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	04/25/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46960 The facility reported a census of 35 residents with 20 residents sampled, that included two residents selected for review related to dignity. Based on interview, observation, and record review, the facility failed to protect the privacy and dignity of Residents (R)24 and R25. This deficient practice led to R24 being disturbed in her room on multiple occasions by another resident with wandering behaviors, and R25 being seated in the dining area wearing a shirt and an incontinence brief with his lap partially covered with a blanket. This practice had the potential to lead to negative psychosocial effects related to dignity. Findings included: - R24's Electronic Health Record (EHR) revealed a diagnosis of benign chronic obstructive pulmonary disease (COPD - a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), diabetes mellitus type two (DM2 - when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), generalized weakness, need for assistance with personal cares and repeated falls. The Annual Minimum Data Set (MDS) dated [DATE], documented a Brief Interview for Mental Status (BIMS) of 15, which indicated intact cognition. R24 required extensive assistance for dressing, toileting and personal hygiene but was otherwise independent for cares. R24 used a wheelchair for locomotion and did not receive oxygen. The Quarterly MDS dated [DATE], documented a BIMS of 15, which indicated intact cognition and that R24 did not use a wheelchair for locomotion and received oxygen. The Care Area Assessment (CAA), dated 06/16/23 documented on all triggered areas (Urinary Incontinence and Indwelling Catheter, Falls, Nutritional Status, Pressure Ulcer/Injury, Pain and ADL [activities of daily living such as walking, grooming, toileting, dressing and eating] Functional / Rehabilitation Potential) that R24 required supervision to extensive assistance for ADL task completion, used a wheelchair and walker for mobility and ambulation (walking) and was at risk for falls. The 04/22/24 Care Plan lacked interventions specific to protecting R24's privacy and dignity. (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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/18/24 at 03:30 PM, observation revealed R35 wandering in the hallway and entered R24's room and was wandering towards R24's over-the-bed table. R24 intercepted R35 and was able to redirect R35 out of her room with staff assistance. On 04/18/24 at 03:13 PM, R24 revealed that R35 frequently came into her room at night and would wake her and her roommate up by pushing items out of her recliner and off her over-the-bed table. R24 stated that sometimes she could redirect R35 out of her room, but with most occasions must press her call light and wait for staff to respond to assist R35 out of her room. On 04/24/24 at 01:30 PM, Licensed Nurse (LN) D and LN S confirmed that R35 had wandering behaviors. On 04/25/24 at 12:04 PM, Certified Nurse Aide (CNA) DD confirmed that R35 had wandering behaviors, which included going into other resident's rooms and that staff would have to assist R35 out of their rooms. On 04/25/24 at 04:35 PM, Administrative Staff A confirmed R35 had wandering behaviors. The facility failed to provide a policy related to resident privacy and dignity as requested on 04/24/24. The facility failed to protect the privacy and dignity of R24. This deficient practice led to R24 being disturbed in her room on multiple occasions by R35 with wandering behaviors. 50659 - Resident (R)25's Electronic Health Record (EHR) revealed a diagnosis of diabetes mellitus type two (DM2-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), generalized muscle weakness, absence of left leg below the knee and abnormalities of gait (manner or style of walking) and mobility. The Admission Minimum Data Set (MDS) dated [DATE], documented a Brief Interview for Mental Status (BIMS) of 15, which indicated intact cognition. R25 had no assistive devices and required maximal to total assist with ADL's (activities of daily living such as walking, grooming, toileting, dressing and eating) except setup assistance for oral care and eating. R25 was always incontinent of bowel. The Quarterly MDS dated [DATE], documented a BIMS of 15, which indicated intact cognition. The Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) dated 01/26/24 lacked analysis of findings documented. The documentation was computer triggered to assist staff in completion of the CAA's. The Care Plan dated 04/22/24, revealed R25 had an Activities of daily living (ADL) self-care performance deficit and provided the following instructions for staff: 1. On 04/22/24, staff were to provide extensive assistance of 2 staff for dressing. 2. On 04/22/24, staff were to provide extensive assistance of 1 staff member for grooming. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. On 04/22/24, staff were to provide extensive assistance of 1 staff member for personal hygiene. The care plan lacked interventions related to maintaining or protecting the resident's privacy or dignity related to what clothing to be worn and shaving. The EHR Physician Orders lacked orders specific to providing privacy or dignity, additionally lacked orders specific to grooming. The Progress Notes reviewed 01/01/24 to 04/22/24 lacked documentation related to privacy, dignity or grooming. Review of the Tasks documentation in the clinical records, from 3/24/24 to 4/24/24 lacked documentation for grooming and hairdresser. On 04/18/24 at 11:58 AM, R25 sat in a wheelchair in the dining room with a blanket over the resident's legs. R25 lacked pants and was only wore an incontinence brief from the waist down. R25 stated that being without pants bothered him. There was a facial hair growth, and R25 stated, I am scruffy. He reported he wanted a shave, but the shavers don't work. On 04/22/24 at 09:13 AM, R25 continued to have a growth of facial hair. On 04/23/24 at 15:33 PM, Administrative Nurse B revealed that all residents should be shaved if they want to be, and they should be dressed per their preferences. On 04/24/24 at 11:30 AM, Certified Nurse Aide (CNA) P stated R25 did not wear any pants or shorts, just wore a brief and staff were to cover his legs with a blanket. CNA P did not know if R25 had any pants or shorts in his room. CNA P stated that she has never asked R25 if he wanted to wear pants or shorts, stated that is how she was trained. CNA P stated that she has not shaved R25, and residents are to be shaved on shower days. The facility failed to provide a policy related to privacy and dignity as requested on 04/24/24. The facility failed to protect the privacy and dignity of R25. This deficient practice led to R25 not having clothing on from waist down covered only by a blanket. In addition, the facility failed to shave this resident as his preference. This practice had the potential to lead to negative psychosocial effects related to dignity.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50659 The facility identified a census of 35 residents which included 20 residents in the sample. Based on observations, interviews, and record review, the facility failed to promote and facilitate resident self-determination through support of resident's choice when Resident (R)25 was not given a choice about the meals he ate. This deficient practice had the potential to have a negative effect on R25's psychosocial well-being. Findings Included: - Resident (R)25's Electronic Health Record (EHR) revealed a diagnosis of diabetes mellitus type two (DM2-when the body cannot use glucose, not enough insulin made, or the body cannot respond to the insulin). The Admission Minimum Data Set (MDS) dated [DATE], documented a Brief Interview for Mental Status (BIMS) of 15, which indicated intact cognition. R25 required maximal to total assist with ADL's (activities of daily living such as walking, grooming, toileting, dressing and eating). The Quarterly MDS dated [DATE], documented a BIMS of 15, which indicated intact cognition. The Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) dated 01/26/24 lacked analysis of findings documented. The documentation was computer triggered to assist staff in completion of the CAA's. The Care Plan dated 04/22/24, revealed R25 had an Activities of daily living (ADL) self-care performance deficit and provided the following instructions for staff: 1. On 04/22/24, staff were to provide set up assist of meals. 2. On 04/22/24, staff were to provide the importance of prescribed diet to the resident and the need for adequate nutritional intake. 3. On 04/22/24, staff were to provide monitored and documented circumstances surrounded mealtimes/refusals to eat. Attempt to determine pattern or cause for behavior. Where possible, alter or remove the cause. 4. On 04/22/24, staff were to provide diet as per ordered. The EHR Physician Orders included: 1. On 05/29/23 Regular diet, Regular texture, Regular consistency. Review of the Progress Notes from 01/01/24 to 04/22/24 revealed: (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/09/2024, a nutrition evaluation revealed R25 received a regular diet. R25 received supplements and used adaptive equipment to aid in self-feeding. The resident's food preferences reviewed and updated as needed. On 01/25/24, a nutrition evaluation revealed the resident's food preferences reviewed. On 04/24/24 at 05:35 PM, observation revealed R25 finished supper that consisted of a hamburger patty with melted cheese, a bag of potato chips and one cookie, and three drinks, which R25 did not consume all of them. R25 raised his right arm, waved it around as staff walked by him and behind him. R25 waved three times between the time of 05:40 PM until 05:55 PM, when (Licensed Nurse) LN W acknowledged R25. LN W asked R25 what was needed. R25 stated he was still hungry and requested more food. LN W asked the resident what he would like to eat. R25 could not verbalize what he wanted and stated he didn't know what was for dinner and stated, I got what I got. LN W told R25 that Dietary Staff X would be notified to talk to him. Dietary Staff Y acknowledged R25 at 06:13 PM and brought R25 a 1/2 peanut butter and jelly sandwich in a bag. R25 declined the sandwich, as he reported he did not like what was offered. Dietary Staff Y explained there was no more food left from dinner and walked away from R25. On 04/24/24 at 06:13 PM, observed after the meal service completed, dietary staff J and dietary staff X and dietary staff Y offered several other residents in the dining room more food, (meatballs, cookies and drinks). Dietary Staff X and Y checked several residents, asked if they needed anything and checked with other residents if the meal was satisfactory. R25 was not acknowledged from 05:20 PM until 06:13 PM by dietary staff. On 04/24/24 at 06:15 PM, Consultant Nurse E and Administrative Nurse F agreed that residents should have a choice of what food they want to eat and in a timely manner to receive the food. Consultant Nurse E talked to R25 offered the anytime menu. R25 ordered food. R25 received food from the anytime menu at 06:45 PM. The facility failed to provide a policy related to resident choices as requested on 04/24/24. The facility failed to promote and facilitate resident self-determination through support of resident's choice when R25 was not given a choice about the meals he ate. This deficient practice had the potential to have a negative effect on R25's psychosocial well-being.

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	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** 31078 The facility census totaled 35 residents, with 20 residents included in the sample. Based on observation, interview, and record review, the facility failed to ensure an environment free from neglect and alleged abuse, which had the potential to negatively affect all residents of the facility. 1. The facility failed to prevent the neglect of Resident (R)89, a resident with chronic kidney disease and electrolyte imbalances, through the lack of appropriate nursing care and follow-up/monitoring after R89 returned to the facility on [DATE], following a 17-day hospitalization for sepsis (infection in the blood stream). The facility licensed nursing staff failed to prevent medication errors for R89 when staff did not enter R89's 04/04/24 re-admission medication orders into the Electronic Medication Administration Record (eMAR) for five days. This failure resulted in staff incorrectly administering medications from a prior order, with some at incorrect dosages and omitted medications that were ordered in R89's treatment after return from the hospital. The facility failed to ensure competent nursing staff to respond to the change -in condition of R89 on 04/07/24 when he reported he had not voided in two days. The facility staff failed to ensure licensed nursing staff assessed, followed-up, and notified the physician of R1's critically low to complete lack of urine output. The facility failed to ensure staff monitored R89's oral input and urinary output for 12 hours as ordered on 04/08/24, after over three days of R89 reporting little to no urinary output. As a result of this negligence on 04/09/24, R89 became unresponsive and required emergency medical transfer to a local hospital for kidney failure. The resident was then readmitted to hospital on 04/09/24 and returned on 04/16/24. The cumulative deficient practices of neglect placed R89's in immediate jeopardy. 2. The facility failed to ensure R19 was free from resident abuse and neglect when R19 was on one-on-one observation on 03/19/24 due to screaming and yelling since 05:00 AM. Certified Nurse Aide (CNA) C was in the 'quiet room' with only R19, and the doors closed. Around 10:00 AM CNA C reported to Licensed Nurse (LN) D that R19 fell to the floor when CNA C looked away to get something out of her purse. R19 repeatedly stated CNA C struck her and R19 had bruising and scuffs to her eye and a knot on her forehead. CNA C continued to sit in a chair next to R19, in one-on-one observation. LN D reported the incident to Administrative Nurse B, but the incident was not investigated or reported to the state agency until 04/24/24. On 04/24/24 the facility suspended CNA C and Administrative Nurse B. This failure paced R19 in immediate jeopardy, an placed all residents at risk for potential abuse. 3. The facility failed to ensure an environment free from neglect, when staff did not know how to provide transfer assistance safely and appropriately to R35. On 04/24/24 at 06:25 PM, CNA G proceeded to lift and drag R35 backwards across the dining room floor during meal service, approximately five feet, with his heels dragging the floor. These cumulative deficient practices resulted in immediate jeopardy and placed all residents at risk for abuse and neglect. Findings included: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	- Resident (R)89's Electronic Medical Record (EMR) dated 04/04/24 revealed the following diagnoses: heart failure (heart disease), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), essential (primary) hypertension (elevated blood pressure), edema (swelling resulting from an excessive accumulation of fluid in the body tissues), lymphedema (swelling caused by accumulation of lymph), alcohol abuse, other stimulant abuse, atrial fibrillation (rapid irregular heart beat), acute kidney failure (inability of the kidneys to excrete wastes, concentrate urine and conserve electrolytes), hypomagnesemia (less than normal magnesium levels in the blood), hyperkalemia (greater than normal amount of potassium in the blood), major depressive disorder (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness and hopelessness) severe with psychotic features (any major mental disorder characterized by a gross impairment in reality testing), systolic (congestive) heart failure (a condition with low heart output and the body becomes congested with fluid), chronic pain, morbid (severe) obesity due to excess calories (the state or condition of being very fat or overweight), hypothyroidism (condition characterized by decreased activity of the thyroid gland), cellulitis of right lower limb (skin infection caused by bacteria characterized by heat, redness and swelling), and hyponatremia (lower than normal sodium blood level). R89's Annual Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The resident was occasionally incontinent of urine. R89 had two stage two pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, because of pressure, or pressure in combination with shear and/or friction) on his buttock. Medications R89 received included antipsychotic (class of medications used to treat major mental conditions which cause a break from reality), antidepressant (class of medications used to treat mood disorders), diuretic (medication to promote the formation and excretion of urine), and opioid pain medications daily during the look-back period. The Quarterly MDS dated [DATE], revealed a BIMS score of 15, indicating intact cognition. The resident had no skin breakdown documented on the assessment. Medications R89 received included antipsychotic, antidepressant, antibiotic, opioid pain medication and antiplatelet (medication to prevent blood clots) daily during the look-back period. The Care Area Assessment (CAA) dated 12/22/23 revealed: The Functional Abilities CAA documented R89's was independent with daily cares, required supervision at times, and was continent of bowel and bladder. He triggered for fall risk, but gait was steady, and R89 could ambulate as he wanted to, without the use of an assistive device. R89 required medications that could increase his risk for falls, with no recent history of falls. He triggered on nutrition due to his high body mass index (BMI) and documented he triggered for pain and had medications for comfort. The Pressure Ulcer CAA revealed R89 had pain and required medication for pain relief. He had a history of pressure ulcers/ulcers to lower extremities. On 12/21/23, R89 had one open area to his left buttock and two open areas to his right buttock. The Baseline Care Plan dated 04/04/24 revealed the resident was alert and could communicate with staff. The resident was independent with eating, personal hygiene, and toileting. R89 was frequently incontinent of urine, used a walker and a wheelchair for mobility, and received psychotropics, diuretics, and opioid pain medications. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of the EMR revealed R89 transferred to the hospital on 03/18/24 and returned 17 days later on 04/04/24. Review of R89's hospital discharge orders revealed during the 17-day hospital stay to treat R89's sepsis, R89 received multiple intravenous antibiotics and placement of a urinary catheter (generally necessary to assist in bladder emptying, until someone cannot empty their bladder). The urinary catheter was removed prior to R89's discharge to the facility on [DATE]. The Nurse Note dated 04/04/24 at 05:39 PM, revealed the resident returned to the facility at 04:35 PM via facility transportation from a local hospital. R89 had cellulitis on both lower legs as well as dry skin. The resident required assistance of one to two staff with a gait belt and used a walker for mobility. He used a urinal for bladder and could use the toilet for bowel. Review of R89's readmission orders from the hospital dated 04/04/24 revealed the resident was to receive the following medications as ordered: Duloxetine, 30 milligrams (mg), PO (by mouth), daily, as an antidepressant. Gabapentin, 200 mg, three times a day (TID), for antiseizure and nerve pain relief. Bumex, 2 mg, daily, for diuretic. Metolazone, 2.5 mg, three times a week, for diuretic. Multivitamin tab, daily, for supplement. Oxycodone, 5 mg, every 6 hours, as needed (PRN). Nitroglycerin, 0.4 mg, sublingual (under the tongue), PRN, for chest pain. Protonix, 20 mg, daily, for gastric acid reducer. Risperidone, 1 mg, daily, for depression with psychosis. Senna, 8.6 mg, daily, as a laxative. Spironolactone, 50 mg, daily, as a diuretic. Review of the electronic Medication Administration Record (eMAR) from 04/01/24 through 04/30/24 revealed the resident received the following medications from 04/04/24 to 04/09/24, five days. (These were the medication orders in the facility system from prior to R89's 03/18/24 hospitalization). Amiodarone HCl (medication used for heart irregularities), 200 mg, one 1 tablet by mouth, one time a day. Aspirin tablet delayed release, 81 mg, one tablet by mouth, one time a day (anticoagulant). Duloxetine (antidepressant medication), 90 mg, PO, every day. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Famotidine (medication used as an acid blocker), 20 mg, daily. Glucosamine (supplement), 500 mg, three capsules, daily. Levothyroxine (hormone for thyroid), 100 micrograms (mcg), daily. Lipitor medication used to reduce blood cholesterol),10 mg, daily. Metolazone (diuretic medication), 2.5 mg, three times a week. Risperidone (antipsychotic medication), 3 mg, at bedtime (HS). Sodium Chloride (supplement), One Gm (gram), daily. Trazadone, (antidepressant medication), 100 mg, give 150 mg, at HS. Coreg (cardiac medication), 12.5 mg twice a day (BID). Entresto (cardiac medication), 49-51 mg, BID. Mag-oxide (supplement) 800 mg, BID. Spironolactone (diuretic medication) 50 mg, BID. Topamax, medication used for seizures), 25 mg, 2 tabs (50 mg), BID. Gabapentin (medication used for nerve pain) 450 mg, three times a day (TID). Percocet (opioid pain medication), 5-325 mg, TID. The Nurse Note dated 04/07/24 at 06:12 PM, revealed the resident refused to get up for a daily weight. The resident stated he had not voided (urinated) for two days. Staff reported he did void in his urinal yesterday (04/06/24). The notes documented unsure of (urinary) output on the night shift. The nurse tried to palpate R89's bladder but due to the resident's size, it was difficult. R89 reported he did not feel like he needed to void when the nurse applied pressure to his bladder area. Staff encouraged the resident to drink lots of water. Fresh water provided as well as Sprite (flavor of soda). Resident stated he would call when he felt the urge to void. The Nurse Note dated 04/08/24 at 11:51 AM, revealed the resident went out with staff for his first cigarette in a few weeks. While resident was outside, he became weak, complained of a headache and feeling weird. Vital signs were normal for the resident. His oxygen (O2) was 90 percent on room air (No supplemental O2). The nurse and nursing staff transferred the resident to his wheelchair, put him in his bed, and started O2 per nasal cannula. R89 reported his headache was gone. R89 reported he only urinated about 300 cubic centimeters (cc) in 24 hours. The resident reported he would try to void within the next hour. If unable to void, the nurse would reach out to R89's primary care physician. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The Nurse Note dated 04/08/24 at 02:36 PM, revealed the R89's blood pressure was 90/60 millimeters of mercury (mmHg), which was low for the resident. The resident had still not voided. The nurse called Nurse Practitioner V and received orders to monitor R89's urinary output for the next 12 hours and monitor R89's blood pressure every four hours, while awake, and encourage him to drink water. Review of the Physician Order revealed the 04/08/24 order to monitor R89's urinary output for the next 12 hours and manually monitor blood pressure every four hours while awake. Review of the Treatment Administration Record (TAR) for 04/24 revealed the orders had been added to the TAR although no intake or output monitored. Documentation for the time period just had check marks but no amount of fluid or urine to be monitored. The Nurse Note dated 04/09/24 at 08:15 AM, revealed the resident and staff informed the nurse that the resident had not voided since yesterday morning. R89 was not tracking mentally and had decreased LOC (level of consciousness). Staff performed a sternal rub (involves applying firm pressure to the sternum, or the flat bone in the middle of the chest, using the knuckles of a closed fist. This action creates a painful stimulus meant to provoke a response from the patient.) to rouse him. R89 had involuntary twitching. Staff rechecked R89's blood pressure and recorded it as 98/54 mmHg and rechecked with reading of 100/56 mmHg (low for resident). His O2 saturation was 99 percent on 3 liters (L) O2 per nasal cannula. R89's physician was in the building and at 08:30 AM, R89's physician assessed the resident and gave the nurse a verbal order to transfer the resident via Emergency Medical Services (EMS) for possible renal failure. The Nurse Note dated 04/09/24 at 03:17 PM, revealed the nurse received a call from the hospital and informed the facility the resident was admitted to Neuro Intensive Care Unit (ICU) for renal failure. During an interview on 04/15/24 at 12:30 PM, Certified Nurse Aide/Certified Medication Aide (CNA/CMA) Q reported she did not work directly with the resident as she passed medications but had heard other CNAs had been reporting to the nurses the resident had not voided. During an interview on 04/07/24 at 02:45 PM, CNA R reported on 04/15/24 all shift R89 only voided 300 cc urine in his urinal. She tried to get him to drink more and gave him extra fluids, but he still did not void. When she came back on shift the next day, she was told he still had not voided. She reported this information to the nurse, and they tried to get him to stand but the resident reported he did not even feel like he could void. She was off duty the next two days and when she came back, he was in the hospital. She reported she told the nurses for two days that R89 was unable to void. During an interview on 04/15/24 at 12:50 PM, Licensed Nurse (LN) S reported she worked the day R89 transferred to the hospital. LN S stated it was reported to her that the resident had not voided at all that night. LN S said the resident was hard to rouse and not himself, so she notified Physician U, who was present in the facility. The physician checked the resident and gave an order to transport R89 to the hospital. The resident had a history of kidney problems, but never had concerns about not voiding before, so staff did not monitor his intake or urinary output (I&O). There was no documentation in his record. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview on 04/15/24 at 11:30 AM, Administrative Nurse B reported the resident had a long history of kidney disease. Administrative Nurse B said R89 reported he had not voided, but staff said he did and was incontinent in a chair in the commons area. The nurse called Nurse Extender V to report his lack of voiding and received instructions to watch R89's voiding over the next 12 hours. Physician U also saw R89 on rounds on 04/09/24 and ordered to transfer the resident to the hospital. There were medication errors for R89, because the facility's admitting nurse did not process the resident's admission orders on return from the hospital (on 04/04/24), so the resident received the same medications from his prior facility admission. Administrative Nurse B stated R89's (prior) medication cards were still in the medication cart to be passed. During an interview on 04/15/24 at 01:30 PM, Administrative Nurse B reported that the resident returned to the facility on [DATE] at approximately 04:35 PM. Administrative Nurse B said LN T checked the resident in and passed report to LN W. Administrative Nurse B stated she told LN W it was her responsibility to readmit the resident and gave her the admission packet. Administrative Nurse B said the nurse did not check any of his orders or update his medications and as a result, the resident received all his previous medications and did not receive the new medications in the hospital discharge orders. Administrative Nurse B said it was not discovered until the admitting hospital questioned and compared his orders from the facility against his discharge orders he had when he left the hospital on 04/04/24. The discrepancy in medications was discovered and reported to the state (agency). During an interview on 04/15/24 at 03:45 PM, Physician U, who also serves as the facility medical director, reported she could not find the admission orders in the resident's EMR. The resident received diuretic medications prior to and after hospitalization . Physician U said she was concerned about the cardiac and hypertensive medications the resident received in error. Physician U also reported when she got report it was for R89 having low urine and she thought the resident was voiding some, just not much. Physician U said it is a worry that the nurses did not follow the discharge orders, but they do not have to call her for her approval or signature, since she was not the physician who ordered the medications. The facility's policy for Abuse, Neglect and Exploitation dated 2023, revealed it is the policy of the facility to provide protection for the health, welfare, and rights of each resident by developing written policies and procedures that prohibit and prevent abuse, neglect, and exploitation and misappropriation of resident property. Neglect means failure of the facility, its employees or services provided that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. An alleged violation is a situation or occurrence that is observed or reported by staff or other persons but has not yet been investigated and if verified could be indication of noncompliance with the Federal requirements related to neglect. The facility failed to prevent the neglect and alleged abuse of R89, a resident with chronic kidney disease and electrolyte imbalances, through the lack of appropriate nursing care after R1 returned to the facility following a 17-day hospitalization for sepsis. This deficient practice placed R89 in immediate jeopardy. On 04/16/24 at 01:20 PM, Administrative Staff A was provided the Immediate Jeopardy template and notified of the facility's failure to prevent the neglect of Resident (R)89, a resident with chronic kidney disease and electrolyte imbalances, through the lack of appropriate nursing care and services, follow-up, after R1 returned to the facility following a 17-day hospitalization for sepsis and reported he had not voided. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The immediate jeopardy was determined to first exist on 04/04/24 for the failure to monitor the resident's inability to void, and then when R89 was readmitted to the facility, it was discovered from the hospital that the facility failed to update the resident's medications. 1. All licensed nurses were reeducated on the admission/readmission checklist process. This was initiated on 04/10/24 and completed on 04/12/24 at 06:00 PM to the last licensed nurse, prior to starting her shift. All nurses were educated prior to the start of next shift. 2. All licensed nurses were reeducated on change of condition, notification to physician, and power of attorney (POA) of change of condition and reeducated in Abuse, neglect, and exploitation (ANE) regarding lack of follow up in residents change in condition completed on 04/16/24. 3. Facility will educate direct care staff to report to charge nurse immediately of any noticeable change in residents baseline activities of daily living (ADLs) including no urinary output or behavior prior to next shift. No staff will work until they have received this education. All licensed nurses were reeducated on change of condition and physician notification immediately or as soon as feasible on 04/16/24. The surveyor verified the facility implemented the above corrective measures onsite on 04/18/24 at 08:00 AM. The deficient practice remained at a scope and severity level of a L, following the implementation of the removal plan. 46960 - R19's Electronic Health Record (EHR) revealed diagnoses of generalized anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), obsessive-compulsive disorder (OCD is an anxiety disorder characterized by recurrent and persistent thoughts, ideas and feelings of obsessions severe to cause marked distress, consume considerable time or significantly interfere with the resident's occupational, social or interpersonal functioning), cognitive communication deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness), and major depressive disorder with psychotic symptoms (a major mood disorder which causes persistent feelings of sadness with a gross impairment in reality perception). The Admission Minimum Data Set (MDS) dated [DATE], documented a Brief Interview for Mental Status (BIMS) could not be completed due to R19 was rarely or never understood. The staff assessment documented R19 had memory problems with severely impaired cognition. The MDS documented R19 had hallucinations (sensing things while awake that appear to be real, but the mind created) and lacked documentation of any behaviors toward self or others. R19 required a wheelchair for locomotion and substantial/maximal assistance for all cares except eating which required setup and supervision. The MDS documented staff could not determine if R19 had any falls prior to admission, or fracture (broken bone) related to a fall in the six months prior to admission. The Falls Care Area Assessment (CAA) dated 12/04/23, documented R19 required extensive assistance of staff for all cares, was at risk for falls, and had a fall since admission with a fracture of nasal bones. The Behavioral Symptoms CAA did not trigger. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The Psychosocial Well-Being CAA dated 12/04/23, documented R19 was admitted to the facility after a battle with depression and had psychiatric services ordered. R19 had episodes of behaviors that included hallucinations and delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue) and required staff to assist one-on-one (1:1) for interactions. The Quarterly MDS dated [DATE], documented R19 had a BIMS of 13, which indicated intact cognition. R19 had delusions (an untrue persistent belief or perception held by a person although evidence shows it was untrue) and hallucinations and lacked documentation of any behaviors toward self or others. R19 required partial/moderate assistance with all cares except toileting, bathing, and putting on/taking off footwear. R19 was dependent on staff for locomotion. R19 had two or more falls since admission and lacked documentation of any injuries from falls. The 04/22/24 Care Plan, initiated on 11/28/23, documented the resident was at risk for falls, had an actual fall, and included the following fall interventions: On 11/27/23, R19 had an unwitnessed fall in the dining area and instructed staff on 11/28/23 that R19 was to remain within an arm's reach while R19 was up in her wheelchair. On 11/28/23, staff were to obtain a bolster cover to help define the edges of R19's bed. On 11/28/23, staff were to provide R19 with activities or conversation when she was exhibiting signs of anxiety or restlessness. On 11/28/23, staff were to place a fall mat next to R19's bed to decrease injuries if the resident rolled out of the bed. On 11/28/23, staff were to move the resident to her room to rest in bed if she became restless in the dining area or commons area. On 03/06/24, R19 had an unwitnessed fall without injury and instructed staff to offer to get the resident up out of bed around 03:00 PM so she could people watch in the dining area before the evening meal. The Care Plan lacked interventions specific to R19's falls on 03/19/24 and 03/29/24, and further lacked interventions related to behavioral outbursts. The Nurse Note dated 03/19/24 at 10:12 AM documented R19 was in the quiet room next to the nurse's station with the doors shut and noted the resident was placed on 1:1 observation due to behaviors exhibited since 05:00 AM on 03/19/24 of yelling and screaming all morning and in a paranoia delusion that we are trying to hurt and poison her. The note included that a Certified Nurse Aide (CNA) [CNA C] came to get Licensed Nurse (LN) D and reported that the resident fell out of her wheelchair onto the floor when the CNA [CNA C] looked away for 5 seconds to grab something out of her purse. The note documented R19 had a scuffed and bruised right eye and R19 kept stating that CNA [CNA C] had hit her in the face, and she was yelling it out. The note included R19 was very reluctant to allow the LN to obtain her vitals. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of the facility's fall investigation and witness statements provided by Administrative Staff A and Consultant Nurse E on 04/24/24 at 12:26 PM, revealed the following information regarding the incident: 1. LN D documented on 03/19/24 at 07:20 AM that R19 fell from her wheelchair and sustained minor injuries to her face noting her right eye was scuffed and bruised and R19 made the allegation that the CNA (CNA C) had hit her. 2. LN D's undated witness statement signed and notarized on 04/24/24, documented she reported the allegation to the Director of Nursing (Administrative Nurse B) and resident's Primary Care Provider (PCP). The witness statement further documented that LN D did not hear or witness any abuse or neglect. LN D's witness statement lacked mention of removal of CNA C from working in the facility and/or with the resident further after the incident. 3. The 03/19/24 fall report lacked documentation of causal factors for the fall, immediate interventions initiated by the LN on duty, or permanent care plan interventions to prevent further falls for R19. Furthermore, the fall report lacked documentation that the allegation of abuse was investigated further or reported to the State Agency (SA - a state governmental agency that provides oversight for the Centers for Medicare & Medicaid Services [CMS - the federal government agency that administers the nation's major healthcare programs]) or local law enforcement, by Administrative Staff A or investigated by Administrative Nurse B. 4. Review of the unsigned and unnotarized witness statement photograph, provided by the facility that the facility claimed was from CNA C, dated March 13 of an unknown year, documented CNA C was providing 1:1 supervision of R19 in the lounge room where R19 had been trying to stand up from her wheelchair. The document further included that at an unknown time, CNA C became hungry and went to the other side of the room to retrieve a snack from her personal bag. CNA C turned around and discovered R19 had stood up unassisted. CNA C then walked swiftly towards R19 and witnessed R19 fall to the ground. CNA C documented that R19 claimed CNA C hit her, but that staff knew that to not be true because there was no handprint on R19 and R19 had developed a knot on her forehead. The document further noted for the remainder of her shift CNA C performed 1:1 supervision of R19 in a chair seated right next to R19 and did not leave until another staff member was present. During an interview on 04/24/24 at 12:26 PM, Administrative Staff A and Consultant Nurse E stated they were previously unaware of R19's allegation of abuse and stated they expected staff to report allegations of abuse directly to either Administrative Staff A or Administrative Nurse B. Administrative Staff A and Consultant Nurse E explained the process for abuse allegations included Administrative Staff A or Administrative Nurse B would suspend the individual(s) accused of abuse until a thorough investigation was completed, which included reporting to the SA and local law enforcement. Administrative Staff A and Consultant Nurse E confirmed this had not been completed regarding the 03/19/24 incident involving R19 and CNA C and stated Administrative Nurse B and CNA C were now suspended related to an unreported and uninvestigated allegation of abuse. The facility's undated Abuse, Neglect and Exploitation Policy documented the facility would provide protections for the health, welfare and rights of each resident to prohibit and prevent abuse, neglect and exploitation. The facility would implement policies and procedures to prevent and prohibit all types of abuse to achieve a safe environment free from abuse. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The facility failed to ensure R19 was free from abuse and neglect on 03/19/24, when R19 allegedly fell out of her wheelchair hurting her face, while on one-on-one observation in a closed room with CNA C, and R19 repeatedly stated CNA C struck her. The facility did not investigate the allegation of abuse or protect R19 from potential further abuse, and CNA C continued to work in the facility until her suspension on 04/24/24, 36 days after the allegation. The facility further failed to report the allegation of abuse to the State Agency. On 04/24/24 at 05:50 PM, Administrative Staff A, Consultant Nurse E and Administrative Nurse F were provided the Immediate Jeopardy (IJ) template for failure to ensure R1 was free from resident abuse and neglect when R19 reported CNA C struck her in the face. The facility submitted an acceptable plan for removal of the immediate jeopardy on 04/25/24 at 05:40 PM which included the following: On 04/24/24 at 12:10 PM, Administrative Nurse B and CNA C were suspended by the Administrative Staff A and Administrative Nurse F, respectively. On 04/24/24 at 12:45 PM, Administrative Staff A, Administrative Nurse F, Administrative Staff I, Maintenance Director H, Dietary Manager J, Housekeeping Manager K, Social Services Designee (SSD) L and Therapy Staff M were re-educated regarding ANE policy and processes by Consultant Nurse E. On 04/24/24 at 01:15 PM, the local police department notified and arrived at the community and initiated their investigation. On 04/24/24 at 01:25 PM, staff completed a head-to-toe assessment of R19 with no changes in skin conditions found. On 04/24/24 at 01:40 PM, the facility notified R19's Responsible Party/Power of Attorney of the incident that occurred on 03/19/24. On 04/24/24 at 01:47 PM, the facility notified R19's physician of the incident that occurred on 03/19/24 and received no new orders. On 04/24/24 at 02:45 PM, the facility held an Ad Hoc QAPI (quality assurance process improvement - a process by which a facility identifies and improves on problem areas). On 04/24/24 at 03:00PM, the facility completed and submitted a facility reported incident (FRI) report to the Kansas Department of Aging and Disability Services (KDADS/SA) related to the event of 03/19/2024. On 04/25/24 at 07:00 PM, the facility documented on 04/24/24 at an unknown time, Consultant Nurse E conducted a review of documentation of current residents, retrospectively back 12:00 AM on 03/19/24, with no findings of abuse identified by the facility. On 04/24/24 at 07:47 PM, the resident impacted by the event (R19) on 03/19/24, had a post trauma assessment completed on 04/24/24. SSD L reviewed the assessment as documented and showed no avert changes from resident's prior assessment. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 04/24/24 at an unknown time the facility safe surveys were conducted of nine alert and oriented residents. There were no concerns or additional findings identified by the facility. On 04/24/24 at an unknown time, the staff interviews were initiated with six current team members. These were completed on 04/25/24 at an unknown time, with no new concerns identified by the facility. On 04/24/24 at an unknown time, all current team members were to be re-educated [TRUNCATED]

