed a urinary catheter and noted 10 milliliters (ml) of dark orange/red urine with obvious pus and R4 required placement of an intraosseous to her right lower tibia (shinbone). The hospital admitted R4 with acute respiratory failure, pneumonia (inflammation of the lungs), sepsis (life threatening systemic reaction that develops due to infections which cause inflammation throughout the entire body), and comfort care with an onset date of [DATE]. Hospital staff noticed 25 ml of a creamy white/green substance in R4's urinary catheter tube and R4 died at 09:08 AM on [DATE]. (continued on next page)

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F 0835 Level of Harm - Actual harm Residents Affected - Many	The facility administration failed to ensure staff had appropriate competencies and training when staff failed to provide oxygen to quadriplegic, dependent Resident (R) 4, who became unresponsive and displayed trouble breathing. On [DATE] at around 01:15 AM, staff found the resident unresponsive, cyanotic, with wet lung sounds, and with no urinary output. The staff did not apply oxygen and did not ensure a staff member stayed with R4 during the critical incident. License Nurse (LN) S left the room and called the physician, discussed the situation, received an order to call 911, then she called 911, printed and filled out papers, then went to the bathroom. When emergency responders arrived, they found no staff in the hallway and found the resident alone in her room and with no oxygen applied, even though the staff noted R4 displayed obvious signs of airway distress. R4 required emergency medical services (EMS) response and treatment to include obtaining her oxygen saturation level of 77%, a systolic blood pressure of 44 millimeters of mercury (mmHg) and could not obtain her diastolic pressure. R4 required supplemental oxygen and EMS took R4 to the local hospital for treatment. The Emergency Department (ED) staff documented R4 appeared in poor health, appeared toxic, in severe distress, with flat jugular veins, cyanotic nail beds, lethargic, confused, only made sounds of moan/groans, and appeared poorly groomed, disheveled, malodorous. The ED placed a urinary catheter and noted 10 milliliters (ml) of dark orange/red urine with obvious pus and R4 required placement of an intraosseous to her right lower tibia (shinbone). The hospital admitted R4 with acute respiratory failure, pneumonia (inflammation of the lungs), sepsis (life threatening systemic reaction that develops due to infections which cause inflammation throughout the entire body), and comfort care with an onset date of [DATE]. R4 died at 09:08 AM on [DATE]. The facility administration failed to ensure staff had the appropriate competencies and training to care for R1 and ensure she received trauma informed care in accordance with professional standards of practice, accounting for her experiences and preferences, and eliminating or mitigating triggers that could cause re-traumatization when the facility failed to implement person centered interventions for R1 after R3 entered her room, uninvited, attempted to get in her bed, touched her private parts, and the facility failed to recognize the impact to R1's psychosocial wellbeing. Since the incident with R3, facility staff reported R1 has isolated herself more and had changed in her day-to-day behavior and R1 reported she felt punished by the facility, embarrassed at multiple requests for skin checks of her private parts, and had to minimize her existence in her daily life. The facility administration failed to ensure staff had the appropriate competencies and training to ensure Resident (R) 11, who was diagnosed with a mental disorder, received the appropriate treatment and services to attain the highest practicable mental and psychosocial well-being, when the resident became notably more tearful over a few weeks, voiced auditory and visual hallucinations, and reported he had voices telling him to doing something naughty to other residents. The facility administration failed to provide medically related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. The facility failed to provide medically-related social services to serve as an advocate in asserting Resident (R)1's rights as a resident and further failed to meet the needs of R1 when she began showing signs of distress after a traumatic event and through the transition process with her. Review of the undated (copyright 2023) facility policy Administration of Facility revealed the facility would provide policies and systems to ensure it was administered in a manner that focused on attaining and maintaining the highest practicable physical, mental, and psychosocial well-being of each resident. (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 0835 Level of Harm - Actual harm Residents Affected - Many	Facility administration failed to ensure the facility was ran in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. The outcome of these failures placed Resident (R)1 and R4 in immediate jeopardy. The failures further caused harm to R2, R11, R3, and R5.