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Protect each resident from the wrongful use of the resident's belongings or money. 50659 The facility reported a census of 35 residents with 20 residents included in the sample. Based on observation, interview, and record review the facility failed to ensure an effective system in place to prevent the misappropriation of resident property when staff diverted controlled medications and could not account for numerous controlled/missing narcotic medications affecting five residents of the facility. This deficient practiced affected Resident (R) 40, R39, R41, R24, and R89 and placed any resident who received controlled medications at risk for staff diversion of their medication and potential untreated symptoms management that could negatively affect their physical, mental, and psychosocial well-being. Findings included: - During the onsite health resurvey and complaint investigations revealed a concern regarding staff misappropriation of resident narcotic/controlled medication and drug diversion. Review of the facility reported incident (FRI) history for the facility revealed two FRI investigations regarding drug diversions. FRI#3574 was investigated with a prior complaint survey (92M411) on 10/25/23. The FRI investigation revealed Administrative Nurse B reported a drug diversion regarding discontinued medications for R39 and R41. The facility investigation revealed on 10/18/23 at approximately 06:30PM Administrative Nurse B and LN RR noticed a narcotic card of R39's Oxycodone (opioid narcotic medication used to treat severe pain) 5/325 mg looked suspicious, and the back side of the card appeared to have tape covering 4 torn open holes. Upon further investigation another card of Oxycodone HCL ER oral Tablet 12HR for R41 appeared to be missing one original pill as the color and size were slightly different and was also taped in the bubble pack. Administrative Nurse B's undated and signed witness statement into the 10/18/23 issue revealed R39's Oxycodone 5/325 mg card with the four taped over areas and R41's Oxycontin 5mg IR card with the 1 taped over area, did not have a matching imprint for the medication, and turned out to be Hydralazine (vasodilator medication, used to lower blood pressure), in their place. Administrative Nurse B's witness statement included the facility conducted on the spot re-education, and any discontinued/discharged narcotics must be given to Administrative Nurse B for safe secured storage within 24 hours of the resident medication being discontinued/resident discharged . The narcotics in question were stored in a double locked area of the medication cart until they could be destroyed by the pharmacist since the Oxycodone they discovered belonged to R39, who discharged from the facility on 09/27/23 and the oxycodone HCl ER Oral Tablet ER 12HR was prescribed to R41, but was discontinued on 10/13/23. The facility was unable to determine when these medications were taken and was not able to determine who has taken them. The facilty determined that no resident missed any scheduled doses of their pain medication related to this incident. The investigation included an addendum which documented LN RR, employed at the facility from 10/11/23 to 10/27/23, was terminated and turned into the State Board of Nursing for erratic behavior and suspected. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Corrective Actions for FRI #3574 included Administrative Nurse B would audit narcotic counts and verify cards have not been tampered with twice weekly for four weeks, then once a week for four weeks, then monthly as needed. Any non-compliance would immediately be addressed with reeducation and taken to the facility QAPI team. All CMAs and LNs received additional education on 10/24/23 on the process of narcotic administration, narcotic counts and documentation of controlled narcotics. All CMAs and LNs including agency staff who have not been educated would have face-to-face education prior to working their next shift. QAPI Ad Hoc meeting held on 10/19/23. The Facility Reported Incident (FRI) #5420 investigation revealed the facility discovered a drug diversion regarding discontinued controlled substances for R40, R39, R41, R24, and R89. Per the report, during the monthly pharmacy narcotic destruction on 01/23/24 at approximately 10:15 AM, the consultant Pharmacist and Administrative Nurse F discovered a potential medication diversion of narcotics with previously discharged resident medications. The FRI revealed the pharmacist noted the narcotic count sheets could potentially be copies of the original narcotic count sheets; however, per the facility report they concluded the narcotic sheets were the originals. The FRI noted on 01/23/24 all discontinued controlled medication present in the narcotic waste cabinet were destroyed per policy. The FRI identified potential missing medication cards and could not account for the missing cards of medications. On 01/24/24 at approximately 11:00 AM, the facility reviewed clinical records with the Pharmacy records and discovered the missing medication cards were not destroyed during the previous narcotic destruction. At approximately 11:30 AM the nursing leadership performed a controlled substance count and noted all controlled medications in the medication carts, along with count sheets were reviewed and no discrepancies in the count or cards were identified. For R40: The facility reported 96 tabs of 7.5 milligram (mg) Norco were unaccounted for/missing for R40. The onsite surveyor investigation revealed R40 had a diagnosis of chronic pain, was care planned for his mixed acute and chronic pain related to pelvic fracture and previous hip fracture. The Care Plan for R40 included the resident's pain was alleviated/relieved by pain medication regimen, the staff were to anticipate the resident need for pain relief and respond immediately to any complaint of pain, monitor for non-verbal indicators of pain, and included the resident preferred to have pain controlled by: Oxycontin as prescribed. R40 passed away on 10/26/23, almost three months prior. For R39: The facility reported 97 tabs of 5/325 mg Oxycodone were unaccounted for/missing for R39. The onsite surveyor investigation revealed R39 admitted to the facility after surgery (amputation) of toes on both feet, then discharged to the hospital on 09/27/23 where she passed away (almost four months prior). For R41 (also listed in FRI 3574): The facility reported 44 tabs of 20 mg Oxycodone and 46 tabs of 10 mg Oxycodone were unaccounted for/missing for R41. The onsite surveyor investigation revealed R41 discharged from the facility on 11/08/23 (2.5 months prior). For R24 (also listed in FRI 3574): The facility reported 2 tabs of 5mg Oxycodone were unaccounted for/missing for R24. The onsite surveyor investigation revealed R24 was a current resident of the facility and had diagnoses which included spinal stenosis, pain her right knee, chronic obstructive pulmonary disease, and right thigh bone fracture. For R89: The facility reported 33 half tabs of 5 mg Oxycodone were unaccounted for/missing for R89. The onsite surveyor investigation revealed R89 had a diagnosis of chronic pain. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility reported the incident to the State Agency and informed the state agency the interventions they put in place to prevent the incident from happening in the future included: A process change to all discontinued narcotics. All narcotics were placed in a double locked file cabinet in the Director of Nursing office. The facility began staff education on narcotic diversion, and initiated nursing education on the proper removing of medications from the medication carts. Observation during the onsite survey on 04/18/24 at 10:05 AM revealed the following concerns: The narcotic sheet for R18 noted a PRN Oxycodone was removed and signed out but did not contain the date staff signed it out for administration. The medication cart contained R10's Ativan 0.5 mg tablets in a blister pack with 27 pills, prescribed to R10. The label on the pack instructed to administer one tabled by mouth every three hours as needed (PRN), for anxiety. The surveyor noted three of the pills were wasted. The narcotic sheet did not contain a date entry for two of the wasted Ativan, and the one wasted Ativan was dated 02/09/24. All three were signed off by two staff members the Ativan were wasted. Surveyor investigation revealed R10 did not have an order for Ativan since the 11/07/23 end date. Observation on 04/18/24 at 10:42 AM revealed R35's Narcotic sheet did not contain a prescription number to be able to compare to the Narcotic card for R35's 5 mg Diazepam or R35's 10 mg Diazepam. Further observation revealed R15's as needed Ativan for anxiety, in the PRN section of the Narcotic Book, with the last dose documented on 11/21/23. The surveyor investigation revealed R15's Ativan order was discontinued on 03/19/24 (almost 4 months prior). During an interview on 04/18/24 at 10:35 AM, CMA CC stated when a narcotic medication was discontinued CMAs let the LN know, then the LN pulled the medication from the cart and destroyed it. CMA CC said she thought there was a destroy box in the medication room, but she was not sure. When asked what she does with her narcotic keys when she leaves the facility grounds to go to lunch, CMA CC stated she gave her keys to the LN if she left the facility grounds. When asked if she performed a narcotic medication count when she leaves the keys with the LN, CMA CC said no. During an interview on 04/18/24 at 10:38 AM, LN T stated the discontinued narcotic medications were picked up by Administrative Nurse F and Administrative Nurse B pick up the discontinued narcotics and lock them in a triple locked cabinet in Administrative Nurse B's office. During an interview on 04/18/24 at 11:00 AM, Administrative Nurse F stated the narcotics stayed in the med cart to be counted until both her and Administrative Nurse B were in the building together to collect the discontinued narcotic medications. Administrative Nurse F said they check every morning for discontinued narcotics and pull them out of the Narcotics drawer. Administrative Nurse F reported that each have their own key for the different locks on the cabinets and when asked what happens when one of the staff with a key go on vacations, Administrative Nurse F stated, not sure probably give our key to Administrative Staff A or Social Services Staff L. (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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 04/23/24 at 11:15 AM with Administrative Nurse B, Administrative Nurse F, and Consultant Nurse E revealed the narcotic medications that are discontinued remained in the medication car and were counted until both Administrative Nurse B and Administrative Nurse F can pull them the next day from the medication cart to lock up. When asked about the keys for the Narcotics lock box, Administrative Nurse B said she and Administrative Nurse F have their own keys on their key rings, they do not share keys or hand their keys off to no one. Administrative Nurse B further stated when they are not in the facility together or on vacation, they expected the discontinued narcotic medications to remain in the medication carts and be counted until they are removed by the two of them. When asked if they knew there were two residents with discontinued medications in the narcotic box on the medication cart, they both answered no. Administrative Nurse B stated the procedure for narcotic keys when a CMA left the facility included the charge nurse and CMA complete a narcotic count with every key release. The facility policy named Medication Errors dated 2023 revealed it is the policy of the facility to provide protections for the health, welfare, and rights of each resident by ensuring residents receive care and services safely in an environment free of significant medication errors. A significant medication error means one which causes the resident discomfort or jeopardizes his health and safety. The facility shall ensure medications will be administered according to physician orders. The facility's undated Discontinued Medications F755 policy revealed staff shall destroy medications or shall return them to the dispensing pharmacy in accordance with facility policy and state law. A practitioner's order to discontinue a resident's medication must be documented in the resident's clinical record and on the medication administration record (MAR). The nurse receiving the order to discontinue a medication is responsible for recording that information and notifying the dispensing pharmacy of the discontinuation. The facility failed to ensure an effective system in place to prevent the misappropriation of resident property when staff diverted controlled medications and could not account for numerous controlled/missing narcotic medications affecting five residents of the facility. This deficient practiced affected R40, R39, R41, R24, and R89 and placed any resident who received controlled medications at risk for staff diversion of their medication and potential untreated symptoms management that could negatively affect their physical, mental, and psychosocial well-being.