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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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37026 The facility census totaled 31 with 16 included in the sample. Based on observation, interview, and record review the facility failed to ensure an effective Quality Assurance and Performance Improvement (QAPI) program. The QAPI program failed to develop, implement, and maintain an effective, comprehensive, data driven program that focused on indicators of outcomes of quality of care and quality of life for residents in the facility as evidenced by the number and severity of tags cited on the [DATE] survey with event ID SW0D11. Findings included: - The facility failed to ensure Resident (R)1 had a right to designate a representative of her choice who could exercise her rights as she delegated to the representative without fear of reprisal and/or honoring the resident's right to have her representative present during interactions with facility staff. (See F551) The facility census totaled 31, with 16 included in the sample, and one resident reviewed for discharge requirements. Based on observation, interview, and record review the facility failed to ensure R1 had a right to make choices about her life in the facility that were significant to her, which included the right to have only one staff present during cares as requested by the R1 when the facility failed to provide a valid rationale to the resident for the use of two staff for cares and interactions with the resident. (See F561) The facility failed to provide a safe, clean, and homelike environment when observations revealed dirty and scuffed floors, brown liquid down the hallway, and staff served the residents their meals on Styrofoam plates. This failure had the potential to affect all residents. (See F584) (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175450	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/13/2024
NAME OF PROVIDER OR SUPPLIER Anew Healthcare Oxford		STREET ADDRESS, CITY, STATE, ZIP CODE 200 S Ohio St Oxford, KS 67119	

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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility failed to the prevent the neglect of quadriplegic, dependent Resident (R)4, when facility nursing staff did not adequately monitor or follow up on the decreased urinary output and decline experienced on [DATE], just one day after R4 completed antibiotic treatment for a Urinary Tract Infection (UTI). On [DATE] at around 01:15 AM, staff found the resident unresponsive, cyanotic, with wet lung sounds, and with no urinary output. The staff did not apply oxygen and did not ensure a staff member stayed with R4 during the critical incident. When emergency staff responded they found no staff in the hallway and found the resident was alone in her room and with no oxygen applied, even though the staff noted R4 displayed obvious signs of airway distress. R4 required emergency medical services (EMS) response and treatment to include obtaining her oxygen saturation level of 77%, a systolic blood pressure of 44 millimeters of mercury (mmHg) and could not obtain her diastolic pressure. R4 required supplemental oxygen and EMS took R4 to the local hospital for treatment. The Emergency Department (ED) staff documented R4 appeared in poor health, appeared toxic, in severe distress, with flat jugular veins, cyanotic nail beds, lethargic, confused, only made sounds of moan/groans, and appeared poorly groomed, disheveled, malodorous. The ED placed a urinary catheter and noted 10 milliliters (ml) of dark orange/red urine with obvious pus and R4 required placement of an intraosseous to her right lower tibia (shinbone). The hospital admitted R4 with acute respiratory failure, pneumonia (inflammation of the lungs), sepsis (life threatening systemic reaction that develops due to infections which cause inflammation throughout the entire body), and comfort care with an onset date of [DATE]. Hospital staff noticed 25 ml of a creamy white/green substance in R4's urinary catheter tube and R4 died at 09:08 AM on [DATE]. The failure of facility staff to adequately follow up on the decreased urinary output and decline, placed R4 in immediate jeopardy. (See F600) The facility failed to ensure facility staff assessed for the preferences of Resident (R) 5, to prevent the potential involuntary seclusion of R5. Facility staff did not know why they continued to place R5 into the same spot of the facility each day, taking all meals in this same spot removed from the dining area and other residents, and spending much of R5's day in this same spot, without staff offering to include him in the main dining or into another area. The facility further failed to ensure they did not involuntarily seclude R5 to his room at night, when surveyors entered the facility (at approximately 11:17 PM) and found R5's wheelchair, his only mode of transportation, to be in the hallway outside of