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46960 The facility reported a census of 35 residents with 20 residents reviewed for abuse. Based on observation, interview, and record review, the facility failed to ensure the timely reporting of alleged abuse to the State Agency (SA - a state governmental agency that provides oversight for the Centers for Medicare & Medicaid Services [CMS - the federal government agency that administers the nation's major healthcare programs]) or local law enforcement, as required. On 03/19/24 at around 10:00 AM, CNA C was on one-on-one observation in a closed-door room with just herself and cognitively impaired R19, due to the resident was yelling and screaming since 05:00 AM. CNA C reported that R19 allegedly fell out of her wheelchair to the floor obtaining a knot on her forehead, bruising, and abrasion to her eye. R19 repeatedly stated CNA C hit her. The Licensed Nurse reported the incident to the Director of Nursing, however the facility failed to report the allegation of abuse to the Administrator, State Agency, and local law enforcement regarding R19 repeatedly stating CNA C hit her. CNA C remained in a chair next to R19 for the remainder of her shift and continued to work at the facility with residents. The facility did not report the incident until 04/24/24, during the onsite survey, 36 days after the allegation. This deficient practice placed R19 immediate jeopardy and all residents at risk for abuse. Findings included: - R19's Electronic Health Record (EHR) revealed diagnoses of generalized anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), obsessive-compulsive disorder (OCD is an anxiety disorder characterized by recurrent and persistent thoughts, ideas and feelings of obsessions severe to cause marked distress, consume considerable time or significantly interfere with the resident's occupational, social or interpersonal functioning), cognitive communication deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness), and major depressive disorder with psychotic symptoms (a major mood disorder which causes persistent feelings of sadness with a gross impairment in reality perception). The Admission Minimum Data Set (MDS) dated [DATE], documented a Brief Interview for Mental Status (BIMS) could not be completed due to R19 was rarely or never understood. The staff assessment documented R19 had memory problems with severely impaired cognition. The MDS documented R19 had hallucinations (sensing things while awake that appear to be real, but the mind created) and lacked documentation of any behaviors toward self or others. R19 required a wheelchair for locomotion and substantial/maximal assistance for all cares except eating which required setup and supervision. The MDS documented staff could not determine if R19 had any falls prior to admission, or fracture (broken bone) related to a fall in the six months prior to admission. The Falls Care Area Assessment (CAA) dated 12/04/23, documented R19 required extensive assistance of staff for all cares, was at risk for falls, and had a fall since admission with a fracture of nasal bones. The Behavioral Symptoms CAA did not trigger. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The Psychosocial Well-Being CAA dated 12/04/23, documented R19 admitted to the facility after a battle with depression and had psychiatric services ordered. R19 had episodes of behaviors that included hallucinations and delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue) and required staff to assist one-on-one (1:1) for interactions. The Quarterly MDS dated [DATE], documented R19 had a BIMS of 13, which indicated intact cognition. R19 had delusions (an untrue persistent belief or perception held by a person although evidence shows it was untrue) and hallucinations and lacked documentation of any behaviors toward self or others. R19 required partial/moderate assistance with all cares except toileting, bathing, and putting on/taking off footwear. R19 was dependent on staff for locomotion. R19 had two or more falls since admission and lacked documentation of any injuries from falls. The 04/22/24 Care Plan, initiated on 11/28/23, documented the resident was at risk for falls, had an actual fall, and included the following fall interventions: On 11/27/23, R19 had an unwitnessed fall in the dining area and instructed staff on 11/28/23 that R19 was to remain within an arm's reach while R19 was up in her wheelchair. On 11/28/23, staff were to obtain a bolster cover to help define the edges of R19's bed. On 11/28/23, staff were to provide R19 with activities or conversation when she was exhibiting signs of anxiety or restlessness. On 11/28/23, staff were to place a fall mat next to R19's bed to decrease injuries if the resident rolled out of the bed. On 11/28/23, staff were to move the resident to her room to rest in bed if she became restless in the dining area or commons area. On 03/06/24, R19 had an unwitnessed fall without injury and instructed staff to offer to get the resident up out of bed around 03:00 PM so she could people watch in the dining area before the evening meal. The Care Plan lacked interventions specific to R19's falls on 03/19/24 and 03/29/24, and further lacked interventions related to behavioral outbursts. The Nurse Note dated 03/19/24 at 10:12 AM documented R19 was in the quiet room next to the nurse's station with the doors shut and noted the resident was placed on 1:1 observation due to behaviors exhibited since 05:00 AM on 03/19/24 of yelling and screaming all morning and in a paranoia delusion that we are trying to hurt and poison her. The note included that a Certified Nurse Aide (CNA) [CNA C] came to get Licensed Nurse (LN) D and reported that the resident fell out of her wheelchair onto the floor when the CNA [CNA C] looked away for 5 seconds to grab something out of her purse. The note documented R19 had a scuffed and bruised right eye and R19 kept stating that CNA [CNA C] had hit her in the face, and she was yelling it out. The note included R19 was very reluctant to allow the LN to obtain her vitals. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of the facility's fall investigation and witness statements provided by Administrative Staff A and Consultant Nurse E on 04/24/24 at 12:26 PM, revealed the following information regarding the incident: 1. LN D documented on 03/19/24 at 07:20 AM that R19 fell from her wheelchair and sustained minor injuries to her face noting her right eye was scuffed and bruised and R19 made the allegation that the CNA (CNA C) had hit her. 2. LN D's undated witness statement signed and notarized on 04/24/24, documented she reported the allegation to the Director of Nursing (Administrative Nurse B) and resident's Primary Care Provider (PCP). The witness statement further documented that LN D did not hear or witness any abuse or neglect. LN D's witness statement lacked mention of removal of CNA C from working in the facility and/or with the resident further after the incident. 3. The 03/19/24 fall report lacked documentation of causal factors for the fall, immediate interventions initiated by the LN on duty, or permanent care plan interventions to prevent further falls for R19. Furthermore, the fall report lacked documentation that the allegation of abuse was investigated further or reported to the SA or local law enforcement, by Administrative Staff A or investigated by Administrative Nurse B. 4. Review of the unsigned and unnotarized witness statement photograph, provided by the facility that the facility claimed was from CNA C, dated March 13 of an unknown year, documented CNA C was providing 1:1 supervision of R19 in the lounge room where R19 had been trying to stand up from her wheelchair. The document further included that at an unknown time, CNA C became hungry and went to the other side of the room to retrieve a snack from her personal bag. CNA C turned around and discovered R19 had stood up unassisted. CNA C then walked swiftly towards R19 and witnessed R19 fall to the ground. CNA C documented that R19 claimed CNA C hit her, but that staff knew that to not be true because there was no handprint on R19 and R19 had developed a knot on her forehead. The document further noted for the remainder of her shift CNA C performed 1:1 supervision of R19 in a chair seated right next to R19 and did not leave until another staff member was present. During an interview on 04/24/24 at 12:26 PM, Administrative Staff A and Consultant Nurse E stated they were previously unaware of R19's allegation of abuse and stated they expected staff to report allegations of abuse directly to either Administrative Staff A or Administrative Nurse B. Administrative Staff A and Consultant Nurse E explained the process for abuse allegations included Administrative Staff A or Administrative Nurse B would suspend the individual(s) accused of abuse until a thorough investigation was completed, which included reporting to the SA and local law enforcement. Administrative Staff A and Consultant Nurse E confirmed this had not been completed regarding the 03/19/24 incident involving R19 and CNA C and stated Administrative Nurse B and CNA C were now suspended related to an unreported and uninvestigated allegation of abuse. The facility's undated Abuse, Neglect and Exploitation Policy documented the facility would provide protections for the health, welfare, and rights of each resident to prohibit and prevent abuse, neglect and exploitation. The facility would implement policies and procedures to prevent and prohibit all types of abuse to achieve a safe environment free from abuse. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The facility failed to ensure an allegation of abuse was reported to the Administrator, State Agency, and local law enforcement, as required. On 03/19/24, R19 allegedly fell out of her wheelchair hurting her face while on one-on-one observation in a closed-door room with only CNA C present, and R19 repeatedly stated CNA C struck her. The facility did not report the allegation of abuse or protect R19 from potential further abuse, and CNA C continued to work in the facility until her suspension on 04/24/24, 36 days after the allegation. On 04/24/24 at 05:50 PM, Administrative Staff A, Consultant Nurse E and Administrative Nurse F were provided the Immediate Jeopardy (IJ) template for failure to report incidents of alleged abuse to the State Agency when R19 reported CNA C struck her in the face. The facility submitted an acceptable plan for removal of the immediate jeopardy on 04/25/24 at 05:40 PM which included the following: On 04/24/24 at 12:10 PM, Administrative Nurse B and CNA C were suspended by the Administrative Staff A and Administrative Nurse F, respectively. On 04/24/24 at 12:45 PM, Administrative Staff A, Administrative Nurse F, Administrative Staff I, Maintenance Director H, Dietary Manager J, Housekeeping Manager K, Social Services Designee (SSD) L and Therapy Staff M were re-educated regarding ANE policy and processes by Consultant Nurse E. On 04/24/24 at 01:15 PM, the local police department notified and arrived at the community and initiated their investigation. On 04/24/24 at 01:25 PM, staff completed a head-to-toe assessment of R19 with no changes in skin conditions found. On 04/24/24 at 01:40 PM, the facility notified R19's Responsible Party/Power of Attorney of the incident that occurred on 03/19/24. On 04/24/24 at 01:47 PM, the facility notified R19's physician of the incident that occurred on 03/19/24 and received no new orders. On 04/24/24 at 02:45 PM, the facility held an Ad Hoc QAPI (quality assurance process improvement - a process by which a facility identifies and improves on problem areas). On 04/24/24 at 03:00PM, the facility completed and submitted a facility reported incident (FRI) report to the Kansas Department of Aging and Disability Services (KDADS/SA) related to the event of 03/19/2024. On 04/25/24 at 07:00 PM, the facility documented on 04/24/24 at an unknown time, Consultant Nurse E conducted a review of documentation of current residents, retrospectively back 12:00 AM on 03/19/24, with no findings of abuse identified by the facility. On 04/24/24 at 07:47 PM, the resident impacted by the event (R19) on 03/19/24, had a post trauma assessment completed on 04/24/24. SSD L reviewed the assessment as documented and showed no avert changes from resident's prior assessment. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 04/24/24 at an unknown time the facility safe surveys were conducted of nine alert and oriented residents. There were no concerns or additional findings identified by the facility. On 04/24/24 at an unknown time, the staff interviews were initiated with six current team members. These were completed on 04/25/24 at an unknown time, with no new concerns identified by the facility. On 04/24/24 at an unknown time, all current team members were to be re-educated at mandatory training regarding Abuse Neglect and Exploitation (ANE) that began on 04/24/24 at an unknown time. Any team member who did not attend the in-person, mandatory training would receive verbal education no later than 12:00 AM on 04/25/24. This education would be completed by the Administrative Staff A with support from Administrative Staff N, if necessary. On 04/24/24 at an unknown time, R19 would be on every shift charting for 72 hours (three days). This documentation would be reviewed by Administrative Staff A during morning clinical review on each day that followed the documentation. On 04/25/24 at 07:00 PM, the facility provided documentation that R19 was followed by Physician Extender O who specialized in psychiatric care. On 04/25/24 at 07:00 PM, the facility provided documentation that when new team members would begin employment, they would receive ANE training as a part of their initial onboarding. All other employees would receive ANE training annually, and with any allegation or investigation regarding abuse. The surveyor verified the facility implemented the above corrective measures on-site on 04/25/24 at 07:11 PM. The deficient practice remained at a scope and severity level of a I, following the implementation of the removal plan.

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Respond appropriately to all alleged violations. 46960 The facility reported a census of 35 residents, with 20 residents included in the sample. Based on observation, interview, and record review, the facility failed to thoroughly investigate incidents of alleged abuse and failed to protect residents from further abuse. On 03/19/24, cognitively impaired R19 obtained a knot on her forehead, and a scuffed and bruised right eye while under the one-on-one supervision of Certified Nurse Aide (CNA) C, while in a closed-door room with no other witnesses. R19 had been yelling and screaming since 05:00 AM and at around 10:00 AM CNA C reported to Licensed Nurse (LN) D that R19 fell on to the floor when CNA C went to get something out of her purse. The LN documented that upon assessment R19 repeatedly stated CNA C hit her in the face and was yelling it out. The facility did not investigate the allegation of abuse or protect R19 from potential further abuse, which allowed CNA C to continue to sit in the chair right beside R19 in one-on-one observation and CNA C continued to work in the facility until her suspension on 04/24/24, 36 days after the allegation, when the facility started the investigation into the 03/19/24 allegation of abuse. This deficient practice placed R19 in immediate jeopardy and placed all residents at risk for abuse. Findings included: - During an onsite survey a concern regarding an unreported and uninvestigated allegation of staff to resident abuse was identified involving CNA C and R19 from 03/19/24, 36 days prior. (See R19 finding under F600). R19's Electronic Health Record (EHR) revealed a Nurse Note dated 03/19/24 at 10:12 AM which documented R19 was in the quiet room next to the nurse's station with the doors shut and noted the resident was placed on one-on-one (1:1) observation due to behaviors exhibited since 05:00 AM on 03/19/24. The note described the behaviors of yelling and screaming all morning and in a paranoia delusion that we are trying to hurt and poison her. The note included that a Certified Nurse Aide (CNA) [CNA C] came to get Licensed Nurse (LN) D and reported that the resident fell out of her wheelchair onto the floor when the CNA [CNA C] looked away for 5 seconds to grab something out of her purse. The note documented R19 had a scuffed and bruised right eye and R19 kept stating that CNA [CNA C] had hit her in the face, and she was yelling it out. The note included R19 was very reluctant to allow the LN to obtain her vitals. Review of the facility's 9-page Fall Investigation and witness statements provided by Administrative Staff A and Consultant Nurse E on 04/24/24 at 12:26 PM, revealed the following three items: (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	1. On a printed document with #267 Un-witnessed listed on the top line dated 03/19/24 at 07:20 AM, LN D identified R19 as the resident involved and the Incident Location as Other. The incident description included R19 was in the quiet room next to the nurse's station with the door shut. The resident was on 1:1 due to behaviors since 05:00 AM. LN D documented the resident was yelling and screaming all morning and in a paranoia delusion that we are trying to hurt and poison(sic) her. LN D documented she was in the middle of getting medication ready that was ordered from R19's physician when the CNA told her that [R19] had fallen out of her wheelchair. The CNA stated she looked away for five second to grab something out of her purse and the resident fell out of her wheelchair and onto the floor. The form noted in the immediate action taken that R19 had a scuffed and bruised right eye and kept stating that the CNA had hit her in the face, and she was yelling it out. The LN noted R19 was very reluctant to let the nurse get her vitals. The form included No injuries observed at the time of incident. Under the Level of Pain section, the following details were included for each item: Breathing: normal; Negative Vocalization: repeated troubled calling out, loud moaning or groaning, crying; Facial Expression: facial grimacing; Body Language: rigid, fists clenched, knees pulled up, pulling or pushing away, striking out; Consolability: Unable to Console, Distract or Reassure. The LN marked None and Wheelchair for the Predisposing Situation Factors. The form included under the Witnesses section: No Witnesses found. The form further included under Agencies/People Notified the following were notified on 03/19/24 at 07:30 AM: R19's DPOA, Administrative Nurse B, and Physician U. The from did not include any electronic signatures. 2. LN D's handwritten witness statement, signed and notarized on 04/24/24 by Administrative Staff A, documented on 03/19/24 at 07:20 AM, [R19] in a paranoid(sic) state and kept repeating we were poisoning her and trying to hurt her during [LN D] drawing up STAT PRN order for medication. This [LN D] was within hearing distance. CNA yelled for nurse that resident on floor, after assessing and neuros resident was assisted into the recliner(sic) and kept repeating aide slapped her but [LN D] did not hear or witness any abuse or neglect. LN D's witness statement noted Administrative Nurse B and Physician U were called and made aware. 3. Review of the photo image of an unnamed, unsigned, undated, and unnotarized handwritten note (which appeared to be written on lined spiral bound paper), provided by the facility and which the facility claimed was from CNA C revealed the following: On March 13th (incorrect date of incident and with no year listed) [R19] was having an(sic) episode where(sic) she cries(sic) and tries(sic) to get up on her own. That morning we decided that I do one on one with her because I am very good and patient with her and she responds really good with me, so I put her in the lounge room with me with the door shut so the noise out in the hallway wouldn't upset her more and so the residents wouldn't get mad at her crying. We were in there most all morning and some time(sic) in the morning I was getting a little hungry and I wanted to get a snack out of my bag real quick. [R19] was in her wheelchair and she hadn't tried to get up for a little bit so I got up and went to my bag real quick which was in the room with us. After I got to my bag and turn around [R19] stood up and I started to quickly get over to her to sit back down as I was headed to her she started to fall and then she hit the floor and got a knot on her forehead. I got the nurse and the whole time the nurse was looking at her she kept saying that I slapped her but we knew that I didn't cause there wasn't a handprint and that the knot on her forehead that she hit her head on the ground and so we got her back up in her wheelchair and I watched the rest of the day not moving from my chair right next to her until I had someone else in the room. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview on 04/24/24 at 12:26 PM, Administrative Staff A and Consultant Nurse E stated they were previously unaware of R19's allegation of abuse and stated they expected staff to report allegations of abuse directly to either Administrative Staff A or Administrative Nurse B. Administrative Staff A and Consultant Nurse E explained the process for abuse allegations included Administrative Staff A or Administrative Nurse B would suspend the individual(s) accused of abuse until a thorough investigation was completed, which included reporting to the SA and local law enforcement. Administrative Staff A and Consultant Nurse E confirmed this had not been completed regarding the 03/19/24 incident involving R19 and CNA C and stated Administrative Nurse B and CNA C were now suspended related to the unreported and uninvestigated allegation of abuse. The facility's undated Abuse, Neglect and Exploitation Policy documented the facility would provide protections for the health, welfare, and rights of each resident to prohibit and prevent abuse, neglect and exploitation. The facility would implement policies and procedures to prevent and prohibit all types of abuse to achieve a safe environment free from abuse. Furthermore, the policy documented that an immediate investigation was warranted when a suspicion or report of abuse, neglect or exploitation occur that included a complete and thorough documentation of the investigation. Additionally, the policy documented that the facility would make all efforts to ensure all residents were protected from physical and psychosocial harm as well as additional abuse during and after the investigation. The facility failed to ensure R19 was free from abuse and neglect on 03/19/24, when R19 allegedly fell out of her wheelchair hurting her face, while on one-on-one observation in a closed room with CNA C, and R19 repeatedly stated CNA C struck her. The facility did not investigate the allegation of abuse or protect R19 from potential further abuse, and CNA C continued to work in the facility until her suspension on 04/24/24, 36 days after the allegation. The facility further failed to report the allegation of abuse to the SA or local law enforcement. On 04/24/24 at 05:50 PM, Administrative Staff A, Consultant Nurse E, and Administrative Nurse F were provided the Immediate Jeopardy (IJ) template for failure to ensure all allegations of abuse were investigated and ensure the protection of residents, when on 03/19/24 R19 reported CNA C struck her in the face and the facility did not investigate the allegation until 04/24/24 and CNA C continued to work with R19 and residents of the facility. The facility submitted an acceptable plan for removal of the immediate jeopardy on 04/25/24 at 05:40 PM which included the following: On 04/24/24 at 12:10 PM, Administrative Nurse B and CNA C were suspended by Administrative Staff A and Administrative Nurse F, respectively. On 04/24/24 at 12:45 PM, Administrative Staff A, Administrative Nurse F, Administrative Staff I, Maintenance Director H, Dietary Manager J, Housekeeping Manager K, Social Services Designee (SSD) L and Therapy Staff M were re-educated regarding ANE policy and processes by Consultant Nurse E. On 04/24/24 at 01:15 PM, the local police department notified and arrived at the community and initiated their investigation. On 04/24/24 at 01:25 PM, staff completed a head-to-toe assessment of R19 with no changes in skin conditions found. (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 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 04/24/24 at 01:40 PM, the facility notified R19's Responsible Party/Power of Attorney of the incident that occurred on 03/19/24. On 04/24/24 at 01:47 PM, the facility notified R19's physician of the incident that occurred on 03/19/24 and received no new orders. On 04/24/24 at 02:45 PM, the facility held an Ad Hoc QAPI (quality assurance process improvement - a process by which a facility identifies and improves on problem areas) meeting. On 04/24/24 at 03:00PM, the facility completed and submitted a facility reported incident (FRI) report to the Kansas Department of Aging and Disability Services (KDADS/SA) related to the event on 03/19/24. On 04/25/24 at 07:00 PM, the facility documented on 04/24/24 at an unknown time, Consultant Nurse E conducted a review of documentation of current residents, retrospectively back 12:00 AM on 03/19/24, with no findings of abuse identified by the facility. On 04/24/24 at 07:47 PM, the resident impacted by the event (R19) on 03/19/24, had a post trauma assessment completed on 04/24/24. SSD L reviewed the assessment as documented and showed no avert changes from resident's prior assessment. On 04/24/24 at an unknown time the facility safe surveys were conducted of nine alert and oriented residents. There were no concerns or additional findings identified by the facility. On 04/24/24 at an unknown time, the staff interviews were initiated with six current team members. These were completed on 04/25/24 at an unknown time, with no new concerns identified by the facility. On 04/24/24 at an unknown time, all current team members were to be re-educated at mandatory training regarding Abuse Neglect and Exploitation (ANE) that began on 04/24/24 at an unknown time. Any team member who did not attend the in-person, mandatory training would receive verbal education no later than 12:00 AM on 04/25/24. This education would be completed by Administrative Staff A with support from Administrative Staff N, if necessary. On 04/24/24 at an unknown time, R19 would be on every shift charting for 72 hours (three days). This documentation would be reviewed by Administrative Staff A during morning clinical review on each day that followed the documentation. On 04/25/24 at 07:00 PM, the facility provided documentation that R19 was followed by Physician Extender O who specialized in psychiatric care. On 04/25/24 at 07:00 PM, the facility provided documentation that when new team members would begin employment, they would receive ANE training as a part of their initial onboarding. All other employees would receive ANE training annually, and with any allegation or investigation regarding abuse. The surveyor verified the facility implemented the above corrective measures on-site on 04/25/24 at 07:11 PM. The deficient practice remained at a scope and severity level of a F, following the implementation of the removal plan.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31078 The facility reported a census of 35 residents with 20 included in the sample. Based on interview and record review the facility failed to notify Resident (R)18, R21, and/or the resident's representative(s) of the transfer or discharge to the hospital and the reasons for the transfer in writing and in a language and manner they understood. This affected two of the three residents reviewed for hospitalization . Findings included: - Resident (R)18's signed Physician Orders dated 03/09/24 revealed diagnoses that included sepsis, (infection in the blood), impulse disorder (difficulty to control impulses), depression (sad mood), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), anoxic brain damage (brain damage caused by lack of oxygen), and nontraumatic intracerebral hemorrhage (brain bleed). R18's Admission Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of nine, indicating moderate cognitive impairment. The resident was dependent for cares and used a wheelchair propelled by staff for mobility. The resident had impaired range of motion (ROM) on one side of the upper extremities and both lower extremities. Review of the Care Area Assessments (CAA) dated 03/15/24 revealed the CAA's lacked any analysis for further investigation. R18's Baseline Care Plan dated 03/09/24, revealed the resident could communicate with staff and make needs known. The resident could feed himself with setup and supervision assistance in the dining room. Review of the 01/23/24 at 04:29 AM Nurse Notes documented R18 had gross hematuria (blood in the urine) when staff checked and changed him. The resident was incontinent with urine that saturated the resident's brief with a moderate amount of bright red blood mixed with urine. R18 picked at his scalp wound behind his right ear at the site of his recent craniotomy (surgical procedure on skull) and found he had a half-dollar sized opening, exposing white hardware or bone with yellow drainage. Staff notified the provider and were instructed to transfer the resident to a hospital in another town via Emergency Medical Services (EMS) for surgical wound dehiscence (opening of a previous surgical site) and gross hematuria of an unknown source. Review of the 01/23/24 at 02:20 PM Nurse's Note revealed the resident admitted to the hospital for surgery. Review of the resident's electronic medical record (EMR) lacked documentation the resident representative was notified in writing of when and why the resident was transferred to the hospital on 01/23/24. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/24/24 at 02:15 PM, Social Service Staff L reported nursing was responsible for notifying resident representatives when residents were hospitalized . On 04/24/24 at 02:30 PM, Consultant Nurse E and Administrator A reported they did not notify the representatives of hospitalization in writing. The nurse in charge of sending the resident to the hospital would call the representative, but they did not send out a written statement. The facility did not provide a policy on written representative notification as requested on 04/24/24. The facility failed to notify R18 and/or their representative with a written notice specifying when the resident was hospitalized and the reason for the hospitalization . - The signed Physician Orders02/16/24 revealed Resident (R) 21's diagnoses, which included type 1 diabetes mellitus (when the body cannot use glucose, not enough insulin is made or the body cannot respond to the insulin), gastroparesis (delayed emptying of intestinal content), ulcerative pancolitis (inflammatory colon disease), and enterocolitis due to clostridium difficile (Infection of the large intestine [colon] caused by bacteria). The Admission Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. The resident used a wheelchair/walker for mobility and required staff assistance with all daily cares. She was occasionally incontinent of urine. R21's Care Plan dated 02/15/24, documented R21 had a potential nutritional problem related to chronic conditions and required a mechanically altered diet. The resident had frequent episodes of nausea and vomiting since admission. Staff were to provide a regular, mechanical sot diet, and monitor the resident's intake and record the percentage every meal. Staff were to monitor R21 for signs of hypoglycemia (less than normal amount of sugar in the blood). The Physician's Order dated 04/14/24, directed staff to send the resident to the hospital if they vomited or had symptoms of diabetic ketoacidosis (DKA is a potentially life-threatening complication of diabetes with signs and symptoms that may include vomiting, abdominal pain, deep gasping breathing, increased urination). The 04/14/24 at 08:34 AM Nurse's Notes revealed the resident vomited and required hospitalization for the vomiting. Review of the resident's electronic medical record (EMR) lacked documentation of written notification of when the resident was hospitalized and the reason for the hospitalization . On 04/24/24 at 02:15 PM, Social Service Staff L reported nursing was responsible for notifying representatives when residents were hospitalized . On 04/24/24 at 02:30 PM, Consultant Nurse E and Administrator A reported they did not notify the representatives of hospitalization in writing. The nurse in charge of sending the resident to the hospital would call the representative, but they did not send out a written statement. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility did not provide a A Request for a policy on written representative notification as requested on 04/24/24. The facility failed to notify R21 and/or their representative with a written notice specifying when the resident was hospitalized and the reason for the hospitalization .

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31078 The facility reported a census of 35 residents with 20 included in the sample, including three residents reviewed for hospitalization . Based on interview and record review, the facility failed to provide a copy of the facility bed hold policy to Resident (R) 18 and R21 and/or their representative with a written notice specifying the duration and cost of the bed hold policy, at the time of the residents' transfer to the hospital. Findings included: - Resident (R)18's signed physician orders dated 03/09/24 had diagnoses that included sepsis, (infection in the blood), impulse disorder (difficulty to control impulses), depression (sad mood), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), anoxic brain damage (brain damage caused by lack of oxygen), nontraumatic intracerebral hemorrhage (brain bleed). R18's Admission Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of nine, indicating moderate cognitive impairment. The resident was dependent for care and used a wheelchair propelled by staff for mobility. The resident had impaired range of motion (ROM) on one side on upper extremity and both lower extremities. The Care Area Assessment (CAA) dated 03/15/24 revealed the CAA's lacked analysis for further investigation. R18's Baseline Care Plan dated 03/09/24, revealed the resident was able to communicate with staff and make needs known. The resident could feed himself with setup and supervision in the dining room. The Nurses's Note dated 01/23/24 at 04:29 AM documented the resident had gross hematuria (blood in the urine) during check and change. The resident was incontinent with urine that saturated the resident's brief with a moderate amount of bright red blood mixed with urine. R18 picked at his scalp wound behind his right ear at the site of his recent craniotomy (surgical procedure on skull) and found to have a half-dollar sized opening, exposing white hardware or bone with yellow drainage. Staff notified the provider and instructed to transfer to a hospital in another town via Emergency Medical Services (EMS) for Surgical Wound Dehiscence (opening of a previous surgical site) and gross hematuria of an unknown source. The Nurse's Note dated 01/23/24 at 02:20 PM revealed the resident admitted to the hospital for surgery. Review of the resident's electronic medical record (EMR) revealed it lacked a signed bed hold for hospitalization on [DATE]. On 04/23/24 at 01:10 PM, Administrative Nurse F reported social service staff was responsible for bed holds for the families when residents were sent to the hospital. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/24/24 at 02:15 PM, Social Service Staff L reported nursing was responsible for the bed holds when residents were hospitalized . On 04/24/24 at 02:30 PM, Consultant Nurse E and Administrator A reported social service staff was responsible to send bed holds to residents or their representatives for signatures. Administrative Staff A reported they had a training about a month ago on that very issue. The undated facility policy for Bed Hold revealed the community staff shall inform residents upon admission and prior to a transfer for hospitalization (unless for an emergency) or therapeutic leave of the bed hold policy. The bed hold information will include any charges that the resident may incur as well as the time limit established by the State Medicaid Plan for which the facility will reserve the resident's bed space. The facility failed to notify R18 and/or their representative with a written notice specifying the duration and cost of the bed hold policy at the time of the resident's transfer to the hospital. - The signed physician orders dated 02/16/24 revealed Resident (R) 21 had diagnoses, which included type 1 diabetes mellitus (when the body cannot use glucose, not enough insulin is made or the body cannot respond to the insulin), gastroparesis (delayed emptying of intestinal content), ulcerative pancolitis (inflammatory colon disease), and enterocolitis due to clostridium difficile (Infection of the large intestine [colon] caused by bacteria). The Admission Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. The resident used a wheelchair/walker for mobility and required staff assistance with all daily cares. She was occasionally incontinent of urine. R21's Care Plan dated 02/15/24, documented R21 had a potential nutritional problem related to chronic conditions and required a mechanically altered diet. The resident had frequent episodes of nausea and vomiting since admission. Staff were to provide a regular, mechanical sot diet, and monitor the resident's intake and record the percentage every meal. Staff were to monitor R21 for signs of hypoglycemia (less than normal amount of sugar in the blood). The Physician's order dated 04/14/24, revealed the resident was to be sent to the hospital if vomiting or having symptoms of diabetic ketoacidosis (DKA is a potentially life-threatening complication of diabetes with signs and symptoms that may include vomiting, abdominal pain, deep gasping breathing, increased urination). On 4/14/2024 at 08:34 AM, the nurse's notes revealed the resident had vomiting. R21 required hospitalization for the vomiting. Review of the resident's electronic medical record (EMR) revealed it lacked a signed bed hold for hospitalization on [DATE]. On 04/23/24 at 10:40 AM, Certified Nursing Assistant (CNA) P reported the resident was currently in the hospital for vomiting and unable to keep anything down. On 04/23/24 at 01:10 PM, Administrative Nurse F reported Social Services staff was responsible for bed holds for the families when residents were sent to the hospital. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/24/24 at 02:15 PM, social service staff L reported nursing was responsible for the bed holds when residents were hospitalized . On 04/24/24 at 02:30 PM, Consultant Nurse E and Administrator A reported it was the responsibility of the social service staff to send bed holds for signature. Administrative staff A reported they had a training about a month ago on that very issue. The undated facility policy for Bed Hold revealed the community staff shall inform residents upon admission and prior to a transfer for hospitalization (unless for an emergency) or therapeutic leave of the bed hold policy. The bed hold information will include any charges that the resident may incur as well as the time limit established by the State Medicaid Plan for which the facility will reserve the resident's bed space. The facility failed to notify R21 and/or their representative with a written notice specifying the duration and cost of the bed hold policy at the time of the resident's transfer to the hospital.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31078 The facility census totaled 35 residents with 20 residents included in the sample. Based on interview and record review, the facility failed to complete or complete an analysis of the Care Area Assessments (CAAs) triggered on the residents Minimum Data Set (MDS) for four residents that included Resident (R) 25, R18, R21, and R22. Findings included: - Resident (R)18's signed physician orders dated 03/09/24 had diagnoses that included sepsis, (infection in the blood), impulse disorder (difficulty to control impulses), depression (sad mood), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), anoxic brain damage (brain damage caused by lack of oxygen), nontraumatic intracerebral hemorrhage (brain bleed). R18's Admission Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of nine, indicating moderate cognitive impairment. The resident was dependent for care and used a wheelchair propelled by staff for mobility. The resident had impaired range of motion (ROM) on one side on upper extremity and both lower extremities. The Care Area Assessment (CAA) dated 03/15/24 revealed the CAA's lacked analysis for further investigation. R18's Baseline Care Plan dated 03/09/24, revealed the resident was able to communicate with staff and make needs known. The resident could feed himself with setup and supervision in the dining room. On 04/23/24 at 03:30 PM Administrative nurse B, Administrative Nurse F and Consultant Nurse E, Agreed the residents care (in office together) was the primary focus. They reported the MDS Coding, CAA development, and care plans should be completed in keeping with the guidance of the RAI manual. The CAA lacked analysis of findings related to the CAA's noted were merely a restatement of the codes themselves rather than an analysis to underlying issues as required to develop a care plan for individual resident's root cause of triggered areas. The care plan served as communication with the direct care staff to direct the care to meet the individual needs of each resident. A request for the MDS, CAA development was made on 04/23/24 at 04:00 PM. No policy provided. The facility failed to develop comprehensive assessments by the failure to complete the Care Area Assessments (CAAs) for further investigation and development of the comprehensive care plan. - Resident (R) 21's signed physician orders dated 02/16/24, revealed the following diagnoses that included type 1 diabetes mellitus (when the body cannot use glucose, not enough insulin is made or the body cannot respond to the insulin), gastroparesis (delayed emptying of intestinal content), ulcerative pancolitis (inflammatory colon disease), and enterocolitis due to clostridium difficile (Infection of the large intestine [colon] caused by bacteria). (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Admission Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. The resident used a wheelchair/walker for mobility and required staff assistance with all daily cares. She was occasionally incontinent of urine. The Care Area Assessment (CAA) dated 02/16/24 lacked analysis for further investigation and development of a comprehensive care plan. On 04/23/24 at 03:30 PM Administrative nurse B, Administrative Nurse F and Consultant Nurse E, Agreed the residents care (in office together) was the primary focus. They reported the MDS Coding, CAA development, and care plans should be completed in keeping with the guidance of the RAI manual. The CAA lacked analysis of findings related to the CAA's noted were merely a restatement of the codes themselves rather than an analysis to underlying issues as required to develop a care plan for individual resident's root cause of triggered areas. The care plan served as communication with the direct care staff to direct the care to meet the individual needs of each resident. A request for the MDS, CAA development was made on 04/23/24 at 04:00 PM. No policy provided. The facility failed to develop comprehensive assessments by the failure to complete the Care Area Assessments (CAAs) for further investigation and development of the comprehensive care plan. - Resident (R) 22's signed physician orders dated 04/22/24 revealed the following diagnoses that included Diabetes Mellitus (when the body cannot use glucose, not enough insulin is made or the body cannot respond to the insulin) with neuropathy (weakness, numbness and pain from nerve damage, usually in the hands and feet, congestive heart failure (CHF is a condition with low heart output and the body becomes congested with fluid, hypertension (elevated blood pressure), and chronic kidney disease. The Admission Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating normal cognition. The resident was independent with daily cares. R 22 received scheduled pain medication for occasional pain rated at a 5/10. Medications included insulin, antianxiety (class of medication used to calm and relax people), antidepressant (class of medication used to treat mood disorders), diuretic (medication to promote the formation and excretion of urine, and opioid pain medications. The Care Area Assessment (CAA) dated 08/18/23 revealed the CAA's lacked analysis for further investigation. On 04/23/24 at 03:30 PM Administrative nurse B, Administrative Nurse F and Consultant Nurse E, Agreed the residents care (in office together) was the primary focus. They reported the MDS Coding, CAA development, and care plans should be completed in keeping with the guidance of the RAI manual. The CAA lacked analysis of findings related to the CAA's noted were merely a restatement of the codes themselves rather than an analysis to underlying issues as required to develop a care plan for individual resident's root cause of triggered areas. The care plan served as communication with the direct care staff to direct the care to meet the individual needs of each resident. A request for the MDS, CAA development was made on 04/23/24 at 04:00 PM. No policy provided. (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility failed to develop comprehensive assessments by the failure to complete the Care Area Assessments (CAAs) for further investigation and development of the comprehensive care plan. 50659 - Resident (R)25's Electronic Health Record (EHR) revealed a diagnosis of diabetes mellitus type two (DM2-when the body cannot use glucose, not enough insulin made, or the body cannot respond to the insulin), generalized muscle weakness, absence of left leg below the knee and abnormalities of gait (manner or style of walking) and mobility, and delusional disorder (untrue persistent belief or perception held by a person although evidence shows it was untrue). The Admission Minimum Data Set (MDS) dated [DATE], documented a Brief Interview for Mental Status (BIMS) of 15, which indicated intact cognition. R25 required maximal to total assist with ADL's (activities of daily living such as walking, grooming, toileting, dressing and eating). R25 had impairment to one side of upper extremity and impairment to both sides of the lower extremity. Falls were not assessed. The Quarterly MDS dated [DATE], documented a BIMS of 15, which indicated intact cognition. The Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) dated 01/26/24, lacked analysis of findings documented. The documentation was computer triggered to assist staff in completion of the CAA's. The Falls CAA dated 01/26/24, did not trigger on MDS as falls were not assessed on the annual MDS. The Care Plan dated 04/22/24, revealed R25 had an Activities of daily living (ADL) self-care performance deficit and provided the following instructions for staff: On 04/22/24, staff were to provide extensive assistance of two staff for bed mobility and two staff for transfers with a Hoyer lift (total body mechanical lift). The Care Plan identified R25 was a high risk for falls staff were to follow the facility's fall protocol. Staff were to provide call light within the resident's reach. Staff were to respond promptly to requested assistance. On 01/03/24 at 01:35 PM, staff completed a fall risk evaluation and revealed R25 was a low risk for falls. On 01/11//24 at 05:34 AM, staff completed a fall risk evaluation and revealed R25 was a high risk for falls. The Electronic Health Records (EHR) Physician Orders lacked specific orders for safety or falls prevention. Review of the Progress Notes and Standard Assessments from 01/01/24 to 04/22/24 revealed the following: (continued on next page)

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	175450	A. Building B. Wing	04/25/2024