R5's room, with his room door closed. These failures, using reasonable person concept, involuntarily secluded R5 to his room. (See F603) The facility failed to provide evidence R1 met discharge requirement as outlined in the State Operations Manual, Appendix PP when administrative staff issued an involuntary discharge notice to R1, but failed to recognize the impact to R1 after R3 entered her room, uninvited, attempted to get in her bed, touched her private parts, and the facility failed to recognize the impact to R1's psychosocial wellbeing. Since the incident with R3, facility staff reported R1 isolated herself more, changed in her day-to-day behavior, and R1 reported she felt punished by the facility, embarrassed at multiple requests for skin checks of her private parts, and had to minimize her existence in her daily life. (See F622) The facility failed to ensure the contents of an involuntary, facility-initiated discharge included all required elements at the time they provided the notice to R1. (See F623) The facility failed to ensure qualified staff performed a medical technique to assess for a resident's level of consciousness, when two Certified Nurse Aides (CNA) performed a sternal rub on an unresponsive resident prior to notifying the Licensed Nurse (LN). (See F659) (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175450	A. Building B. Wing	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Anew Healthcare Oxford	200 S Ohio St Oxford, KS 67119

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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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility failed to ensure staff provided Activities of Daily Living (ADL) care to dependent residents to ensure their highest physical, mental, and psychosocial well-being and to decrease the risk of infection. On [DATE] when Emergency Medical Services (EMS) transferred Resident (R) 4 they noted her brief needed changed and she had odor; the local hospital further described R4 as looking disheveled and malodorous. (See F677) The facility failed to ensure staff would properly identify and monitor R2 when he received blood/blood products at the hospital on [DATE] between 10:55 AM and 07:27 PM. Upon the resident's return from the hospital, the facility failed to monitor the resident for signs of adverse reaction, which included respiratory distress or bronchospasm. At approximately 11:13 PM the resident used his emergency call light to inform staff he was having a hard time breathing. After 10 to 15 minutes of waiting on the nurse with no response the resident called EMS himself and his roommate assisted in reporting concerns to EMS. When the nurse entered the resident's room, she failed to obtain the resident's vital signs even after the resident reported respiratory distress and being scared. The nurse scolded the resident for not waiting on nursing staff response before calling EMS himself and documented the resident's actions as being rude. The resident was sent back to the hospital due to low oxygen levels and exacerbation of chronic obstructive pulmonary disease with (acute) exacerbation (COPD - progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing). (See F684) The facility failed to ensure staff had the appropriate competencies and training when they failed to transfer R16 according to her plan of care, which resulted in a fall. The facility further failed to ensure staff provided adequate supervision, while providing one-on-one supervision to the R3, and the resident fell out of bed and sustained a laceration to the back of his head. (See F 689) The facility failed to ensure adequate hydration for quadriplegic, dependent Resident (R) 4, who experienced decreased urinary output and decline R4 on [DATE], just one day after she completed antibiotic treatment for a Urinary Tract Infection (UTI). On [DATE] at around 01:15 AM, staff found the resident unresponsive, cyanotic, with wet lung sounds, and with no urinary output. R4 required emergency medical services (EMS) response and treatment to include a systolic blood pressure of 44 millimeters of mercury (mmHg) and could not obtain her diastolic pressure. EMS took R4 to the local hospital for treatment. The Emergency Department (ED) staff documented R4 appeared in poor health, appeared toxic, in severe distress, with flat jugular veins, cyanotic nail beds, lethargic, confused, only made sounds of moan/groans, and appeared poorly groomed, disheveled, malodorous. The ED placed a urinary catheter and noted 10 milliliters (ml) of dark orange/red urine with obvious pus and R4 required placement of an intraosseous to her right lower tibia (shinbone). The hospital admitted R4 with acute respiratory failure, pneumonia (inflammation of the lungs), sepsis (life threatening systemic reaction that develops due to infections which cause inflammation throughout the entire body), and comfort care with an onset date of [DATE]. Hospital staff noticed 25 ml of a creamy white/green substance in R4's urinary catheter tube and R4 died at 09:08 AM on [DATE]. (See F692) The facility failed to ensure staff provided feeding tube care in accordance with professional standards of practice. On [DATE], a Certified Nurse Aide (CNA) pulled out R3's feeding tube, which required emergency medical transportation to a local hospital for surgical replacement. (See F693) (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Anew Healthcare Oxford		STREET ADDRESS, CITY, STATE, ZIP CODE 200 S Ohio St Oxford, KS 67119	