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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/28/23 at 12:55 PM, staff documented R25 had attempted to crawl out of the bed and was combative with staff that included behaviors of biting and hitting. R25 was lowered to the floor for the purpose of easier transfer to bed with the Hoyer lift. On 01/03/24 at 08:09 AM, staff documented R25 placed self on the floor from the bed as R25 was not assisted out of bed fast enough for the resident. On 01/03/24 at 10:52 PM, staff documented fall follow up. R25 denied pain or discomfort. On 01/11/24 at 05:35 AM, staff documented R25 was on the floor in the bedroom lying on the left side of the bed by the window. R25's (urinary) catheter tube (a flexible tube inserted through a narrow opening into a body cavity, particularly the bladder, for removing fluid) unattached from the drainage bag. Urine was on the floor around R25. Emesis (vomit) noted on the bed and the resident. Staff assisted R25 to bed with a Hoyer lift transfer. On 04/23/24 at 03:33 PM, Administrative Nurse B, Administrative Nurse F and Consultant Nurse E, agreed that residents care was the primary focus. They reported the MDS Coding, CAA development and care plans should be completed with Resident Assessment Instrument process (RAI) (provides a structured framework for assessing residents' physical, cognitive, and psychosocial functioning). The CAA lacked analysis of findings related to the CAA's noted were merely a restatement of the codes themselves rather than an analysis to underlying issues as required to develop a care plan for individual residents' root cause of triggered areas. They stated MDS's were completed off site and verified the MDS coding based on the documented information captured in the medical record review during the look back period. On 04/25/24 at 04:37 PM, Consultant Nurse EE stated that MDSs were completed remotely by several MDS nurses, and that information is obtained from chart notes, assessments and uploaded forms from the EHR. Consultant Nurse EE stated that she would call the facility, and question staff if more information is required to complete the MDSs. Consultant Nurse EE stated that if assessments are not completed, the facility will be called and reminded assessments need to be completed so MDS could be completed. On 04/23/24 at 03:33 PM, Consultant Nurse E, states there is no policy for MDS, that the RAI manual is utilized as a reference. The facility failed to complete an accurate comprehensive annual assessment on the MDS and an analysis of findings on resident (R)25 for falls. This practice had the potential to lead to negative psychosocial effects related to safety and uncommunicated needs.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36881 The facility reported a census of 35 residents with 20 residents selected for review. Based on observation, interview, and record review, the facility failed to accurately complete the Minimum Data Set (MDS) for sampled residents, Residents (R)3 and R23 related to inaccurate documentation of restraints, R24 related to use of wheelchair and Oxygen usage, R25 related to inaccurate documentation of falls, urinary catheter (a flexible tube inserted through a narrow opening into a body cavity, particularly the bladder, for removing fluid) and contracture (abnormal permanent fixation of a joint or muscle) to R25's left hand, R28 related to inaccurate documentation of falls and R32 related to no CAA development. These deficient practices had the potential to lead to uncommunicated need for care and services to meet each individual residents' needs. Findings included: - Resident (R)28's Electronic Medical Record (EMR) revealed the following diagnoses included Williams syndrome (A rare genetic disorder that causes developmental and learning disabilities), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), psychosis (any major mental disorder characterized by a gross impairment in reality testing), unsteady gait (gait (manner or style of walking), muscle weakness, history of falls, Downs syndrome (chromosomal abnormality characterized by varying degrees of mental retardation and multiple defects). R28's Admission Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. The resident required extensive assistance of two staff for transfers, locomotion, toileting, and personal hygiene. The resident was non-ambulatory with unsteady balance and required the use of a walker and wheelchair for mobility. The Quarterly MDS dated [DATE], revealed a BIMS score of 11, indicating moderate cognitive impairment. No significant changes in daily care with no falls since the last admission or last assessment dated [DATE], although the MDS lacked documentation of the resident's fall on 12/10/23. The resident was dependent on a wheelchair for mobility. Review of the facility's fall notes revealed the following: On 12/10/2023 at 08:50 PM, R28 fell and was found on the floor, laying on his back. On 02/22/2024 at 03:20 AM, R28 fell and was on the floor next to his bed. R28 appeared to have attempted a self-transfer. On 04/23/24 at 03:30 PM, Administrative Nurse B, Administrative Nurse F, and Consultant Nurse E agreed the resident care was the primary focus. They reported the MDS Coding and CAA development, and care plans should be completed in keeping with the guidance of the Resident Instrument Manual (RAI manual). MDS's are completed off site and verified the MDS coding should be based on the documented information captured in the medical record review during the look back period. (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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/25/24 at 04:37 PM, Licensed Nurse (LN) EE reported she completes MDS's off site. LN EE stated there were three facility nurses that were to sign off on the MDS's. Information obtained for the MDS was what information the facility had in their charting system. The facility staff should complete assessments so the MDS's could be completed. When the assessments were not completed on time, LN EE reported she would notify the facility and inform them they need to be completed so the MDS could be completed. LN EE reported she has not completed an MDS for the facility for several months, other than to complete a resident's entry MDS and would schedule other MDS's to be completed. LN EE reported she has not completed a care plan in over a year. The facility lacked a policy for completion of the MDS as staff use the RAI manual as a reference. The facility failed to accurately complete the Minimum Data Set (MDS) for this sampled resident These deficient practices had the potential to lead to uncommunicated need for care and services to meet each R28's residents' needs. - Resident (R)24's diagnoses from the electronic medical record (EMR) included chronic obstructive pulmonary disease (COPD- progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), generalized weakness, repeated falls, and osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain). R24's Annual Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. She required extensive assistance of one staff for dressing, toileting and personal hygiene and used a wheelchair for locomotion. The resident received an opioid pain medication on daily basis. The MDS lacked use of R24's oxygen. The 06/16/23 Falls Care Area Assessment (CAA) documented R24 had a history of bilateral (both) knee replacements. R24 required supervision to extensive assistance with activities of daily living (ADL) task completion and required a wheelchair and a walker for mobility/ambulation. R24 could transfers herself with assist as needed. The resident was at risk for falls. The Quarterly MDS dated [DATE], the resident had a BIMS score of 15, indicating intact cognition. The assessment included her use of oxygen but failed to document her use of a wheelchair or walker for mobility. The Electronic Health Records (EHR) Physician Orders dated 05/09/23 revealed Oxygen at 2 liters per minute (LPM) via nasal cannula (NC), to maintain oxygen saturation above 92 percent % as needed. Observation on 04/18/24 at 03:07 PM, revealed the resident seated in a wheelchair in room with her oxygen in place. On 04/23/24 at 03:30 PM, Administrative Nurse B, Administrative Nurse F, and Consultant Nurse E agreed the resident care was the primary focus. They reported the MDS Coding and CAA development, and care plans should be completed in keeping with the guidance of the Resident Instrument Manual (RAI manual). MDS's are completed off site and verified the MDS coding should be based on the documented information captured in the medical record review during the look back period. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/25/24 at 04:37 PM, Licensed Nurse (LN) EE reported she completes MDS's off site. LN EE stated there were three facility nurses that were to sign off on the MDS's. Information obtained for the MDS was what information the facility had in their charting system. The facility staff should complete assessments so the MDS's could be completed. When the assessments were not completed on time, LN EE reported she would notify the facility and inform them they need to be completed so the MDS could be completed. LN EE reported she has not completed an MDS for the facility for several months, other than to complete a resident's entry MDS and would schedule other MDS's to be completed. LN EE reported she has not completed a care plan in over a year. The facility lacked a policy for completion of the MDS as staff use the RAI manual as a reference. The facility failed to accurately complete the Minimum Data Set (MDS) for R24. These deficient practices had the potential to lead to uncommunicated need for care and services to meet R24's needs. - Review of Resident (R)32's undated Physician Orders, documentation included diagnoses of acute respiratory failure (difficulty breathing), dependence on supplemental oxygen, chronic obstructive pulmonary disease with acute exacerbation (COPD is a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), pneumonia (inflammation of the lungs), and tobacco use (smoker). The Admission Minimum Data Set, dated dated [DATE], documentation included the resident with a Brief Interview for Mental Status, (BIMS) score of 15, indicating intact cognition. He had functional limitation in range of motion on one side of upper and lower extremities. The resident smoked and exhibited shortness of breath on exertion. He received oxygen as a special treatment. The Care Area Assessment (CAA), dated 02/13/24, documentation lacked causal factors for further investigation for developing a comprehensive care plan. The Physician Order documentation related to respiratory care included the following orders: 1. Nebulizer: Change tubing and mouthpiece. Change filter and clean the nebulizer with sanitation wipe, every bedtime on Sundays, ordered 02/11/24. 2. Ipratropium-Albuterol Inhalation Solution, 0.5-2.5 (3.0) milligrams (MG)/3.0 milliliters (ML)(Ipratropium-Albuterol), every four hours as needed for COPD, ordered 04/18/24. On 04/23/24 at 03:30 PM, Administrative Nurse B, Administrative Nurse F, and Consultant Nurse E agreed the resident care was the primary focus. They reported the MDS Coding and CAA development, and care plans should be completed in keeping with the guidance of the Resident Instrument Manual (RAI manual). MDS's are completed off site and verified the MDS coding should be based on the documented information captured in the medical record review during the look back period. (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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/25/24 at 04:37 PM, Licensed Nurse (LN) EE reported she completes MDS's off site. LN EE stated there were three facility nurses that were to sign off on the MDS's. Information obtained for the MDS was what information the facility had in their charting system. The facility staff should complete assessments so the MDS's could be completed. When the assessments were not completed on time, LN EE reported she would notify the facility and inform them they need to be completed so the MDS could be completed. LN EE reported she has not completed an MDS for the facility for several months, other than to complete a resident's entry MDS and would schedule other MDS's to be completed. LN EE reported she has not completed a care plan in over a year. The facility lacked a policy for completion of the MDS as staff use the RAI manual as a reference. The facility failed to accurately complete the Minimum Data Set (MDS) for R32. These deficient practices had the potential to lead to uncommunicated need for care and services to meet R32's needs. - Review of Resident (R) 3's Physician Orders, dated 04/21/24 documentation revealed diagnoses which included Schizophrenia (mental disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought), obesity (severely overweight) , insomnia (inability to sleep , and depression (a mood disorder that causes a persistent feeling of sadness and loss The Admission Minimum Data Set, (MDS), dated [DATE], documented the resident was admitted on [DATE]) with a Brief Interview for Mental Status (BIMS) of 15, indicating cognitively intact. She did not exhibit any behaviors. The resident required extensive assistance of staff with activities of daily living (ADL) which included bed mobility, and transfers. The side rails were not used as restraints. The Quarterly MDS, dated [DATE], documented the resident with a BIMS score of 15, indicating cognitively intact. The MDS documentation noted the side rails were used daily as a physical restraint (physical restraints are any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body coded as used daily bed rails). On 04/18/24 at 03:46 PM , the resident sat in her wheelchair holding her right hand with her left hand with her right arm close to her side holding her right hand over her chest holding with her left hand. On 04/23/24 at 11:07 AM, Certified Nurse Aide s (CNA) AA and BB, and Certified Medication Aide (CMA) Q assisted the resident with transfer from the toilet. The staff positioned a gait belt one stood on her left side, another on her right side and a third in front of her while the resident pushed up from the toilet using her left hand with her right hand and arm in a sling. The staff provided verbal cues and physical guidance while reassuring the resident throughout the process. The resident pivoted with three staff assist to sit. The staff reapplied foot pedals to wheelchair and returned the resident to her room. The resident had grab bars/siderails at the head of her bed. She reported she used them to reposition herself in the bed and they did not limit her mobility. On 04/23/24 at 08:16 AM Licensed Nurse (LN) D reported the resident used her siderails (grab bars) at the head of her bed to turn and reposition. LN D stated R23 was independent with entering and exiting her bed. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/23/24 at 03:30 PM, Administrative Nurse B, Administrative Nurse F, and Nurse Consultant E agreed the facility did not use side rails as restraints in the facility. They confirmed the MDS's were completed by an offsite nurse, verified the MDS for R23 was inaccurate, and stated R23 did not use side rails as a physical restraint. Administrative Nurse B, Administrative Nurse F, and Nurse Consultant E agreed the Facility used the Resident Assessment Instrument (RAI) Manual for guidance to accurately code the MDS. The RAI Manual, dated 10/2023 defined physical restraints as any manual method physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body. The documented guidance included the intent of this section of the MDS was to record the frequency that the resident was restrained by any of the listed devices. Assessors should evaluate whether a device meets the definition of a physical restraint and code only the devices that meet the definitions in the appropriate categories. The facility failed to complete an accurate MDS assessment for R3 related to physical restraints. - Review of Resident (R)23's undated Physician Orders revealed diagnoses which included alcohol use with unspecified alcohol induced disorder, and major depression disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). The Admission Minimum Data Set (MDS), dated [DATE], documented the resident admitted to the facility on [DATE] and had a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. She did not exhibit any behaviors. The resident was independent with activities of daily living (ADL) which included bed mobility, transfers, and walking. The resident received antidepressants for five days of the look back period. The side rails were not used as restraints. The Quarterly MDS, dated [DATE], documented the resident with a BIMS score of 15, indicating cognitively intact. The MDS documentation noted the side rails were used daily as a physical restraint (physical restraints are any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body coded as used daily bed rails). Observation on 04/22/24 at 09:56 AM revealed R23 sat in a chair in her room. She stood from her chair at bedside, reached for her walker, and sat down independently. The bed had grab bars as siderails at the head of her bed. Upon inquiry, the resident reported she used the siderails (grab bars) to reposition herself and to enter and exit the bed. R23 stated the siderails (grab bars) did not prevent her from entering or leaving the bed voluntarily. On 04/23/24 at 08:16 AM Licensed Nurse (LN) D reported the resident used her siderails (grab bars) at the head of her bed to turn and reposition. LN D stated R23 was independent with entering and exiting her bed. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/23/24 at 03:30 PM, Administrative Nurse B, Administrative Nurse F, and Nurse Consultant E agreed the facility did not use side rails as restraints in the facility. They confirmed the MDS's were completed by an offsite nurse, verified the MDS for R23 was inaccurate, and stated R23 did not use side rails as a physical restraint. Administrative Nurse B, Administrative Nurse F, and Nurse Consultant E agreed the Facility used the Resident Assessment Instrument (RAI) Manual for guidance to accurately code the MDS. The RAI Manual, dated 10/2023 defined physical restraints as any manual method physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body. The documented guidance included the intent of this section of the MDS was to record the frequency that the resident was restrained by any of the listed devices. Assessors should evaluate whether a device meets the definition of a physical restraint and code only the devices that meet the definitions in the appropriate categories. The facility failed to complete an accurate MDS assessment for R23 related to physical restraints. 50659 - Resident (R)25's Electronic Health Record (EHR) revealed a diagnosis of diabetes mellitus type two (DM2-when the body cannot use glucose, not enough insulin made, or the body cannot respond to the insulin), generalized muscle weakness, absence of left leg below the knee and abnormalities of gait (manner or style of walking) and mobility, delusional disorder (untrue persistent belief or perception held by a person although evidence shows it was untrue), contracture (abnormal permanent fixation of a joint or muscle) of left hand muscle and neuromuscular dysfunction of bladder (the muscles that control the flow of urine out of the body do not relax and prevent the bladder from fully emptying). The Admission Minimum Data Set (MDS) dated [DATE], documented a Brief Interview for Mental Status (BIMS) of 15, which indicated intact cognition. R25 required maximal to total assist with ADL's (activities of daily living such as walking, grooming, toileting, dressing and eating). R25 had impairment to one side of upper extremity and impairment to both sides of the lower extremity. The falls assessment was not completed. The MDS documented that R25 was always continent of bladder and that R25 had a supra-pubic catheter (urinary bladder catheter inserted through the abdomen into bladder). The Quarterly MDS dated [DATE], documented a BIMS of 15, which indicated intact cognition. No impairment to one upper side extremity as was documented on previous MDSs and documented that R25 was occasionally incontinent of bladder. R25 had a supra-pubic catheter. The Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) dated 01/26/24, lacked analysis of findings documented. The documentation was computer triggered to assist staff in completion of the CAA's. The Falls CAA dated 01/26/24, did not trigger on MDS as falls were not assessed on the annual MDS. The Urinary Incontinence and Indwelling Catheter CAA dated 01/26/24, lacked analysis of findings documented. The documentation was computer triggered to assist staff in completion of the CAA's. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Care Plan dated 04/22/24, revealed R25 had an Activities of daily living (ADL) self-care performance deficit and provided the following instructions for staff: On 04/22/24, staff were to provide extensive assistance of two staff for bed mobility and two staff for transfers with a Hoyer lift (total body mechanical lift). The Care Plan identified R25 was a high risk for falls staff were to follow the facility's fall protocol. Staff were to provide call light within the resident's reach. Staff were to respond promptly to requested assistance. The Care Plan did not identify R25 with a Left -hand contracture. Staff were to apply a splint to be placed in the hand six-to-eight hours during AM shift and remove at dinner. The Care Plan identified supra-pubic catheter diagnosis of benign prostatic hyperplasia (BPH-non-cancerous enlargement of the prostate which can lead to interference with urine flow, urinary frequency and urinary tract infections). Staff were to provide catheter care each shift. Staff were to keep the catheter secured with an anchor device. Staff were to record the catheter output each shift. Staff were to keep the catheter always drain bag below the bladder. On 01/03/24 at 01:35 PM, staff completed a fall risk evaluation and revealed R25 was a low risk for falls. On 01/11//24 at 05:34 AM, staff completed a fall risk evaluation and revealed R25 was a high risk for falls. The Electronic Health Records (EHR) Physician Orders lacked specific orders for safety or falls prevention. The physician's order dated 02/03/24, staff were to administer hand splint to the left hand. Take the splint off during meals and at bedtime. May need washcloth over the hand split in the morning due to the hand splint being washed at night. Wash the hand splint with soap and water and hang it an over towel rack to dry until morning. Review of the Progress Notes and Standard Assessments from 01/01/24 to 04/22/24 revealed the following: On 12/28/2023 at 12:55 PM, staff documented R25 had attempted to crawl out of the bed and was combative with staff that included behaviors of biting and hitting. R25 was lowered to the floor for the purpose of easier transfer to bed with the Hoyer lift. On 01/03/2024 at 08:09 AM, staff documented R25 placed self on the floor from the bed as R25 was not assisted out of bed fast enough for the resident. On 01/03/2024 at 10:52 PM, staff documented fall follow up. R25 denied pain or discomfort. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/11/2024 at 05:35 AM, staff documented R25 was on the floor in the bedroom lying on the left side of the bed by the window. R25's (urinary) catheter tube (a flexible tube inserted through a narrow opening into a body cavity, particularly the bladder, for removing fluid) unattached from the drainage bag. Urine was on the floor around R25. Emesis (vomit) noted on the bed and the resident. Staff assisted R25 to bed with a Hoyer lift transfer. On 04/23/24 at 03:05 PM, CNA P (Certified Nurse Assistant), agreed R25 was to wear a left- hand splint or rolled washcloth every day. On 04/23/24 at 3:15 PM, Therapy Staff M, agreed R25 was to wear a left- hand splint every day, except for meals and bedtime. On 04/23/24 at 03:33 PM, Administrative Nurse B, Administrative Nurse F and Consultant Nurse E, agreed that residents care was the primary focus. They reported the MDS Coding, CAA development and care plans should be completed with Resident Assessment Instrument process (RAI) (provides a structured framework for assessing residents' physical, cognitive, and psychosocial functioning). The CAA lacked analysis of findings related to the CAA's noted were merely a restatement of the codes themselves rather than an analysis to underlying issues as required to develop a care plan for individual residents' root cause of triggered areas. They stated MDS's were completed off site and verified the MDS coding based on the documented information captured in the medical record review during the look back period. On 04/25/24 at 08:40 AM, CNA P stated R25 had a supra-pubic catheter. On 04/25/24 at 04:37 PM, Consultant Nurse EE stated that MDSs were completed remotely by several MDS nurses, and that information is obtained from chart notes, assessments and uploaded forms from the EHR. Consultant Nurse EE stated that she would call the facility, and question staff if more information is required to complete the MDSs. Consultant Nurse EE stated that if assessments are not completed, the facility will be called and reminded assessments need to be completed so MDS could be completed. On 04/23/24 at 3:33 PM, Consultant Nurse E, states there is no policy for MDS, that the RAI manual is utilized as a reference. The facility failed to complete an accurate comprehensive assessment on the MDS and an analysis of findings on resident (R)25 for falls, contracture of left hand and urinary incontinence. This practice had the potential to lead to negative psychosocial effects related to safety and uncommunicated needs.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46960 The facility reported a census of 35 residents with 20 residents selected for review. Based on observation, interview, and record review, the facility failed to accurately complete comprehensive care plan for four of the sampled residents, Resident (R)32, R22, and R3, and R 35. These deficient practices had the potential to lead to uncommunicated need for care and services to meet each individual residents' needs. Findings included: - Review of Resident (R)32's undated Physician Orders, documentation included diagnoses of acute respiratory failure (difficulty breathing), dependence on supplemental oxygen, chronic obstructive pulmonary disease with acute exacerbation (COPD is a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), pneumonia (inflammation of the lungs), and tobacco use (smoker). The Admission Minimum Data Set, dated dated [DATE], documentation included the resident with a Brief Interview for Mental Status, (BIMS) score of 15, indicating intact cognition. He had functional limitation in range of motion on one side of upper and lower extremities. The resident smoked and exhibited shortness of breath on exertion. He received oxygen as a special treatment. The Care Area Assessment (CAA), dated 02/13/24, documentation lacked causal factors for further investigation for developing a comprehensive care plan. The care plan lacked documentation related to respiratory care, oxygen delivery or nebulized medication use. The Physician Order documentation related to respiratory care included the following orders: 1. Nebulizer: Change tubing and mouthpiece. Change filter and clean the nebulizer with sanitation wipe, every bedtime on Sundays, ordered 02/11/24. 2. Ipratropium-Albuterol Inhalation Solution, 0.5-2.5 (3.0) milligrams (MG)/3.0 milliliters (ML)(Ipratropium-Albuterol), every four hours as needed for COPD, ordered 04/18/24. On 04/23/24 at 03:30 PM, Administrative Nurse B, Administrative Nurse F, and Consultant Nurse E agreed the resident care was the primary focus. They reported the MDS Coding and CAA development, and care plans should be completed in keeping with the guidance of the Resident Instrument Manual (RAI manual). On 04/25/24 at 05:26 PM, Administrative Staff A reported that care plans were done in the facility with each department filling out their section with final approval to be made by Administrative Nurse B. Consultant Nurse E and Administrative Staff A confirmed missing information on the resident's care plans. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's undated Comprehensive Care Plans policy documented a comprehensive care plan was a thorough assessment that includes the MDS and physician's orders assessments of residents and were ongoing and revised as needed. The policy failed to document the facility's responsibility or timeline of creation of comprehensive care plans. The facility failed to complete an accurate comprehensive care plan for R32. This deficient practice has the potential to lead to uncommunicated needs that would have a negative impact on the physical and psychosocial wellbeing of the resident. 36881 - Review of the Electronic Medical Record (EMR) for R3 revealed the resident had the following diagnoses: abnormalities of gait and mobility and morbid obesity (severely overweight) due to excess calories. Review of the Quarterly Minimum Data Set (MDS) dated [DATE] revealed the resident had a Brief Interview for Mental Status (BIMS) Score of 15, which indicated intact cognition. The resident had no impairment of range of motion of the upper or lower extremities and used a wheelchair for mobility. The resident required partial/moderate assistance for rolling left and right in bed. The resident required substantial/maximal assistance of staff for sitting to laying and laying to sitting in bed. Review of the Annual MDS dated [DATE] revealed the resident had a BIMS score of 15, which indicated intact cognition. The resident required partial/moderate assistance of staff for toileting hygiene, showering/bathing. The resident required substantial/maximal assistance of staff for upper and lower body dressing. R3 required partial/moderate assistance from staff for moving from sitting on the side of a bed to lying flat on the bed, lying to sitting on the side of the bed, sitting to standing, transferring to the toilet. The resident required supervision or touching assistance to roll to the left and right in bed. Review of the ADL Functional/Rehabilitation Potential Care Area assessment dated [DATE] lacked any further development or additional information indicating the resident required assistance with bed mobility. Review of the Care Plan dated 09/18/23 lacked any direction to staff regarding the ADL assistance R3 required until 04/23/24 (6 days after X-Ray verified the resident's right shoulder was dislocated, with suspected fracture). Review of the 04/18/24 at 04:08 PM Nurse Note revealed the resident reported that overnight a nursing staff member pulled on the resident's sore arm while assisting her into bed. Resident reports she feels like it was abuse. The writer informed the resident's physician of the resident's complaint, and she ordered an X-Ray of the right shoulder. Review of the 04/18/24 at 06:03 PM, a Nurse Note revealed X-Ray results revealed the resident had a dislocation and there was concern of an associated Hill Sachs (dent in the humerus caused by a dislocated shoulder) fracture. The resident would be sent out to the local Emergency Department to be evaluated and treated for injury. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the 04/18/24 at 10:42 PM, a Nurse Note revealed return to facility order to follow up with her provider within one two days. The resident had an arm sling in place, however there was no mention of a sling in the hospital discharge instructions. The hospital reported they were unable to determine the age of dislocation and further stated they were not going to attempt relocation. During an interview with the resident on 04/18/24 at 03:46 PM stated a nurse got her up and pulled her on her right arm. The resident held her right arm close to her side and held her right hand to her chest with her left hand. The resident felt like the staff member was mean and stated she did not deserve that. Observation on 04/23/24 at 10:47 AM revealed CNA AA and Certified Medication Aide (CMA) BB and CMA Q, transferred the resident to the toilet. R3 requested the third staff member for assistance. The resident sat in her wheelchair with a sling on her right arm. R3 stated she could only push herself up using her left hand. R3 told the staff she would need them to pull her pants down. Staff assisted the resident to stand and pivot to toilet. Staff removed the resident's brief and stated she was normally wet when toileting, it was part of their routine to toilet every two hours but stated she did not tell them when she had to go. With the use of a gait belt the resident stood from the toilet and pivoted with three staff assistance to sit. During an interview on 04/23/24 at 03:30 PM with Administrative Nurse B, Administrative Nurse F, and Consultant E, identified the nurse reported by the resident to have hurt her right arm on 04/18/24 as CNA HH. Administrative Nurse B, Administrative Nurse F, and Consultant E agreed the care plans should be completed according to the Resident Assessment Instrument (RAI) manual. They verified the CAA lacked analysis of findings and verified they were merely a restatement of the codes themselves rather than an analysis to underlying issues as required to develop a care plan for individual residents and identifying the root cause of triggered areas. They stated the care plan served as communication with the direct care staff to direct the care needed to meet the individual needs of each resident. They agreed the resident's care plan lacked addressing the individual needs of the resident. R3's care plan did not address ADLs or pain management, which R3 had been reporting for some time, prior to the 04/18/24 report. The undated facility policy titled F656, F657, F658, Comprehensive Care Plan , documentation included the comprehensive care plan is based on a thorough assessment that includes but is not limited to the MDS and physician's orders. Assessments of residents are ongoing and care plans are revised as information about the resident and the resident's condition change. Each resident's comprehensive care plan is designed to incorporate risk factors associated with identified problems. The facility failed to develop a plan of care related to ADLs for R3, which included instructions to staff for the resident's transfers and/or bed mobility. This failure resulted in actual harm when on 04/18/24 CNA FF pulled on R3's sore arm while assisting her into bed, R3 was transported to the local Emergency Department (ED) and diagnosed with a right shoulder dislocation and suspicion of a Hill Sachs Fracture. 31078 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Resident (R) 22's signed physician orders dated 04/22/24 revealed the following diagnoses that included Diabetes Mellitus (when the body cannot use glucose, not enough insulin is made or the body cannot respond to the insulin) with neuropathy (weakness, numbness and pain from nerve damage, usually in the hands and feet, congestive heart failure (CHF is a condition with low heart output and the body becomes congested with fluid, hypertension (elevated blood pressure), and chronic kidney disease. The Admission Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating normal cognition. The resident was independent with daily cares. R 22 received scheduled pain medication for occasional pain rated at a 5/10. Medications included insulin, antianxiety (class of medication used to calm and relax people), antidepressant (class of medication used to treat mood disorders), diuretic (medication to promote the formation and excretion of urine, and opioid pain medications. The Care Area Assessment (CAA) dated 08/18/23 revealed the CAA's lacked analysis for further investigation. The facility lacked a care plan related to his medication needs. On 04/23/24 at 03:30 PM Administrative nurse B, Administrative Nurse F and Consultant Nurse E, Agreed the residents care (in office together) was the primary focus. They reported the MDS Coding, CAA development, and care plans should be completed in keeping with the guidance of the RAI manual. The CAA lacked analysis of findings related to the CAA's noted were merely a restatement of the codes themselves rather than an analysis to underlying issues as required to develop a care plan for individual resident's root cause of triggered areas. The care plan served as communication with the direct care staff to direct the care to meet the individual needs of each resident. The undated facility policy for Comprehensive Care Plans revealed the comprehensive care plan is based on a thorough assessment that includes, but not limited to, the MDS and physician's orders. Assessments of residents are ongoing and care plans are revised as information about the resident and the resident's condition change. The facility failed to develop a comprehensive care plan for R22. 50659 - Resident (R)35's Electronic Health Record (EHR) revealed diagnoses of insomnia (inability to sleep), generalized anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), cerebral palsy (a progressive disorder of movement, muscle tone or posture caused by injury or abnormal development in the immature brain, most often before birth), trisomy 21(a genetic disorder), translocation type of downs syndrome (chromosomal abnormality characterized by varying degrees of mental retardation and multiple defects) and dysphasia (a condition that affects the ability to produce and understand spoken language). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Admission Minimum Data Set (MDS) dated [DATE], documented a Brief Interview for Mental Status (BIMS) could not be completed due to R35 was rarely or never understood. The staff assessment documented R35 had memory problems with severely impaired cognition. The MDS documented always incontinent of bowel and bladder, other behavioral symptoms and wandering occurred daily during the seven-day look-back period, and R35 was dependent on staff for all cares. The Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) was not triggered on the 04/09/24 MDS. The Cognitive Loss/Dementia CAA dated 04/09/24 lacked analysis of findings documented. The documentation was computer triggered to assist staff in completion of the CAA's. The Urinary Incontinence and Indwelling Catheter (a flexible tube inserted through a narrow opening into a body cavity, particularly the bladder, for removing fluid) CAA dated 04/09/24, lacked analysis of findings documented. The documentation was computer triggered to assist staff in completion of the CAA's. The 04/22/24 Care Plan lacked instructions for staff related to ADL's (activities of daily living such as walking, grooming, toileting, dressing and eating), transfers, or safety related to resident's preference to sit on the floor in random places/patterns. The 04/22/24 Care Plan lacked interventions related to maintaining or improving total incontinence of bladder and bladder. Review of the Progress Notes and Standard Assessment from 03/28/24 to 04/25/24 revealed the following: On 03/28/24 at 02:34 PM, staff documented R35 arrived at the facility via transportation. R35 had a pleasant behavior, ambulated by walking and used a wheelchair, R35 was NPO (nothing by mouth), and incontinent of bowel and bladder. On 03/29/24 at 07:17 AM, staff documented R35 awake most of the night, and slept on the floor at times. R35 wandered into other residents' rooms, was non-verbal and was easily re-directed. On 04/01/24 at 11:16 AM, staff documented R35 was nonverbal, and his mentality was like a ten-year-old. R35 had difficulty focusing attention (easily distracted, out of touch, or difficulty following what was said), and was continuously present. R35's thinking was continuously disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject). On 04/01/24 at 11:31 AM, staff documented R35 was on one to one monitoring for safety as R35 was all over the facility in a wheelchair or ambulated independently. On 04/03/24 at 05:55 AM, staff documented R35 was awake all night until 05:40 AM. R35 fell asleep in the wheelchair when being propelled up and down the hallways. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/22/24 at 08:48 AM, observed R35 in R4's room he wandered behind R4 seated in a wheelchair. R35 opened the top drawer of nightstand. At 08:49 AM, Certified Nurse Aide (CNA) P entered R4's room and closed the door. At 08:50 AM, CNA P opened the door and had R35 leave the room. R35 sat down on the floor in front of a resident's room. Staff walked by R35 as he sat on the floor. On 04/24/24 at 02:02 PM, R35 seated on the floor hallway Old Mill where the fire doors close. 2 staff members walked by resident, then came back at 02:04 PM. Staff assisted R35 to a wheelchair used 2 staff assist and a gait belt. R35's pants were very wet on back down legs. On 4/25/24 at 5:26 PM, Administrative Staff A, reported care plans completed in house hasn't been a certain person. The facility would be working with each department to complete their sections. Previously it was the Director of Nursing that completed the care plans. The undated policy on Comprehensive Care Plans documented an individualized comprehensive person-centered care plan that included measurable objectives and time frames to meet the resident's medical, nursing, mental, cultural, and psychological needs is developed for each resident. The comprehensive care plan is based on thorough assessment that included, but not limited to, the MDS and physician's orders. Assessments of residents are ongoing and care plans are revised as information about the resident and resident's condition change. The facility failed to develop and implement an individualized comprehensive person-centered developed and implemented to meet R35' preferences and goals, to address the resident's physical, mental and psychosocial needs as required, and within the required time frame. This practice had the potential to lead to negative psychosocial effects related to safety and risk for unmet care needs.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50659 The facility reported a census of 35 residents, with 20 residents reviewed. Based on record review and interview, the facility failed to revise a care plan for Resident (R) 25, related to falls. Findings included: - Resident (R)25's Electronic Health Record (EHR) revealed a diagnosis of diabetes mellitus type two (DM2-when the body cannot use glucose, not enough insulin made, or the body cannot respond to the insulin), generalized muscle weakness, absence of left leg below the knee and abnormalities of gait (manner or style of walking) and mobility, and delusional disorder (untrue persistent belief or perception held by a person although evidence shows it was untrue). The Admission Minimum Data Set (MDS) dated [DATE], documented a Brief Interview for Mental Status (BIMS) of 15, which indicated intact cognition. R25 required maximal to total assist with ADL's (activities of daily living such as walking, grooming, toileting, dressing and eating). R25 had impairment to one side of upper extremity and impairment to both sides of the lower extremity. Falls were not assessed. The Quarterly MDS dated [DATE], documented a BIMS of 15, which indicated intact cognition. The Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) dated 01/26/24, lacked analysis of findings documented. The documentation was computer triggered to assist staff in completion of the CAA's. The Falls CAA dated 01/26/24, did not trigger on MDS as falls were not assessed on the annual MDS. The Care Plan dated 04/22/24, revealed R25 had an Activities of daily living (ADL) self-care performance deficit and provided the following instructions for staff: On 04/22/24, staff were to provide extensive assistance of two staff for bed mobility and two staff for transfers with a Hoyer lift (total body mechanical lift). The Care Plan identified R25 was a high risk for falls staff were to follow the facility's fall protocol. Staff were to provide call light within the resident's reach. Staff were to respond promptly to requested assistance. The care plan lacked an intervention for staff guidance when staff lowered the resident to the floor when combative on 12/28/23. The care plan lacked staff guidance when R25 was on the floor on 01/03/24 to prevent possible further falls. The care plan lacked staff guidance when R25 was on the floor on 01/11/24 to prevent possible further falls. On 01/03/24 at 01:35 PM, staff completed a fall risk evaluation and revealed R25 was a low risk for falls. On 01/11//24 at 05:34 AM, staff completed a fall risk evaluation and revealed R25 was a high risk for falls. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Electronic Health Records (EHR) Physician Orders lacked specific orders for safety or falls prevention. Review of the Progress Notes and Standard Assessments from 01/01/24 to 04/22/24 revealed the following: On 12/28/2023 at 12:55 PM, staff documented R25 had attempted to crawl out of the bed and was combative with staff that included behaviors of biting and hitting. R25 was lowered to the floor for the purpose of easier transfer to bed with the Hoyer lift. On 01/03/2024 at 08:09 AM, staff documented R25 placed self on the floor from the bed as R25 was not assisted out of bed fast enough for the resident. On 01/03/2024 at 10:52 PM, staff documented fall follow up. R25 denied pain or discomfort. On 01/11/2024 at 05:35 AM, staff documented R25 was on the floor in the bedroom lying on the left side of the bed by the window. R25's (urinary) catheter tube (a flexible tube inserted through a narrow opening into a body cavity, particularly the bladder, for removing fluid) unattached from the drainage bag. Urine was on the floor around R25. Emesis (vomit) noted on the bed and the resident. Staff assisted R25 to bed with a Hoyer lift transfer. On 04/23/24 at 03:33 PM, Administrative Nurse B, Administrative Nurse F and Consultant Nurse E, agreed that residents care was the primary focus. They reported the MDS Coding, CAA development and care plans should be completed with Resident Assessment Instrument process (RAI) (provides a structured framework for assessing residents' physical, cognitive, and psychosocial functioning). The CAA lacked analysis of findings related to the CAA's noted were merely a restatement of the codes themselves rather than an analysis to underlying issues as required to develop a care plan for individual residents' root cause of triggered areas. They stated MDS's were completed off site and verified the MDS coding based on the documented information captured in the medical record review during the look back period. On 04/25/24 at 04:37 PM, Consultant Nurse EE stated that MDSs were completed remotely by several MDS nurses, and that information is obtained from chart notes, assessments and uploaded forms from the EHR. Consultant Nurse EE stated that she would call the facility, and question staff if more information is required to complete the MDSs. Consultant Nurse EE stated that if assessments are not completed, the facility will be called and reminded assessments need to be completed so MDS could be completed. On 04/25/24 at 05:26 PM, Administrative Staff A, reported care plans completed in house hasn't been a certain person. Will be working with each department to complete their sections. Previously it was the Director of Nursing that completed the care plans. On 04/23/24 at 03:33 PM, Consultant Nurse E, states there is no policy for MDS, that the RAI manual is utilized as a reference. The facility failed to revise care plan when appropriate for R25 after falls occurred. This practice had the potential to lead to negative psychosocial effects related to safety could cause more falls.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50659 The facility identified a census of 35 residents, which included 20 residents in the sample. Based on interviews and record review, the facility failed to provide services to meet professional standards of care when staff failed to assess Resident (R)35's feeding tube for proper placement before administering water and medications. This deficient practice had the potential to have a negative effect on R35's physical well-being. Findings included: - Resident (R)35's Electronic Health Record (EHR) revealed diagnoses of cerebral palsy (a progressive disorder of movement, muscle tone or posture caused by injury or abnormal development in the immature brain, most often before birth), trisomy 21(a genetic disorder), translocation type of downs syndrome (chromosomal abnormality characterized by varying degrees of mental retardation and multiple defects), and congenital esophageal stenosis (intrinsic narrowing of esophagus at birth). The Admission Minimum Data Set (MDS) dated [DATE], documented a Brief Interview for Mental Status (BIMS) could not be completed due to R35 was rarely or never understood. The staff assessment documented R35 had memory problems with severely impaired cognition. The MDS documented R35 had a feeding tube (tube for introducing high calorie fluids into the stomach) and R35 was dependent on staff for all cares. The Feeding Tube Care Area Assessment CAA dated 04/09/24, lacked analysis of findings documented. The documentation was computer triggered to assist staff in completion of the CAA's. The Nutritional Status CAA dated 04/09/24 lacked analysis of findings documented. The documentation was computer triggered to assist staff in completion of the CAA's. The Dehydration/Fluid Maintenance CAA dated 04/09/24 lacked analysis of findings documented. The documentation was computer triggered to assist staff in completion of the CAA's. The 04/22/24 Care Plan lacked instructions for nursing staff on how to assess a feeding tube prior to feeding tube being used for administration of fluids and medications. The Physician's Order, dated 04/18/24, documented staff were to administer enteral nutrition via gravity or bolus: Jevity (a liquid nutrition product), 237 milliliter (ml), five times a day, per feeding tube. The physician's order lacked direction to assess placement of feeding tube prior to administering feeding. Review of the Progress Notes and Standard Assessment from 03/28/24 to 04/25/24 revealed the following: On 03/28/24 at 02:34 PM, staff documented R35 arrived at the facility via transportation. R35 was NPO (nothing by mouth). (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/29/24 at 07:17 AM, staff documented R35 tolerated the feeding well, and the percutaneous endoscopic gastrostomy (PEG) tube placement verified per auscultation (listening to sounds with a stethoscope). On 04/22/24 11:51 AM, Licensed Nurse (LN) D failed to check the placement of feeding tube prior to water administration thru the PEG tube. LN D agreed that staff should check placement prior to administering water, medications or feeding. On 4/22/24 12:15 PM, Administrative Nurse B reported staff should assess for placement of the feeding tube prior to any type of administration. The undated policy of Enteral Nutrition lacked documentation on assessing feeding tube prior to administration of water, medications, or enteral nutrition. The facility failed to provide services that meet professional standards of quality when Resident (R)35 did not have feeding tube evaluated for correct placement before administering water and medications. This deficient practice had the potential to have a negative effect on R35's physical well-being.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - 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** 36881 The facility census totaled 35 with 20 residents in the sample, including three residents reviewed for Activities of Daily Living (ADLs). Based on observation, interview, and record review the facility failed to provide appropriate ADL care to Resident (R)3, when staff hurt this resident's shoulder. This failure resulted in actual harm when on 04/18/24 Certified Nurse Aide (CNA) HH pulled on R3's sore arm while assisting her in bed, R3 transported to the local Emergency Department (ED) where she was diagnosed with a right shoulder dislocation and suspicion of a Hill Sachs Fracture (dent in the humerus caused by a dislocated shoulder). Additionally, the facility failed to provide assistance for dependent residents during meals for R8. Furthermore, the facility failed to provide grooming assistance for R25. Findings included: - Review of the Electronic Medical Record (EMR) for R3 revealed the resident had the following diagnoses: abnormalities of gait and mobility and morbid obesity (severely overweight) due to excess calories. Review of the Quarterly Minimum Data Set (MDS) dated [DATE] revealed the resident had a Brief Interview for Mental Status (BIMS) Score of 15, which indicated intact cognition. The resident had no impairment of range of motion of the upper or lower extremities and used a wheelchair for mobility. The resident required partial/moderate assistance for rolling left and right in bed. The resident required substantial/maximal assistance of staff for sitting to laying and laying to sitting in bed. Review of the Annual MDS dated [DATE] revealed the resident had a BIMS score of 15, which indicated intact cognition. The resident required partial/moderate assistance of staff for toileting hygiene, showering/bathing. The resident required substantial/maximal assistance of staff for upper and lower body dressing. R3 required partial/moderate assistance from staff for moving from sitting on the side of a bed to lying flat on the bed, lying to sitting on the side of the bed, sitting to standing, transferring to the toilet. The resident required supervision or touching assistance to roll to the left and right in bed. Review of the ADL Functional/Rehabilitation Potential Care Area assessment dated [DATE] lacked any further development or additional information indicating the resident required assistance with bed mobility. Review of the Care Plan dated 09/18/23 lacked any direction to staff regarding the ADL assistance R3 required until 04/23/24 (6 days after X-Ray verified the resident's right shoulder was dislocated, with suspected fracture). Review of the 04/18/24 at 04:08 PM Nurse Note revealed the resident reported that overnight a nursing staff member pulled on the resident's sore arm while assisting her into bed. Resident reports she feels like it was abuse. The writer informed the resident's physician of the resident's complaint, and she ordered an X-Ray of the right shoulder. (continued on next page)