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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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility failed to ensure staff provided oxygen to quadriplegic, dependent Resident (R) 4, who became unresponsive and displayed trouble breathing. On [DATE] at around 01:15 AM, staff found the resident unresponsive, cyanotic, with wet lung sounds, and with no urinary output. The staff did not apply oxygen and did not ensure a staff member stayed with R4 during the critical incident. License Nurse (LN) S left the room and called the physician, discussed the situation, received an order to call 911, then she called 911, printed and filled out papers, then went to the bathroom. When emergency responders arrived, they found no staff in the hallway and found the resident alone in her room and with no oxygen applied, even though the staff noted R4 displayed obvious signs of airway distress. R4 required emergency medical services (EMS) response and treatment to include obtaining her oxygen saturation level of 77%, a systolic blood pressure of 44 millimeters of mercury (mmHg) and could not obtain her diastolic pressure. R4 required supplemental oxygen and EMS took R4 to the local hospital for treatment. The Emergency Department (ED) staff documented R4 appeared in poor health, appeared toxic, in severe distress, with flat jugular veins, cyanotic nail beds, lethargic, confused, only made sounds of moan/groans, and appeared poorly groomed, disheveled, malodorous. The ED placed a urinary catheter and noted 10 milliliters (ml) of dark orange/red urine with obvious pus and R4 required placement of an intraosseous to her right lower tibia (shinbone). The hospital admitted R4 with acute respiratory failure, pneumonia (inflammation of the lungs), sepsis (life threatening systemic reaction that develops due to infections which cause inflammation throughout the entire body), and comfort care with an onset date of [DATE]. R4 died at 09:08 AM on [DATE]. (See F695) The facility administration failed to ensure staff had the appropriate competencies and training to care for R1 and ensure she received trauma informed care in accordance with professional standards of practice, accounting for her experiences and preferences, and eliminating or mitigating triggers that could cause re-traumatization when the facility failed to implement person centered interventions for R1 after R3 entered her room, uninvited, attempted to get in her bed, touched her private parts, and the facility failed to recognize the impact to R1's psychosocial wellbeing. Since the incident with R3, facility staff reported R1 has isolated herself more and had changed in her day-to-day behavior and R1 reported she felt punished by the facility, embarrassed at multiple requests for skin checks of her private parts, and had to minimize her existence in her daily life. (See F699) The facility failed to ensure sufficient staff who provided direct services to residents with the appropriate competencies and skill sets to provide nursing and related services for Resident (R) 11, who was diagnosed with a mental disorder, and ensure he received the appropriate treatment and services to attain the highest practicable mental and psychosocial well-being, when the resident became notably more tearful over a few weeks, voiced auditory and visual hallucinations, and reported he had voices telling him to doing something naughty to other residents. (See F741) The facility failed to ensure staff had the appropriate competencies and training to ensure Resident (R) 11, who was diagnosed with a mental disorder, received the appropriate treatment and services to attain the highest practicable mental and psychosocial well-being, when the resident became notably more tearful over a few weeks, voiced auditory and visual hallucinations, and reported he had voices telling him to doing something naughty to other residents. (See F742) The facility failed to provide medically related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. The facility failed to provide medically-related social services to serve as an advocate in asserting Resident (R)1's rights as a resident and further failed to meet the needs of R1 when she began showing signs of distress after a traumatic event and through the transition process with her. (See F745) (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Anew Healthcare Oxford	200 S Ohio St Oxford, KS 67119