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F 0677 Level of Harm - Actual harm Residents Affected - Few	Review of the 04/18/24 at 06:03 PM Nurse Note revealed X-Ray results revealed the resident had a dislocation and there was concern of an associated Hill Sachs (dent in the humerus caused by a dislocated shoulder) fracture. The resident would be sent out to the local Emergency Department to be evaluated and treated for injury. Review of the 04/18/24 at 10:42 PM Nurse Note revealed return to facility order to follow up with her provider within one two days. The resident had an arm sling in place, however there was no mention of a sling in the hospital discharge instructions. The hospital reported they were unable to determine the age of dislocation and further stated they were not going to attempt relocation. During an interview with the resident on 04/18/24 at 03:46 PM stated a nurse got her up and pulled her on her right arm. The resident held her right arm close to her side and held her right hand to her chest with her left hand. The resident felt like the staff member was mean and stated she did not deserve that. Observation on 04/23/24 at 10:47 AM revealed CNA AA and Certified Medication Aide (CMA) BB and CMA Q, transferred the resident to the toilet. R3 requested the third staff member for assistance. The resident sat in her wheelchair with a sling on her right arm. R3 stated she could only push herself up using her left hand. R3 told the staff she would need them to pull her pants down. Staff assisted the resident to stand and pivot to toilet. Staff removed the resident's brief and stated she was normally wet when toileting, it was part of their routine to toilet every two hours but stated she did not tell them when she had to go. With the use of a gait belt the resident stood from the toilet and pivoted with three staff assistance to sit. During an interview on 04/23/24 at 03:30 PM with Administrative Nurse B, Administrative Nurse F, and Consultant E, identified the nurse reported by the resident to have hurt her right arm on 04/18/24 as CNA HH. Administrative Nurse B, Administrative Nurse F, and Consultant E agreed the care plans should be completed according to the Resident Assessment Instrument (RAI) manual. They verified the CAA lacked analysis of findings and verified they were merely a restatement of the codes themselves rather than an analysis to underlying issues as required to develop a care plan for individual residents and identifying the root cause of triggered areas. They stated the care plan served as communication with the direct care staff to direct the care needed to meet the individual needs of each resident. They agreed the resident's care plan lacked addressing the individual needs of the resident. R3's care plan did not address ADLs or pain management, which R3 had been reporting for some time, prior to the 04/18/24 report. The undated facility policy titled F656, F657, F658, Comprehensive Care Plan , documentation included the comprehensive care plan is based on a thorough assessment that includes but is not limited to the MDS and physician's orders. Assessments of residents are ongoing and care plans are revised as information about the resident and the resident's condition change. Each resident's comprehensive care plan is designed to incorporate risk factors associated with identified problems. The facility failed to develop a plan of care related to ADLs for R3, which included instructions to staff for the resident's transfers and/or bed mobility. This failure resulted in actual harm when on 04/18/24 CNA FF pulled on R3's sore arm while assisting her into bed, R3 was transported to the local Emergency Department (ED) and diagnosed with a right shoulder dislocation and suspicion of a Hill Sachs Fracture. (continued on next page)

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F 0677 Level of Harm - Actual harm Residents Affected - Few	50659 - Resident (R)8's Electronic Health Record (EHR) revealed a diagnosis of ataxia (impaired ability to coordinate movement), cerebrovascular diseases (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), dementia (progressive mental disorder characterized by failing memory, confusion) and extrapyramidal (movement disorders as a result of taking certain medications). The Annual Minimum Data Set (MDS) dated [DATE], documented Brief Interview for Mental Status (BIMS) score of six, which indicated severe cognitive impairment. R8 required supervision or touch assist with ADL's (activities of daily living such as grooming, shower, footwear,) and was independent with eating, R8 was 73 inches tall and weighed 157 pounds. R8 had a weight loss of 5 percent (%) or more and was not on prescribed weight-loss regimen. The Quarterly MDS dated [DATE], documented a BIMS score of six, which indicated severe cognitive impairment. R8 required supervision or touch assist with ADLs with eating. R8 weighed 164 pounds and had a weight loss of 5% or more, R8 was not on a prescribed weight-loss regimen. The Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) dated 03/01/24 lacked analysis of findings documented. The documentation was computer triggered to assist staff in completion of the CAA's. The Nutritional Status CAA, dated 03/01/24, lacked analysis of findings documented. The documentation was computer triggered to assist staff in completion of the CAA's. The Care Plan dated 04/04/24, revealed R8 had a significant weight loss and had a five percent weight loss in one month. Staff were provided the following instructions: On 04/04/24 staff were to provide a regular diet with regular liquids. R8 may have regular hamburgers/cold cut sandwiches with direct supervision. R8 sometimes required staff assistance and would sometimes refuses meals. Staff were to offer to help when needed, offer snacks and encourage R8 to eat. Staff were to provide R8 with a divided plate, built-up silverware, and a covered mug. The Registered dietician was to evaluate and make diet changes and recommendations as needed. The Physician Orders dated 11/22/24, included to serve the resident a regular diet, regular consistency, and cut up food. Remeron (antidepressant medication), 30 milligrams, by mouth for weight loss, at bedtime, ordered 03/28/24. House supplement, twice a day, for weight loss, dated 04/07/24. Review of the Progress Notes from 10/12/23 to 04/24/24 documented: (continued on next page)

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F 0677 Level of Harm - Actual harm Residents Affected - Few	On 01/08/2024 at 10:22 AM, staff completed a Nutritional Assessmet and documented the resident's current weight as 163.8 pounds on 01/04/24. The resident's Body Mass Index (BMI is a medical screening tool that measures the ratio of weight and height to estimate body fat) was underweight for the resident's age. The resident received a regular diet. Meal intakes averaged 76 to 100 percent over the past week. The resident fed self independently, received health shakes, and Remeron daily. On 04/18/24 at 08:30 AM, R8 sat in his wheelchair by the main entrance with an over-the-bed table in front of him with a standard plate of food and standard silver wear on the table. R8 appeared to have trouble as he attempted to consume the food no staff assisted R8. The resident lacked a divided plate or built-up tableware as recommended in the nutritional assessment. On 04/23/24 at 12:47 PM, R8 seated in his wheelchair by the main entrance, R8 lacked built-up silverware and his single portion of fruit cup was unopened. Staff failed to assist R8. On 04/24/24 at 05:20 PM, R8 was seated in his wheelchair by the entrance door with a tray table in front of him. R8 stated he did not like what was served. At 06:08 PM, R8 remained in the location, and had not eaten any of his meal. Staff failed to assist him with eating or with a substitution. At 06:40 PM, dietary staff picked up R8's plate of uneaten food, silverware, and cups. On 04/25/24 at 05:40 PM, Certified Medication Aide (CMA) FF stated that during mealtimes, all staff are to be present in the dining area to provide assistance to residents as needed. On 04/25/24 at 06:20 PM, Consultant Nurse E confirmed R8 had not eaten any of his food. Stated that the expectation was for staff to offer assistance if needed. The undated facility policy titled Quality of Life - Activities of Daily living F676, F677, documentation included the community environment and staff behaviors are directed toward assisting the resident in maintain and/ or achieving independent functioning, dignity and well-being. Residents who are unable to carry out activities of daily living receive the necessary care and services to maintain good nutrition. Residents are provided the appropriate care and services including dining. The facility failed to provide staff assistance for meals to R8. This deficient practice had the potential to lead to negative psychological effects related to nutrition could cause weight loss. - Resident (R)4's electronic health record (EHR) revealed a diagnosis of muscle weakness, diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), dysphagia (swallowing difficulty), and schizophrenia (mental disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought) The Annual Minimum Data Set (MDS) dated [DATE], documented a Brief Interview for Mental Status (BIMS) could not be completed due to R4 was rarely or never understood. The staff assessment documented R4 had memory problems with moderately impaired cognition. R4 required extensive to total assist with activities of daily living (ADLs) except R4 required supervision and touch assistance in eating. The Quarterly MDS dated [DATE], documented a BIMS could not be completed due to R4 was rarely or never understood. The staff assessment documented R4 had memory problems with moderately impaired cognition. R4 required total assistance with ADLs, except set-up for eating. (continued on next page)

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F 0677 Level of Harm - Actual harm Residents Affected - Few	The ADL/Functional/Rehabilitation Potential Care Area Assessment(CAA) dated 07/07/23, documented staff assisted with decision making. Staff should anticipate needs. R4 required extensive/total assistance with ADL dressing, grooming, transfers, incontinent care and mobility. The Care Plan dated 04/22/24, revealed R4 at risk for imbalanced nutrition and ADL deficit and provided the following instructions staff: On 04/22/24, staff were to provide set up assist, and provide assistance and cueing as needed during all meals, staff were to provide cues to R4 to chew and take drink often. The Physician Orders dated 04/22/24, lacked specific orders for ADLs. Review of the Progress Notes and Standard Assessments from 01/01/24 to 04/22/24, revealed the following: The Dietary Manager Quarterly Review dated 02/06/24, documented R4 was independent with eating. The Dietary Manager Quarterly Review dated 03/19/24, documented R4 was independent with eating. On 04/23/24 at 08:10 AM, R4 sat in her wheelchair in the main dining room at a table with her eyes shut with her breakfast meal and drinks in front of her. At 08:24 AM, R7 attempted to wake R4 up, called out R4's name several times, then tapped R4 on her shoulder. R4 opened her eyes for a very short time, took one bite of food, then closed her eyes. R7 stated staff don't really check on R4, stating staff relied on R7 to wake her up. At 08:36 AM, Administrative Staff A was told by another resident who also attempted to wake R4 that R4 was asleep. Administrative Staff A walked over to R4's table, woke her up by saying R4's name, and walked away when R4 opened her eyes. R4 did not attempt to eat. At 08:39 AM R4 had eyes closed again. At 08:40 AM Administrative Staff A woke R4 up again and R4 had her eyes shut again at 08:41 AM. Administrative Staff A had R4 assisted out of dining room by a staff member. R4 consumed a few bites of food thru the meal and approximately twenty five percent of one drink. From 08:10 AM to 08:45 AM, one staff member at a time observed in the dining room to provide assistance with meals. On 4/23/24 at 08:45 AM Administrative Staff A reported that staff should offer residents' assistance as needed for meals. On 04/25/24 at 06:20 PM, Consultant Nurse E stated that the expectation was for staff to offer assistance to residents with eating if needed. The facility failed to provide the assistance for R4 with eating. This deficient practice had the potential to lead to negative psychological effects related to nutrition could cause weight loss. The facility failed to provide the assistance for meals to R4. This deficient practice had the potential to lead to negative psychological effects related to nutrition could cause weight loss.

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46960 The facility census totaled 35 with 20 included in the sample. Based on interview and record review the facility failed to have a clear system in place to document resident's choice regarding code status (indicates the type of resuscitation procedures for a resident, if any, when/if the resident heart stops beating). This failure had the ability to negatively affect the mental, physical, and psychosocial well-being of Resident (R)11, R13, R26, R29, R32, R16 and R18. Findings included: - During an onsite survey the following concerns were identified regarding seven resident's code status: 1. Review of Resident (R)11's census in the facility Electronic Medical Record (EMR) revealed she admitted to the facility on [DATE]. Review of R11's Care Plan revealed an entry dated [DATE] indicating the resident wished to be a Do Not Resuscitate (DNR) (directs providers not to administer CPR in the event of cardiac or respiratory arrest). Review of R11's Physician Orders revealed an order for the resident to have a DNR status, which was discontinued on [DATE]. Review of R11's record lacked any evidence of an order regarding the resident's code status again until [DATE] (approximately three and a half months later), which indicated the resident wished to have a full code (term used to indicate the desire to receive resuscitative measures in the event of cardiac arrest) status. Review of Misc[ellaneous] Tab in R11's EHR revealed a signed DNR dated [DATE] with no revocation of the resident's wishes signed or noted in the resident's record. Review of the < hospital name> Discharge Instructions for R11 printed [DATE] at 09:34 AM, noted the resident had initiated advanced directives (a written document which indicated the resident's medical decisions for health care professions), which included a DNR. 2. Review of R13's census in the facility EMR revealed he admitted to the facility on [DATE]. Review of R13's Physician Orders revealed the resident had an order for full code status dated [DATE], two months after admitting to the facility. Review of R13's Care Plan revealed an entry dated [DATE] (two months after the resident admitted to the facility) which indicated the resident had a full code status. 3. Review of R26's census in the facility EMR revealed she admitted to the facility on [DATE]. (continued on next page)

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R26's Physician Orders revealed an order for the resident to be full code status dated [DATE] (approximately four months after admitting to the facility). Review of R26s Care Plan revealed an entry dated [DATE] (over a year after admission to the facility) indicating the resident had a full code status. 4. Review of R29's census in the facility EMR revealed she admitted to the facility on [DATE]. Review of R29's Physician Orders revealed an order for the resident to be full code status dated [DATE] (approximately six months after admission to the facility). Review of R29's Care Plan revealed an entry dated [DATE] (approximately six months after admission to the facility) indicating the resident had a full code status. 5. Review of R32's census in the facility EMR revealed he admitted to the facility on [DATE]. Review of R32's Physician Orders revealed an order for the resident to be full code status dated [DATE]. Review of R32's Care Plan revealed an entry dated [DATE] (approximately two and a half months later), indicating the resident had a full code status. 6. Review of R16's census in the facility EMR revealed he admitted to the facility on [DATE]. Review of R16's Physician Orders revealed an order for the resident to be full code status dated [DATE]. Review of R16s Care Plan revealed an entry dated [DATE] (approximately two months later), indicating the resident had a full code status. 7. Review R18's census in the facility EMR revealed he admitted to the facility on [DATE]. Review or R18's Physician Orders revealed an order for the resident do be a DNR status dated [DATE] (approximately four months after admission to the facility). Review of R18's Care Plan revealed an entry dated [DATE], indicating the resident had a full code status. Observation of the facility [DATE] through [DATE] lacked evidence the facility had a code system located on resident doors or within their rooms. An interview on [DATE] at 12:23 PM with Housekeeping Staff K, revealed there might be something about resident code status on the doorway to resident rooms, but they would have to ask to be sure. An interview on [DATE] at 12:27 PM with Licensed Nurse (LN) S revealed code status was located on physician orders and staff carried walkie talkies to notify staff in the event the resident required CPR. LN S further indicated the facility did not have a system of indicating a resident code status on resident doors or within resident rooms. (continued on next page)

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview on [DATE] at 12:29 PM with LN T revealed as far as code status everyone had walkies to report to each other as needed and the status had always been on the face sheet. The facility's undated Residents' Rights Regarding Treatment and Advance Directives policy documented that the facility would support and facilitate a resident's right to request, refuse and/or discontinue medical or surgical treatments and to formulate an advanced directive on admission to the facility. Further documented that the facility would, as part of the care planning process, periodically reassess the resident for desired changes related to any advanced directives and would be documented in the resident's EHR. The facility failed to have a clear system in place to document resident's choice regarding code status. This failure had the ability to negatively affect the mental, physical, and psychosocial well-being of Resident (R)11, R13, R26, R29, R32, R16 and R18, and placed all residents at risk for potential negative outcomes regarding a lack of a system to identify and convey resident codes status during an emergency.

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F 0684 Level of Harm - Minimal harm or potential for 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** 36881 The facility reported a census of 35 residents with 20 residents sampled for review, which included one resident (R)23 reviewed for Quality of Care. Based on observation, interview, and record review the facility failed to provide needed care and services that were resident centered, in accordance with the resident's preferences, goals for care and professional standards of practice that would meet resident's physical, mental, and psychosocial needs related to treatment for alcoholism for Resident 23. Findings included: - Review of Resident (R)23's undated Physician Orders revealed diagnoses, which included alcohol use with unspecified alcohol induced disorder, and major depression disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). The Admission Minimum Data Set (MDS), dated [DATE], documented the resident admitted to the facility on [DATE] and had a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. She did not exhibit any behaviors. The resident was independent with activities of daily living (ADL) which included bed mobility, transfers, and walking. The resident received antidepressants for five days of the look back period. She did not receive special treatments, procedures, and programs. The Quarterly MDS, dated [DATE], included the following changes from the above assessment resident with a BIMS score of 15, indicating improved cognition and cognitively intact. The ADL Functional/Rehabilitation Potential Care Area Assessment, (CAA) dated 09/17/23, documentation included the resident recently admitted to facility following an inpatient stay at the hospital behavioral unit with diagnoses alcohol use disorder and major depressive disorder. She is alert and oriented, able to make her needs known, and desires to go home. The resident was independent with activities of daily living (ADL) completion. She currently has a court appointed guardian that reported the resident cannot safely care for herself due to the above diagnoses. The Care Plan (CP), initiated 09/27/23, directed staff the resident had depression to monitor for signs of depression including hopelessness, insomnia, anxiety, sadness, verbalizing statements, repetitive anxious or health related complaints, and/or tearfulness. Discuss with the resident/family/caregivers any concerns, fears issues regarding health or other subjects as often as resident desires. The CP lacked any address of interventions to mitigate risk factors or provide treatment/support to resident regarding alcoholism. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/22/24 at 09:56 AM revealed R23 sat in a chair in her room. She stood from her chair at bedside, reached for her walker, and sat down independently. She was alert and oriented and readily engaged in conversation and stated she was a retired nurse. She reported she drank to much when she retired. The resident checked herself into the hospital to get some help for her alcoholism, and then sent her to the facility for rehabilitation. The counselor told her to stay for a month for alcohol rehabilitation R 23 reported she admitted to this facility around eight months ago does not want to stay. She stated she was not getting any help or support such as Alcohol Anonymous (AA) and was now paying privately to stay while not getting any help with her alcoholism. She reported the guardian was not helpful and do not want to live my life out here. Now my money is going to pay or me to be here. Alcoholism is not addressed here. They do not discuss discharge planning or a treatment plan for alcoholism. There is no communication. On 04/23/24 at 09:32 AM, Social Services Staff L confirmed the resident admitted to the facility from the hospital behavioral unit following a hospital stay for alcoholism. She was aware the resident had a history of alcoholism on admission. The resident was alert and oriented and had not received alcohol rehabilitation treatment and/or services. She stated she did not think the resident needed the services since she was not drinking. Social services staff L reported the facility did not offer AA or Alcohol treatment services until a month ago. She stated the facility had not offered services to the resident to provide for her care and/or treatment of psychosocial needs related to alcoholism since her admission. Additionally, Social services staff L reported the resident had expressed the desire to attend AA meetings. She confirmed the resident's care plan did not address the resident's her psychosocial needs related to her alcoholism. On 04/23/24 at 0:30 PM, Administrative Nurse B, Administrative Nurse F, and Consultant Nurse Q, agreed the resident's primary diagnosis for admission was related to her alcoholism. They verified the facility failed to provide the care, treatment, service for supportive care as the primary focus related to the resident's alcoholism as they should. The undated facility policy F689 Accidents-Substance Use Disorder (SUD), documentation included residents with substance use disorder will receive necessary care and services once admitted to the community. Interventions may include providing substance use treatment services, such as Alcohol anonymous meetings. The facility failed to provide needed care and services that were resident centered, in accordance with the resident's preferences, goals for care and professional standards of practice that would meet resident's physical, mental, and psychosocial needs related to treatment for alcoholism for R23.

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Anew Healthcare Oxford	200 S Ohio St Oxford, KS 67119

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50659 The facility identified a census of 35 residents, which included 20 residents in the sample. Based on observations, interviews, and record review, the facility failed to provide Resident (R) 25 with hand splint (rigid or flexible material used to protect, immobilize, or restrict motion in a body part) to assist in maintaining anatomical alignment of the resident's hand. Findings included: - Resident (R)25's Electronic Health Record (EHR) revealed a diagnoses of diabetes mellitus type two (DM2-when the body cannot use glucose, not enough insulin made, or the body cannot respond to the insulin), generalized muscle weakness, absence of left leg below the knee and abnormalities of gait (manner or style of walking) and mobility, and contracture (abnormal permanent fixation of a joint or muscle) of left hand muscle. The Admission Minimum Data Set (MDS) dated [DATE], documented a Brief Interview for Mental Status (BIMS) of 15, which indicated intact cognition. R25 required maximal to total assist with ADL's (activities of daily living such as walking, grooming, toileting, dressing and eating). R25 had impairment to one side of upper extremity and impairment to both sides of the lower extremity. The Quarterly MDS dated [DATE], documented a BIMS of 15, which indicated intact cognition. No impairment to one upper side extremity as was documented on previous MDSs and documented that R25 was occasionally incontinent of bladder. The Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) dated 01/26/24, lacked analysis of findings documented. The documentation was computer triggered to assist staff in completion of the CAA's. The Care Plan dated 04/22/24, revealed R25 had an Activities of Daily Living (ADL) self-care performance deficit and provided the following instructions for staff: Staff were to apply a splint to be placed in the hand six-to-eight hours during AM shift and remove at dinner. The Care Plan did not identify R25 with a left -hand contracture. The Physician's Order dated 02/03/24, directed staff to administer a hand splint to R25's left hand. The order included the staff would remove the splint during meals and at bedtime and the staff may need to place a washcloth in the hand split in the morning, due to the hand splint being washed at night. The order instructed the staff to wash the hand splint with soap and water and hang it on an over towel rack to dry until morning. Review of the Progress Notes and Standard Assessments from 01/01/24 to 04/22/24 lacked progress notes regarded R25's hand splint. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 5-Day Discharge Communication Notice from 02/05/24, signed by Therapy Staff M, documented the hand splint schedule, training provided, and noted the splint would be on R25 for all hours, except while eating, and R25 signed the form. Observation on 04/22/24 at 09:45 AM, revealed no splint observed on R25's left hand or rolled washcloth. Observation on 04/22/24 at 10:30 AM, revealed no splint observed on R25's left hand or a rolled washcloth. During the observation, R25 stated he was unable to apply the splint independently and the staff needed to put it on the resident, as the resident forgets to do that. During an interview on 04/23/24 at 03:05 PM, Certified Nurse Aide (CNA) P reported R25 was to wear a left-hand splint or rolled washcloth every day. CNA P reported they did not apply the splint or rolled washcloth to R25 and verified they did not let the nurse know. During an interview on 04/23/24 at 03:15 PM, Therapy Staff M reported R25 was to wear a left-hand splint every day, except for meals and bedtime. During an interview on 04/23/24 at 03:15 PM, Licensed Nurse (LN) D reported R25 would remove the splint or rolled washcloth at times. LN D also reported the splint or washcloth was not applied today by LN D. During an interview with Administrative Nurse B and Administrative Nurse F on 04/23/24 at 03:30 PM, Administrative Nurse F stated R25 refused the splint that morning. Administrative Nurse F stated the facility expected the licensed nurses to apply the splint, not the aides. Administrative Nurse F reported the EHR was not signed off by Administrative Nurse F. During an interview on 04/24/24 at 12:56 PM, LN D reported she signed off in the EHR for the 04/22/24 and 04/23/24 application of R25's splint. LN D reported verified that R25's splint was not applied, stated she thought Administrative Nurse F applied it on 04/23/24 and LN D just signed off the record on 04/22/23. LN D agreed documentation should be completed by the nurse who completed it. During an interview on 04/24/24 at 01:40 PM, Administrative Nurse F agreed that documentation in the EHR should be completed by staff member who completed the task. The undated policy Prevention of Decline in Range of Motion (ROM- the full movement potential of a joint, usually its range of flexion and extension) documented: Residents who entered the facility without limited range of motion would not experience a reduction in ROM, unless the resident's clinical condition demonstrated that reductions of ROM was unavoidable. The policy noted assessment, appropriate care planning, and preventative care included assisting residents with assistive devices and monitoring. The facility failed to ensure staff provided a positioning device for R25's left-hand contracture as care planned to maintain as much anatomical alignment as possible and prevent worsening of the contracture.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46960 The facility reported a census of 35 residents, with 20 residents sampled, including four residents reviewed for accident hazards. Based on observations, interviews, and record review, the facility failed to provide an environment as free of accident hazards as possible for all four residents reviewed. The facility failed to place effective and timely fall interventions for R28 who had multiple falls. This failure caused actual harm when R28 fell from his wheelchair on 03/05/24, required transport to the local emergency department, and placement of two staples to the resident's head. The facility failed to identify causal factors for two falls experienced by R19, a dependent resident with repeated falls, to prevent further falls. The facility failed to appropriately monitor for safety for R35, a resident with wandering when the staff pushed R35 in his wheelchair and allowed his feet to drag the floor. These deficient practices led to actual harm for R19 and R28 and at risk for further injury that could negatively affect the overall health and well-being of the residents in the facility. Furthermore, these deficient practices had the potential to have a negative psychosocial impact on the affected residents. Findings included: - Review of the Med Diag[nosis] tab in the Electronic Medical Record (EMR) revealed R28 had the following diagnoses: Williams syndrome (genetic disorder that effects various aspects of the body), abnormalities of gait and mobility, muscle weakness, reduced mobility, history of falling, other symptoms and signs involving the musculoskeletal system. Review of the 08/25/23 Admission Minimum Data Set revealed the resident had a Brief Interview for Mental Status (BIMS) score of 13, which indicated intact cognition. The resident required extensive assistance of one to two staff for bed mobility, transfers, dressing, toilet use and personal hygiene. The resident had no falls in the last month prior to admission/entry. The resident had a fall in the last 2-6 months prior to admission/entry or reentry and a fracture in the 6 months prior to admission/reentry. Review of the Falls Care Area assessment dated [DATE] revealed R28 admitted to the facility from another long-term care facility. The resident had a history of falls with a neck fracture noted among others. R28 required extensive staff assistance with activities of daily living including, dressing, restroom usage, peri-care, grooming, transfers, and mobility. Review of the 02/21/24 Quarterly Minimum Data Set revealed the resident had a Brief Interview for Mental Status (BIMS) score of 11, which indicated moderately impaired cognition. The resident had impairment of both the upper and lower extremities on both sides and he used a wheelchair for mobility. The resident had no falls identified since the prior assessment. Review of the Nursing: Fall Risk Evaluation[s] dated 10/13/23, 11/9/23, 11/12/23, 01/13/24, 02/7/24, 02/21/24, 02/22/24, 03/02/24, 03/05/24, and 03/24/24 revealed the resident had a high risk for falls. Review of the 08/24/23 Care Plan revealed the following: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 11/29/2023 staff would know the resident has had an actual fall related to gait/balance problems, attention seeking behaviors, Intellectual Disability, and psychosis. Review of the 10/13/2023 at 12:43 AM Nurse Note revealed staff summoned the writer to the resident's room at approximately 11:25 PM. Upon entering R28's room the nurse observed the resident on the floor in front of his recliner. The nurse asked the resident if he was okay and if he had any pain and he reported his bottom hurt. The nurse asked the resident what he was trying to do before the fall, and he reported he was trying to get out of bed. R28 reported he rolled out of bed and then slid himself over by his recliner. The nurse and additional staff transferred the resident to his wheelchair with the use of a gait belt. The facility placed an intervention of getting a scoop mattress for the resident and initiated hourly checks until the scoop mattress arrived. Review of the Care Plan intervention dated 10/17/23 revealed on 10/14/23 the resident had a non-injury, unwitnessed fall from his bed while he attempted to sit up on the edge of the bed. The resident had a corner bolster mattress overlay put in place to help define the edge of the bed and prevent resident from falling off of the edge of the bed. Review of the 11/04/23 at 03:19 AM Nurse Note revealed night shift staff reported resident placed himself on the floor beside the bed. The resident put his call light on approximately three times during report and the nurse writer directed staff to please get resident up if that is what he wants. Staff assisted resident off of the floor placed him in his wheelchair. The staff present took the resident to the day room before the resident or scene could be assessed. The resident denied hitting his head this morning. Review of the Care Plan intervention dated 11/04/23 revealed staff would assist the resident to common's area of the facility when he called in the middle of the night or early morning. The resident would request to go back to his room when he was ready. Review of the 11/09/23 at 03:00 PM Nurse Note revealed staff entered the resident's room to answer his call light and found the resident sitting upright beside the bed with his back against the bed frame. The note stated the resident admits to placing self on floor with feet outstretched and stated the resident reported being too impatient to wait on staff per usual. Review of the Care Plan intervention dated 11/10/23 and revised 03/26/24 revealed the resident had an unwitnessed, non- injury fall on 11/09/23 around 03:00 PM. Staff were directed to perform frequent visual checks when the resident was not in the dining room or common's area. Review of the 12/10/23 at 10:53 PM Fall Note revealed at 08:50 PM the resident yelled from his room and was found on the floor, laying on his back. Staff assisted the resident up to bed, performed peri-care, assisted the resident up to wheelchair and assisted the resident to the TV lounge. The resident reported his slid himself to the floor. The note identified a fall intervention to toilet the resident before bed. The resident's Care Plan related to falls lacked any intervention related to the fall on 12/10/23 and further lacked direction to staff to toilet the resident before bed. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the 02/22/24 at 03:20 AM Nurse Note revealed at 03:00 AM an unidentified CNA reported to the nurse that the resident was on the ground next to his bed. Upon entering the resident's room, he appeared to attempt to self-transfer out of bed. The resident stated I am sorry as staff entered his room. Staff assisted the resident back into his wheelchair and reinforced to the resident the importance of using a call light before getting up on his own. Review of the 02/22/24 at 06:35 PM Nurse Note revealed the writer spoke with the charge nurse regarding educating nursing staff to encourage and assist the resident for placement of non-skid socks while in bed. Review of the Care Plan intervention dated 02/22/24 revealed the resident had an unwitnessed non-injury fall. Review of the Care Plan intervention updated 02/27/24 (5 days later) revealed staff were educated to monitor the resident for use of non-skid socks while in bed or when not wearing tennis shoes. Review of the 03/02/2024 at 01:55 PM Nurse Note revealed the resident tried to reposition himself and was found on the floor in hallway outside of his room. The nurse educated resident that he needed to ask staff for help when trying to reposition in his chair. He apologized. Review of the Care Plan intervention dated 03/06/34 related to the 03/02/24 fall revealed the facility placed anti-rollback breaks on the resident's wheelchair. Review of the Care Plan intervention revised on 03/11/24 revealed the facility ordered anti-rollback brakes on the resident's wheelchair and they were placed upon arrival. Review of the 03/05/24 (one day prior to adding the 03/02/06 fall intervention of placing anti-roll back breaks on the resident's wheelchair) at 10:52 PM Nurse Note revealed staff found the resident on the floor in front of his wheelchair in the hallway. The resident sat on his bottom leaning towards his right-side with his wheelchair right behind him and blood coming from the back of his head. Approximately ten minutes prior to fall the resident was re-positioned in wheelchair by nursing staff and encouraged to start heading to his room per his usual nighttime routine as he was next to be laid down by the CNA. Facility staff applied first aid to the laceration on the back of the resident's head with wound cleanser and gauze to clean area. The laceration measured approximately one inch. The resident stated his head hurt and nursing staff assisted the resident into the wheelchair and into nurses' station to continue vital signs and neurological checks. Staff applied a small ice pack, called the resident's provider, and received an order to send the resident to the local emergency department. Staff then called emergency medical services to transport the resident to the hospital. Review of the 03/05/24 Hospital Discharge Instructions dated 03/05/24 revealed the resident had an accidental fall with acute head injury, hypoxia, and laceration of the scalp. The instructions noted the resident required stapled wound care. Review of the 03/06/24 03:03 AM Nurse Note revealed the resident returned from the emergency department via facility transportation. The resident had a new order for oxygen as needed and he had two staples to the laceration on the back of his head. Nursing staff assisted the resident into bed with his call light in reach, bed in lowest position, and staff reinforced the resident need to use his call light for any assistance needed and the resident verbalized understanding. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the 03/11/24 Care Plan intervention for the 03/05/24 fall revealed therapy would assess the resident's wheelchair seat positioning and adjust as needed. The facility replaced the non-slip matt in the resident's wheelchair with a larger piece on top and bottom of the resident's seat cushion. Review of the 03/24/24 at 09:22 AM Nurse Note revealed at 09:15 AM a CNA stated over the facility walkie talkie system that resident was on the floor in his room. Upon entering the resident's room, the resident sat with his bottom on the ground, feet flat in front of him, and his back on the bed with his wheelchair to his right side. The resident stated he was trying to get out of bed. Review of the 03/26/24 Care Plan intervention revealed the resident had a fall in his room after he attempted to self-transfer from his bed. Staff placed a Call don't fall sign in his room. Review of the 03/24/24 at 05:51 PM Nurse Note revealed staff removed two staples from the resident's head. On 04/18/24 at 03:56 PM, R28 observed self-propelling in wheelchair with anti-rollback brakes installed with an interrupted forward and backward motions that lacked a discernable pattern in common area. On 04/22/24 at 09:55 AM, R28 observed self-propelling backward in wheelchair with anti-rollback brakes installed and nearly hit R35 who was sitting on the floor when an unknown staff member called out to R28 who then resumed interrupted forward and backward motions in a random pattern in the common area. On 04/25/25 at 12:34 PM, Certified Medication Aide (CMA) GG stated that if a resident falls to call for help using the walkie-talkie, make sure that the resident is comfortable but not to move them, then follow the instructions of the nurse when they respond. On 04/25/24 at 12:40 PM LN T stated the CNA staff would let the nurse know if resident had a fall or was found on floor then the LN on duty would evaluate the residents, contact Administrative Nurse B or Administrative Nurse F, the resident's physician and the resident's responsible party for any incident. Further stated that if the resident was not injured staff would perform frequent checks and do follow-up charting every shift for 72 hours (three days). If the residents were injured, then the staff would request an order to send them out to the hospital from the physician. Additionally stated that if the care plan should change Administrative Nurse B was who changed the care plan in EHR. LN T stated that during shift-change report, oncoming shifts were changes in care for residents and about the incident. On 04/25/24 at 12:18 PM, Administrative Staff A stated that what happens immediately following a fall is Administrative Nurse B's responsibility. Further stated that the next available day the interdisciplinary team (IDT - a team of staff members from different departments within the facility) would hold a clinical startup meeting where they would discuss the fall and develop permanent interventions to be placed on the resident's care plan. Additionally, confirmed that R19's care plan lacked interventions following the falls that occurred on 03/19/24 and 03/29/24. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 04/25/24 at 12:30 PM, Consultant Nurse E stated that if a fall occurred the expectation for staff was to stay with the resident and not to move them while using the walkie-talkies to request assistance. She then stated that when the LN on duty arrived to where the resident was, they would assess for injuries, offer first-aid as needed, then direct the CNA staff on how to get the resident off the floor. Additionally, Consultant Nurse E stated that after the resident was safe and a full assessment had been performed, that the LN would then notify the resident's physician, family or responsible party, Administrative Nurse B or Administrative Nurse F, and Administrative Staff A. The LN on duty would then implement an immediate intervention to mitigate the risk of further falls for the remainder of the shift. The LN in charge at the time of the fall was also responsible to complete the investigation and to obtain witness statements, if applicable, whether that was a staff nurse or Administrative Nurse B or Administrative Nurse F and would initiate post-fall follow-up checks that consisted of documented checks every 12 hours for 72 hours (3 days). The IDT team would meet the following morning (or Monday if the fall occurred on a weekend) to investigate the fall and develop and implement a permanent person-centered care plan intervention specifically for that fall. Consultant Nurse E confirmed the lack of care plan interventions for the falls on 03/19/24 and 03/29/24. The facility's undated Accidents policy documented that the facility would provide an environment free of accident hazards with safety and supervision and assistance to prevent accidents. Further documented that safety risks and environmental hazards were identified on an ongoing basis with a facility-wide commitment to safety at all levels. The facility failed to place effective and timely fall interventions for R28 who had multiple falls. This failure caused actual harm when R28 fell from his wheelchair, required transport to the local emergency department, and placement of two staples to the resident's head. - R19's Electronic Health Record (EHR) revealed diagnoses of generalized anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), obsessive-compulsive disorder (OCD is an anxiety disorder characterized by recurrent and persistent thoughts, ideas and feelings of obsessions severe to cause marked distress, consume considerable time or significantly interfere with the resident's occupational, social or interpersonal functioning), cognitive communication deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness), and major depressive disorder with psychotic symptoms (a major mood disorder which causes persistent feelings of sadness with a gross impairment in reality perception). The Admission Minimum Data Set (MDS) dated [DATE], documented a Brief Interview for Mental Status (BIMS) could not be completed due to R19 was rarely or never understood. The staff assessment documented R19 had memory problems with severely impaired cognition. The MDS documented R19 had hallucinations (sensing things while awake that appear to be real, but the mind created) and lacked documentation of any behaviors toward self or others. R19 required a wheelchair for locomotion and substantial/maximal assistance for all cares except eating which required setup and supervision. The MDS documented staff could not determine if R19 had any falls prior to admission, or fracture (broken bone) related to a fall in the six months prior to admission. The Falls Care Area Assessment (CAA) dated 12/04/23, documented R19 required extensive assistance of staff for all cares, was at risk for falls, and had a fall since admission with a fracture of nasal bones. The Behavioral Symptoms CAA did not trigger. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The Psychosocial Well-Being CAA dated 12/04/23, documented R19 was admitted to the facility after a battle with depression and had psychiatric services ordered. R19 had episodes of behaviors that included hallucinations and delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue) and required staff to assist one-on-one (1:1) for interactions. The Quarterly MDS dated [DATE], documented R19 had a BIMS of 13, which indicated intact cognition. R19 had delusions (an untrue persistent belief or perception held by a person although evidence shows it was untrue) and hallucinations and lacked documentation of any behaviors toward self or others. R19 required partial/moderate assistance with all cares except toileting, bathing, and putting on/taking off footwear. R19 was dependent on staff for locomotion. R19 had two or more falls since admission and lacked documentation of any injuries from falls. The 04/22/24 Care Plan, initiated on 11/28/23, documented the resident was at risk for falls, had an actual fall, and included the following fall interventions: On 11/27/23, R19 had an unwitnessed fall in the dining area and instructed staff on 11/28/23 that R19 was to remain within an arm's reach while R19 was up in her wheelchair. On 11/28/23, staff were to obtain a bolster cover to help define the edges of R19's be On 11/28/23, staff were to provide R19 with activities or conversation when she was exhibiting signs of anxiety or restlessness. On 11/28/23, staff were to place a fall mat next to R19's bed to decrease injuries if the resident rolled out of the bed. On 11/28/23, staff were to move the resident to her room to rest in bed if she became restless in the dining area or commons area. On 03/06/24, R19 had an unwitnessed fall without injury and instructed staff to offer to get the resident up out of bed around 03:00 PM so she could people watch in the dining area before the evening meal. The Care Plan lacked interventions specific to R19's falls on 03/19/24 and 03/29/24, and further lacked interventions related to behavioral outbursts. The Nurse Note dated 03/19/24 at 10:12 AM documented R19 was in the quiet room next to the nurse's station with the doors shut and noted the resident was placed on 1:1 observation due to behaviors exhibited since 05:00 AM on 03/19/24 of yelling and screaming all morning and in a paranoia delusion that we are trying to hurt and poison her. The note included that a Certified Nurse Aide (CNA) [CNA C] came to get Licensed Nurse (LN) D and reported that the resident fell out of her wheelchair onto the floor when the CNA [CNA C] looked away for 5 seconds to grab something out of her purse. The note documented R19 had a scuffed and bruised right eye and R19 kept stating that CNA [CNA C] had hit her in the face, and she was yelling it out. The note included R19 was very reluctant to allow the LN to obtain her vitals. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the facility fall report revealed on 03/19/24 R19 fell from a standing position and sustained a minor injury. The fall investigation lacked a determination of cause, lacked an immediate intervention put in place by the Licensed Nurse (LN) on duty and lacked a permanent intervention placed in the care plan. The Care Plan lacked an intervention related to R19's 03/19/24 fall. Review of the facility fall report revealed on 03/29/24 R19 fell from her bed without injury. The fall investigation lacked a determination of cause, lacked an immediate intervention put in place by the LN on duty, and lacked a permanent intervention placed in the care plan. The Care Plan lacked an intervention related to R19's 03/19/24 fall. During an interview on 04/25/25 at 12:34 PM, Certified Medication Aide (CMA) GG stated if a resident fell the staff were to call for help using the walkie-talkie, make sure that the resident was comfortable but not to move them, then follow the instructions of the nurse when they respond. During an interview on 04/25/24 at 12:40 PM LN T stated the CNA staff let nurses know if resident fell or was found on floor. LN T said the LN on duty would evaluate the residents, contact Administrative Nurse B or Administrative Nurse F, the resident's physician and the resident's responsible party for any incident. LN T said if the resident was not injured staff would perform frequent checks and do follow-up charting every shift for 72 hours (three days). If the resident were injured, then the staff would request an order from the physician to send them out to the hospital. Additionally LN T stated that if the care plan should change Administrative Nurse B was who changed the care plan in EHR. LN T stated that during shift-change report, oncoming shifts were changes in care for residents and about the incident. On 04/25/24 at 12:18 PM, Administrative Staff A stated that what happens immediately following a fall is Administrative Nurse B's responsibility. Further stated that the next available day the interdisciplinary team (IDT - a team of staff members from different departments within the facility) would hold a clinical startup meeting where they would discuss the fall and develop permanent interventions to be placed on the resident's care plan. Additionally, confirmed that R19's care plan lacked interventions following the falls that occurred on 03/19/24 and 03/29/24. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 04/25/24 at 12:30 PM, Consultant Nurse E stated that if a fall occurred the expectation for staff was to stay with the resident and not to move them while using the walkie-talkies to request assistance. She then stated that when the LN on duty arrived to where the resident was, they would assess for injuries, offer first-aid as needed, then direct the CNA staff on how to get the resident off the floor. Additionally, Consultant Nurse E stated that after the resident was safe and a full assessment had been performed, that the LN would then notify the resident's physician, family or responsible party, Administrative Nurse B or Administrative Nurse F, and Administrative Staff A. The LN on duty would then implement an immediate intervention to mitigate the risk of further falls for the remainder of the shift. The LN in charge at the time of the fall was also responsible to complete the investigation and to obtain witness statements, if applicable, whether that was a staff nurse or Administrative Nurse B or Administrative Nurse F and would initiate post-fall follow-up checks that consisted of documented checks every 12 hours for 72 hours (3 days). The IDT team would meet the following morning (or Monday if the fall occurred on a weekend) to investigate the fall and develop and implement a permanent person-centered care plan intervention specifically for that fall. Consultant Nurse E confirmed the lack of care plan interventions for the falls on 03/19/24 and 03/29/24. The facility's undated Accidents policy documented that the facility would provide an environment free of accident hazards with safety and supervision and assistance to prevent accidents. Further documented that safety risks and environmental hazards were identified on an ongoing basis with a facility-wide commitment to safety at all levels. The facility failed to identify causal factors for two falls experienced by R19, a dependent resident with repeated falls, to prevent further falls. 50659 - Resident (R)35's Electronic Health Record (EHR) revealed diagnoses of insomnia (inability to sleep), generalized anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), cerebral palsy (a progressive disorder of movement, muscle tone or posture caused by injury or abnormal development in the immature brain, most often before birth), trisomy 21 (a genetic disorder), translocation type of downs syndrome (chromosomal abnormality characterized by varying degrees of mental retardation and multiple defects), and dysphasia (a condition that affects the ability to produce and understand spoken language). The Admission Minimum Data Set (MDS) dated [DATE], documented a Brief Interview for Mental Status (BIMS) could not be completed due to R35 was rarely or never understood. The staff assessment documented R35 had memory problems with severely impaired cognition. The MDS documented always incontinent of bowel and bladder, other behavioral symptoms and wandering occurred daily during the seven-day look-back period, and R35 was dependent on staff for all cares. The Functional Abilities Care Area Assessment (CAA) was not triggered on the 04/22/24 MDS. The Cognitive Loss/Dementia CAA dated 04/09/24 lacked analysis of findings documented. The documentation was computer triggered to assist staff in completion of the CAAs. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The Urinary Incontinence and Indwelling Catheter (a flexible tube inserted through a narrow opening into a body cavity, particularly the bladder, for removing fluid) CAA dated 04/09/24 lacked analysis of findings documented. The documentation was computer triggered to assist staff in completion of the CAA's. The 04/22/24 Care Plan lacked instructions for staff related to ADL (activities of daily living such as walking, grooming, toileting, dressing and eating), transfers, or safety related to resident's preference to sit on the floor in random places/patterns. The 04/22/24 Care Plan revealed R35 had an exhibit moderate to potential risk for elopement related to cognitive impairment and wandering behavior and provided the following instructions for the staff: On 04/22/24, staff were to provide frequent visual checks to keep the resident safe. On 04/22/24, staff were to provide building exits secured with a code to prevent elopement (when a cognitively impaired resident leaves the facility without the knowledge or supervision of staff). The 04/22/24 Care Plan lacked interventions related to maintaining or improving total incontinence of bladder and bladder. Lacked interventions related to maintaining or improving ADLs (activities of daily living such as walking, grooming, toileting, dressing and eating). Lacked interventions related to wandering behaviors. On 03/28/24 at 05:23 PM, the wandering and elopement (when a cognitively impaired resident leaves the facility without the knowledge or supervision of staff) evaluation revealed R35 was a moderate risk score of 11 out of 12 for elopement. The (EHR) Physician Orders on 04/24/24 at 08:45 AM lacked any orders for monitoring for safety, frequent checks, wander guard, transfers, ambulation, incontinence, or ADLs. Review of the Progress Notes and Standard Assessment from 03/28/24 to 04/25/24 revealed the following: On 03/28/24 at 02:34 PM, staff documented R35 arrived at the facility via transportation. R35 had a pleasant behavior, ambulated by walking and used a wheelchair, R35 was NPO (nothing by mouth), and incontinent of bowel and bladder. On 03/29/24 at 07:17 AM, staff documented R35 awake most of the night, and slept on the floor at times. Wandered into other residents' rooms, was non-verbal and easily re-directed. On 04/01/24 at 11:16 AM, staff documented R35's wandering did not place the resident at significant risk of getting into a potentially dangerous place. R35 was nonverbal and his mentality was like a ten-year-old. R35 had difficulty focusing attention (easily distracted, out of touch, or difficulty following what was said), and was continuously present. R35's thinking was continuously disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject). On 04/01/24 at 11:31 AM, staff documented R35 was on one-to-one monitoring for safety as R35 was all over the facility in a wheelchair or ambulated independently. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 04/01/24 at 12:35 PM, staff documented R35 ambulated independently, but was a bit unstable. On 04/02/24 at 12:35 PM, staff documented R35 was on one-to-one monitoring for safety as R35 was all over the facility in a wheelchair or R35 ambulated independently. On 04/03/24 at 05:55 AM, staff documented R35 was awake all night until 05:40 AM. R35 fell asleep in the wheelchair when being propelled up and down the hallways. On 04/06/24 at 03:06 PM, staff documented one-on-one with close observation for safety. R35 was mobile all over the facility. Review of the facility's elopement book on 04/25/24 at 04:00 PM revealed R9 and R20 had elopement forms filled out and pictures. R15's information was in the book, but only had R15's face sheet with a picture on it and it lacked completed elopement form. R35 lacked information in the elopement book. Observation on 04/22/24 at 08:48 AM, revealed R35 in R4's room he wandered behind R4 seated in a wheelchair. R35 opened the top drawer of nightstand. At 08:49 AM, Certified Nurse Aide (CNA) P entered R4's room and closed the door. At 08:50 AM, CNA P opened the door and had R35 leave the room. R35 sat down on the floor in front of a resident's room. Staff walked by R35 as he sat on the floor. During an interview on 04/22/24 at 08:55 AM, CNA P stated R35 wanders in and out of a lot of (resident) rooms. CNA P stated staff try to re-direct and can take two staff for assistance. Observation on 04/22/24 at 08:55 AM, revealed R35 scooting himself on his buttock across the floor into a resident's room. Two unidentified staff members assisted R35 off the floor with assist of a gait belt (belt used to help transfer or stabilize during activity). On 04/22/24 at 09:55 AM, R3 sat on the floor in the dining room by the window next to a cord of an oxygen concentrator. At 09:58 AM, R35 got up independently and walked over the cord and wandered into the dining room and picked up a glass [NAME] jar with paper flowers. R7 told R35 to leave the jar alone. R35 sat down on the floor and got back off the floor at 10:00 AM. R35 wandered into the dining room to the desk area and sat down on floor in front of R15. R28 backed up his wheelchair and almost bumped into R35. Staff called out R28's name to stop moving backwards. R35 stood up directly in front of R15 very closely, R15's face had an expression of uncertainty. Staff assisted R35 into a wheelchair at 10:07 AM and placed R35 in the nurse's station to sit with a nurse. On 04/23/24 at 08:30 AM, R35 wandered into the main television area and squeezed himself through the couches. R35 then wandered into the dining room for approximately twenty minutes during the breakfast serving. Observation on 04/25/24 at 05:35 PM, revealed an unknown staff member pushed R35's wheelchair down the hall. The wheelchair lacked foot pedals and the rubber tipped toes of R35's shoes drug on the floor which caused a backward motion of R35's legs as the wheelchair was being propelled forward. Surveyor alerted Administrative Nurse F who identified the staff member as Certified Medication Aide (CMA) BB and confirmed observation and immediately intervened with CMA BB. On 04/25/24 at 12:04 PM, CNA DD stated staf [TRUNCATED]