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility administration failed to ensure the facility was ran in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. The outcome of these failures placed Resident (R)1 and R4 in immediate jeopardy. The failures further caused harm to R2, R11, R3, and R5. (See F835) The facility failed to ensure staff provided care to Resident (R) 3 according to standard infection control practices. This had the potential to affect all 31 residents. (See F880) The facility failed to ensure an effective Quality Assurance and Performance Improvement (QAPI) program. The QAPI program failed to develop, implement, and maintain an effective, comprehensive, data driven program that focused on indicators of outcomes of quality of care and quality of life for residents in the facility as evidenced by the number and severity of tags cited on the [DATE] survey with event ID SW0D11.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35717 The facility reported a census of 31 residents with 16 included in the sample. Based on observation, interview, and record review the facility failed to ensure staff provided care to Resident (R) 3 according to standard infection control practices. This had the potential to affect all 31 residents. Finding included: - The Electronic Health Record revealed Resident (R)3 was [AGE] years old and the 03/28/24 Physician Order revealed Physician U ordered R3's admission to the facility and noted his diagnoses included: cerebral palsy, down's syndrome, autism, congenital stricture of esophagus, and acute respiratory hypoxia. The 04/04/24 Annual Minimum Data Set (MDS) Assessment revealed R3 staff assessment of R3's mental status revealed he had short-term memory problems and severely impaired cognitive skills for daily decision making. The MDS noted R3 had aphasia, cerebral palsy, malnutrition, anxiety, respiratory failure, asthma, chronic obstructive pulmonary disease (COPD) or chronic lung disease. The 06/24/24 Quarterly MDS Assessment revealed R3 had no speech (absence of spoken works), was rarely/never understood and rarely/never understand others, with highly impaired vision. R3 had short and long-term memory problems and severely impaired (never/rarely made decisions) cognitive skills for daily decision making, with continuous inattention and disorganized thinking. The resident was completely dependent on staff for all the effort regarding oral hygiene, toileting hygiene, shower/bathing, dressing, and personal hygiene. The resident did use a manual wheelchair and/or scooter. The Care Plan included the following interventions. 04/22/24- The staff would anticipate and meet R3's needs. 04/22/24, revised 05/13/24- Bathing/showering: The resident was totally dependent on one staff to provide bathing twice weekly and as necessary. 05/17/24- R3 liked to sit on the floor, crawl, slide on buttocks, and would often have his foot and hands in his mouth. R3 had toys he played with when on the floor and the staff were to monitor as needed for safety of him and others. 05/10/24- Staff were to redirect as needed to maintain safety. 05/13/24, revised 07/24/24- Staff were to assist with all daily care; allow R3 to make choices as he was able regarding clothing, activities, food; and monitor to maintain safety with cares. The Care Plan included an 06/17/24 focus which noted R3 was at risk for multi-drug resistant organism (MDRO) colonization/infections related to invasive devices peg tube and included the following intervention: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	06/17/24- Enhanced Barrier Precautions: Use a Gown and Gloves and Mask when performing high-contact activities including toileting/incontinence care, dressing, bathing, and showering, transferring, care of devices, wound care, changing linens or any activity with close contact. Face-shield should also be worn if the activity has a risk for splash or spray. Upon entrance on 07/31/24 at 08:55 AM, tour hallway at 09:26 AM revealed a three-drawer plastic storage container with personal protective equipment located outside of the resident's room. On 08/01/24 at approximately 11:45 AM, the surveyor observed staff pushing R3 in his wheelchair while R3 played on his electronic device. R3 had his feet dangling down with no socks on and feet looked darkened and dirty. R3 had two of his fingers in his mouth with a band of darkly discolored, visibly dirty ring around the base of those two fingers, just below the area he had in his mouth on his fingers. The LN KK began looking for gloves, did not don gloves, and then just used a few wipes to clean R3's dirty fingers. Interview with Administrative Nurse C on 08/06/24 at 03:43 AM revealed R3 had been on one-on-one with staff since the incident with R1 (05/19/24) and said somebody always had an eye on him. The facility failed to ensure staff provided care to R3 according to standard infection control practices.