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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** 46960 The facility reported a census of 35 residents, with 20 in the sample, and three residents reviewed for nutrition. Based on observation, interview, and record review the facility failed to ensure pertinent and timely interventions were implemented as ordered to prevent R8's significant weight loss of 12 percent (%) in 63 days. The facility did not weigh R8 weekly, did not document nutritional intake for R8 as ordered, did not provide appropriate assistive devices to help R8 feed himself, and did not ensure staff knew of the nutritional monitoring system regarding who provided nutritional shakes to R8. This failure resulted in a R8 losing 20.8 pounds (lbs.)/12.06% body weight, in 63 days (and placed the resident at risk for continued decline in nutritional status and at risk for the development of life-threatening symptoms, which could negatively affect the mental, physical, and psychosocial well-being of R8. (See F810) Findings Included: - R8's Electronic Health Record (EHR) documented the pertinent medical diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), dyspepsia (indigestion), dysphagia (difficulty swallowing), and schizophrenia (a mental disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought). R8's Quarterly MDS, dated [DATE] documented a BIMS score of six, which indicated severely impaired cognition and documented that R8 required supervision assistance with eating. R8 had a documented weight loss of five percent (5%) or more in the look-back period and was not on a prescribed weight loss regimen. The Annual Minimum Data Set (MDS) dated [DATE] revealed R8 had a Brief Interview for Mental Status (BIMS) score of six, indicating severe cognitive impairment. The MDS indicated the resident used a wheelchair for mobility, was 73 inches tall, and weighed 157 pounds (lbs.). The MDS noted R8 with weight loss of 5% or more and he was not on a prescribed weight-loss regimen. The MDS documented R8 was not on a mechanically altered or therapeutic diet. R9 had no obvious or likely cavity or broken natural teeth, inflamed or bleeding gums, or loose natural teeth. The 03/01/24 Care Area Assessment (CAA) triggers included Nutritional Status, but the facility did not develop the CAA triggers and lacked analysis of findings and development. The Registered Dietician (RD) assessment dated [DATE] revealed R8 weighed 163.8 pounds on 01/04/24, with a usual body weight of 165 lbs. The RD noted R8 had a Body Mass Index (BMI) of 21.6, which indicated R8 was underweight for his BMI for age. The resident received a regular diet, regular texture, and noted R8 eats good with 76% to 100% consumed, and R8 independently fed himself. The RD noted the resident current weight was below the reference standard for BMI for advanced age, and documented the resident was down 10.4 lbs. (6%) in 30 days. The RD would request a re-weight, R8 received health shakes daily and Remeron daily for appetite stimulant, and the RD would continue to monitor weight trends, labs, and intake, and reassess as indicated. The RD noted to continue with plan of care. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	The Care Plan for R8 noted a recent significant weight loss of 5% in one month, following a recent hospital stay, initiated 04/06/22 and revised 01/08/24. The care plan Goal noted R8 would maintain his weight within 5% during the next review period and included the following interventions all dated 04/06/22: R8 chose what he wished to eat at each meal and if he did not like the meal the staff were to off him an alternative. R8 was eating independently after set-up assistance. Some of the time R8 needed staff assistance, sometimes he refused assistance, and the staff were to offer to help R8 if they saw he needed assistance. R8 had difficulty swallowing certain textures. R8's conditions included hypertension and depression which could affect his appetite or nutritional needs. R8 sometimes asked for a second portion before he finished with the first, and staff were to bring him a second portion. R8 sometimes refused several meals within a week and the staff were to offer R8 snacks and encourage R8 to eat. The staff were to please offer me snacks to prevent weight loss. I will be offered health shakes during the day. Staff were to provide R8 with mealtime set-up and noted R8 used a divided plate and built-up silverware for meals, and also used a mug with a lid on it. The Care Plan also included a focus dated 05/24/22, revised 06/14/22, which noted R8 had a nutritional problem or potential nutritional problem. The Goal included R8 would maintain adequate nutritional status as evidenced by maintaining weight within baseline, with no signs or symptoms of malnutrition, and noted R8 received shakes. The Care Plan Interventions/Tasks included the following interventions initiated on 05/24/22: The staff were to explain and reinforce to the resident the importance of maintaining the diet ordered, encourage the resident to comply, and explain the consequences of refusal, obesity/malnutrition risk factors. The staff were to monitor/document/report as needed any signs or symptoms of dysphagia: pocketing, choking, coughing, drooling, holding food in mouth, several attempts a swallowing, refusing to eat, appears concerned during meals. The staff were to monitor/document/report to the physician as needed any signs and symptoms of malnutrition: emaciation (cachexia), muscle wasting, significant weight loss: 3 lbs. in 1 week, greater than 5% in 1 month, greater than 7.5% in 3 months, or greater than 10% in 6 months. The staff were to provide and serve the diet as ordered for R8 and to monitor intake and record every meal. The Registered Dietician to evaluate and make diet change recommendations as needed. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	The Care Plan included the following revisions for interventions regarding nutritional status concern: On 06/14/22 the staff were to provide and serve R8's supplement, as ordered by the physician. On 07/07/23 intervention included supplement as ordered/desired. A 01/08/24 revision included R8 received a regular diet with regular liquids, and R8 could receive regular hamburgers and cold cut sandwiches with direct supervision. The Care Plan lacked any further interventions addressing R8's weight loss. Review of the EHR for R8 revealed a 07/12/22 Physician Order for staff to administer Health Shakes to R8, if needed, if his intake was less than 50%, as needed (PRN). The EHR for R8 included the following documented weights: On 11/01/23 at 11:45 AM R8 weighed 172.0 pounds On 12/01/23 at 11:21 AM R8 weighed 171.0 lbs. On 12/03/23 at 02:38 PM R8 weighed 174.2 lbs. The 12/11/23 at 11:08 PM Nurse Note revealed the resident remained on antibiotic therapy (Amoxicillin) for a dental infection and R8 denied pain to area at the time. The staff would continue to monitor. The next recorded weight for R8 was just over a month later, on 01/04/24 at 12:55 PM, noting he weighed 163.8 lbs. The EHR documented a 01/04/24 Physician Order for weekly weights, beginning on 01/10/24 on Wednesdays, due to R8's weight loss. The Physician Order also included for staff to administer 15 mg of Remeron, by mouth, every night (HS), for weight loss, starting on 01/04/24. The Nutrition-Amount Eaten documentation included one meal on 01/05/24 for R8 (dated 01/05/24 at 10:21 AM) which documented R8 consumed 76 to 100% of his meal. The EHR contained an order for staff to encourage R8 to isolate in his room from 01/06/24 to 01/12/24. The Nutrition-Amount Eaten documentation revealed: 01/06/24 lacked documentation for R8. 01/07/24 lacked documentation for R8. 01/08/24 lacked documentation for R8. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	01/09/24 lacked documentation for R8. The EHR lacked documented evidence staff weighed R8 on 01/10/24, weekly, as ordered. The Nutrition-Amount Eaten documentation revealed: 01/12/24 at 01:00 PM R8 consumed 0-25%. 01/13/24 at 10:37 AM, R8 consumed 51-75%. 01/14/24 at 04:00 PM R8 consumed 51-75%. 01/16/24 at 01:00 PM noted Resident Refused. 01/17/24 at 10:49 AM, R8 consumed 51-75%. The EHR documented on 01/17/24 at 06:09 PM R8 weighed 167 lbs. The Nutrition-Amount Eaten documentation revealed: 01/18/24 no documentation for R8. 01/20/24 at 10:32 AM, R8 consumed 51-75%. The Nurse Note dated 01/20/24 at 02:15 PM revealed the Physician Extender V saw R8 on 01/19/24 for leukopenia, anemia, and weight loss, and mentioned the resident had gained four pounds since 01/04/24. The nurse documented there were no changes noted in the progress notes from Physician Extender V. The Nutrition-Amount Eaten documentation revealed: 01/21/24 lacked documentation for R8. The EHR lacked documented evidence the staff weighed R8 on 01/24/24, weekly, as ordered. The Nutrition-Amount Eaten documentation revealed: 01/25/24 lacked documentation for R8. 01/26/24 lacked documentation for R8. 01/29/24 lacked documentation for R8. On 02/01/24 at 12:15 PM, the EHR documented R8 weighed 171.2 lbs. The Nutrition-Amount Eaten documentation revealed: 02/02/24 at 02:36 PM R8 consumed 51-75%. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	02/03/24 lacked documentation for R8. 02/05/24 lacked documentation for R8. On 02/07/24 at 09:38 AM, the EHR documented R8 weighted 165.4 lbs. (Indicating 5.8 lbs. weight loss in one week.) The Nutrition-Amount Eaten documentation revealed: 02/08/24 lacked documentation for R8. The EHR lacked documented evidence the staff weighed R8 on 02/14/24, weekly, as ordered. The Nutrition-Amount Eaten documentation revealed the following: 02/15/24 through 02/21/24 documented the resident consumed 1-2 meals per day at 76-100%. On 02/21/24 at 10:31 AM, the EHR documented R8 weighed 172.4 lbs. The Nutrition-Amount Eaten documentation revealed R8 consumed 76-100% of both meals recorded and lacked evidence of a third meal from 02/22/24 through 02/28/24. On 02/28/24 at 12:24 PM, the EHR documented R8 weighed 158.6 lbs. (Indicating R8 experienced a 13.8 lbs. weight loss in one week.) The Nutrition-Amount Eaten documentation revealed: 03/04/24 lacked documentation for R8. 03/05/24 lacked documentation for R8. 03/06/24 lacked documentation for R8. On 03/06/24 at 01:37 PM, the EHR documented R8 weighed 151.4 lbs. (Indicating R8 experienced a 7.4 lbs. weight loss in one week, and a 21.2 lbs. weight loss in two weeks.) The Nutrition-Amount Eaten documentation revealed: 03/08/24 lacked documentation for R8. 03/09/24 lacked documentation for R8. 03/10/24 lacked documentation for R8. The EHR lacked documented evidence the staff weighed R8 on 03/13/24, weekly, as ordered. The Nutrition-Amount Eaten documentation revealed: (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	03/13/24 lacked documentation for R8. 03/14/24 lacked documentation for R8. 03/15/24 lacked documentation for R8. On 03/20/24 at 10:15 AM, the EHR documented R8 weighed 152.0 lbs. The Nutrition-Amount Eaten documentation revealed: 03/22/24 lacked documentation for R8. 03/25/24 lacked documentation for R8. 03/26/24 lacked documentation for R8. 03/27/24 lacked documentation for R8. The EHR lacked documented evidence the staff weighed R8 on 03/27/24, weekly, as ordered. On 03/28/24, the order for 15 mg Remeron, PO at HS for weight loss was discontinued and the physician ordered staff for R8 Remeron, 30 mg, PO at HS, for weight loss. On 04/02/24 at 02:31 PM, the EHR documented R8 weighed 152.2 lbs. On 04/03/24 at 03:44 PM, the EHR documented R8 weighed 151.8 lbs. The Nutrition-Amount Eaten documentation revealed: 04/04/24 lacked documentation for R8. 04/05/24 lacked documentation for R8. 04/08/24 lacked documentation for R8. 04/09/24 lacked documentation for R8. 04/10/24 lacked documentation for R8. On 04/10/24 at 03:22 PM, the EHR documented R8 weighed 152.0 lbs. The Nutrition-Amount Eaten documentation revealed no documentation provided beyond 04/12/24 for R8. On 04/17/24 at 01:59 PM, the EHR documented R8 weighed 151.3 lbs. Review of the EHR for R8 revealed on 04/17/24, the 07/12/22 Physician Order for staff to administer Health Shakes to R8, if needed, if his intake was less than 50%, PRN was discontinued. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Review of the 04/17/24 Physician Order included an order for staff to administer a 4-ounce house supplement shake, two times a day for R8's weight loss, and to document the amount consumed. On 04/24/24 at 08:54 AM, the EHR documented R8 weighed 151.6 lbs. In just over two months, from 02/21/24 when R8 weighed 172.8 lbs. through 04/24/24 when R8 weighed 151. 6 lbs. R8 lost a significant weight of 20.8 lbs., which is 12.06%, in 63 days. On 04/18/24 at 08:30 AM, R8 sat in his wheelchair by the main entrance with an over-the-bed table in front of him with a standard plate of food and standard silverware on the table. R8 appeared to experience difficulty consuming the food. Several staff were in area and did not offer assistance to R8. On 04/23/24 at 12:47 PM, R8 sat in his wheelchair by the main entrance eating the mid-day meal and R8 lacked built-up silverware and the fruit cup was unopened. On 04/24/24 05:20 PM, R8 sat in wheelchair by entrance door with tray table in front of him, food noted on divided plate had built-up silverware. R8 stated he did not like what was served at 05:20 PM. At 06:08 PM R8 remained in same spot in his wheelchair and had the same plate and he had not eaten. At 06:40 PM Dietary staff picked up R8's plate, silverware, and cups and failed to offer R8 a substitute. On 04/25/24 at 12:14 PM, Certified Nurse Aide (CNA) R stated that she did not have access to the facility's EHR to document in the Point of Care (POC) where tasks were documented. CNA R stated she had to tell other staff of tasks she had performed, and they would document it for her, or she would sometimes use the credentials of agency staff to complete the documentation. On 04/25/24 at 05:40 PM Certified Medication Aide (CMA) FF stated that during mealtimes, all staff were supposed to be present in the dining area to provide assistance to residents as needed. CMA FF further stated that the facility did not employ paid feeding assistants, so all the staff were responsible to provide feeding assistance if needed. On 04/24/24 at 12:54 PM, Licensed Nurse (LN) D confirmed that she had signed off on tasks and thought that another staff member had performed the task. On 04/25/24 at 06:20 PM, Consultant Nurse E was made aware of surveyor observations and confirmed that R8 had not eaten any of his food. Consultant Nurse E stated the facility expected the staff to offer assistance if needed and provide additional food choices if a resident did not like the food that was served. On 04/24/24 at 01:40 PM, Administrative Nurse F stated that documentation should only be entered into the EHR by the staff member who performed the task. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	The facility's undated policy Weight Monitoring documented the facility would ensure that all residents maintain acceptable parameters of nutritional status such as usual or desired body weight range unless the resident's clinical condition demonstrated that it is not possible or resident preferences indicated otherwise. Additionally documented that the facility would utilize a systematic approach to optimize the resident's nutritional status which included identification and assessment of each resident's nutritional status, evaluation and analysis of assessment information, development and implementation of pertinent nutritional approaches and monitoring the effectiveness of interventions with revision as appropriate to be consistent with the resident's assessed needs and professional standards to maintain acceptable nutritional status. Additionally documented that significant weight loss was defined as a 5% change in one month (30 days), 7. 5% change in three months (90 days) or a 10% change in six months (180 days). Further documented that the physician should be informed of a significant change in weight and encouraged to document a diagnosis or clinical conditions that may contribute to weight loss, interdisciplinary care team should record meal consumption information and observations documented in the EHR as appropriate. The facility failed to ensure pertinent and timely interventions were implemented as ordered to prevent R8's significant weight loss of 12.06% in 63 days. The facility did not weigh R8 weekly, did not document nutritional intake for R8 as ordered, did not provide appropriate assistive devices to help R8 feed himself, and did not ensure staff knew of the nutritional monitoring system regarding who provided nutritional shakes to R8. This failure resulted in a R8 losing 20.8 pounds (lbs.)/12.06% body weight, in 63 days (and placed the resident at risk for continued decline in nutritional status and at risk for the development of life-threatening symptoms, which could negatively affect the mental, physical, and psychosocial well-being of R8.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46960 The facility reported a census of 35 residents. The sample of 20 residents, which included two residents reviewed for respiratory care. Based on observation, interview, and record review, the facility failed to provide appropriate respiratory care in maintaining respiratory equipment to prevent the spread of infection, consistent with standards of practice and person-centered care plan for one Resident (R)32 related to an unknown clear liquid left in the nebulizer chamber. Findings included: - Review of Resident (R)32's undated Physician Orders, documentation included diagnoses of acute respiratory failure, dependence on supplemental oxygen, chronic obstructive pulmonary disease with acute exacerbation (COPD is a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), pneumonia (inflammation of the lungs), and tobacco use. The Admission Minimum Data Set, dated dated [DATE], documentation included the resident with a Brief Interview for Mental Status, (BIMS) score of 15, indicating cognitively intact. He had functional limitation in range of motion on one side of upper and lower extremities. The resident smoked and exhibited shortness of breath on exertion. He received oxygen as a special treatment. The Care Area Assessment (CAA), dated 02/13/24, documentation lacked address of the resident's oxygen use. The Care Plan, dated 02/01/24, directed staff the resident received oxygen therapy related to ineffective gas exchange. Administer medications as ordered by the physician. Monitor/document side effects and effectiveness. Monitor the resident for signs and symptoms of respiratory distress and report to the physician as needed. The care plan lacked address of sanitation, storage, and instructions for maintenance of oxygen and breathing treatment equipment for the resident. The Physician Order documentation related to respiratory care included the following orders: 1. Nebulizer: Change tubing and mouthpiece. Change filter and clean the nebulizer with sanitation wipe, every bedtime on Sundays, ordered 02/11/24. 2. Ipratropium-Albuterol Inhalation Solution, 0.5-2.5 (3.0) milligrams (MG)/3.0 milliliters (ML)(Ipratropium-Albuterol), every four hours as needed for COPD, ordered 04/18/24. Observation on 04/18/24 at 12:46 PM, revealed R32's nebulizer on the bedside table with an unknown clear liquid that remained in the medication chamber. The nebulizer cannula lacked a date to indicate when staff changed the tubing. Observation on 04/24/24 at 02:52 PM, revealed R32's nebulizer on the bedside table with an unknown clear liquid that remained in the medication chamber. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/18/24 at 12:46 PM, R32 stated staff did not disassemble the medication chamber, clean, or leave to air dry after each breathing treatment. Interview on 04/24/24 at 03:02 PM, Certified Medication Aide (CMA) FF reported at the completion of each breathing treatment, staff should disassemble the nebulizer mask and medication chamber, rinse with tap water, leave it on a paper towel to air dry to prevent infection. Interview on 04/24/24 at 03:03 PM, with Licensed Nurse (LN) D and LN S, both reported and agreed at the completion of a breathing treatment, staff should disassemble the nebulizer mask and medication chamber, and the parts should be cleaned with tap water, placed on a paper towel to air dry, then approximately 30 minutes later, staff should go back and reassemble the nebulizer and place it in a clear plastic bag until the next breathing treatment to prevent infection. Interview on 04/24/24 at 03:45 PM, Consultant Nurse E stated at the completion of a breathing treatment, staff should disassemble the nebulizer mask and medication chamber cleans and rinse the mask and chamber and staff should place the parts on a paper towel to air dry. After a period of time, staff should reassemble the equipment and place it in a plastic bag to prevent infection. The undated facility policy Oxygen Administration lacked address of sanitation and storage of nebulizer equipment after each use to prevent infection. The undated facility policy Nebulizer Therapy documented that nebulizer treatments were to be administered by nursing staff using proper technique and standard precautions that included instructions for staff to clean the equipment after each use and to disassemble, rinse and allow to dry. The facility failed to provide appropriate respiratory care in maintaining respiratory equipment to prevent the spread of infection, consistent with standards of practice and person-centered care plan for one Resident (R) 32 related to unknown clear liquid in the nebulizer chamber

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F 0726 Level of Harm - Actual harm Residents Affected - Many	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46960 The facility reported a census of 35 residents which included 20 residents sampled. Based on interviews, observations and record review, the facility failed to ensure staff possessed the appropriate competencies to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial wellbeing. These deficient practices had the potential have negative physical, mental and psychosocial affects to all the residents in the facility. Findings Included: - R19's Electronic Health Record (EHR) revealed diagnoses of generalized anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), obsessive-compulsive disorder (OCD is an anxiety disorder characterized by recurrent and persistent thoughts, ideas and feelings of obsessions severe to cause marked distress, consume considerable time or significantly interfere with the resident's occupational, social or interpersonal functioning), cognitive communication deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness), and major depressive disorder with psychotic symptoms (a major mood disorder which causes persistent feelings of sadness with a gross impairment in reality perception). The Admission Minimum Data Set (MDS) dated [DATE], documented a Brief Interview for Mental Status (BIMS) could not be completed due to R19 was rarely or never understood. The staff assessment documented R19 had memory problems with severely impaired cognition. The MDS documented R19 had hallucinations (sensing things while awake that appear to be real, but the mind created) and lacked documentation of any behaviors toward self or others. R19 required a wheelchair for locomotion and substantial/maximal assistance for all cares except eating which required setup and supervision. The MDS documented staff could not determine if R19 had any falls prior to admission, or fracture (broken bone) related to a fall in the six months prior to admission. The Falls Care Area Assessment (CAA) dated 12/04/23, documented R19 required extensive assistance of staff for all cares, was at risk for falls, and had a fall since admission with a fracture of nasal bones. The Behavioral Symptoms CAA did not trigger. The Psychosocial Well-Being CAA dated 12/04/23, documented R19 was admitted to the facility after a battle with depression and had psychiatric services ordered. R19 had episodes of behaviors that included hallucinations and delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue) and required staff to assist one-on-one (1:1) for interactions. (continued on next page)

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F 0726 Level of Harm - Actual harm Residents Affected - Many	The Quarterly MDS dated [DATE], documented R19 had a BIMS of 13, which indicated intact cognition. R19 had delusions (an untrue persistent belief or perception held by a person although evidence shows it was untrue) and hallucinations and lacked documentation of any behaviors toward self or others. R19 required partial/moderate assistance with all cares except toileting, bathing, and putting on/taking off footwear. R19 was dependent on staff for locomotion. R19 had two or more falls since admission and lacked documentation of any injuries from falls. The 04/22/24 Care Plan, initiated on 11/28/23, documented the resident was at risk for falls, had an actual fall, and included the following fall interventions: On 11/27/23, R19 had an unwitnessed fall in the dining area and instructed staff on 11/28/23 that R19 was to remain within an arm's reach while R19 was up in her wheelchair. On 11/28/23, staff were to obtain a bolster cover to help define the edges of R19's bed. On 11/28/23, staff were to provide R19 with activities or conversation when she was exhibiting signs of anxiety or restlessness. On 11/28/23, staff were to place a fall mat next to R19's bed to decrease injuries if the resident rolled out of the bed. On 11/28/23, staff were to move the resident to her room to rest in bed if she became restless in the dining area or commons area. On 03/06/24, R19 had an unwitnessed fall without injury and instructed staff to offer to get the resident up out of bed around 03:00 PM so she could people watch in the dining area before the evening meal. The Care Plan lacked interventions specific to R19's falls on 03/19/24 and 03/29/24, and further lacked interventions related to behavioral outbursts. The Nurse Note dated 03/19/24 at 10:12 AM documented R19 was in the quiet room next to the nurse's station with the doors shut and noted the resident was placed on 1:1 observation due to behaviors exhibited since 05:00 AM on 03/19/24 of yelling and screaming all morning and in a paranoia delusion that we are trying to hurt and poison her. The note included that a Certified Nurse Aide (CNA) [CNA C] came to get Licensed Nurse (LN) D and reported that the resident fell out of her wheelchair onto the floor when the CNA [CNA C] looked away for 5 seconds to grab something out of her purse. The note documented R19 had a scuffed and bruised right eye and R19 kept stating that CNA [CNA C] had hit her in the face, and she was yelling it out. The note included R19 was very reluctant to allow the LN to obtain her vitals. Review of the facility's fall investigation and witness statements provided by Administrative Staff A and Consultant Nurse E on 04/24/24 at 12:26 PM, revealed the following information regarding the incident: 1. LN D documented on 03/19/24 at 07:20 AM that R19 fell from her wheelchair and sustained minor injuries to her face noting her right eye was scuffed and bruised and R19 made the allegation that the CNA (CNA C) had hit her. (continued on next page)

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F 0726 Level of Harm - Actual harm Residents Affected - Many	2. LN D's undated witness statement signed and notarized on 04/24/24, documented she reported the allegation to the Director of Nursing (Administrative Nurse B) and resident's Primary Care Provider (PCP). The witness statement further documented that LN D did not hear or witness any abuse or neglect. LN D's witness statement lacked mention of removal of CNA C from working in the facility and/or with the resident further after the incident. 3. The 03/19/24 fall report lacked documentation of causal factors for the fall, immediate interventions initiated by the LN on duty, or permanent care plan interventions to prevent further falls for R19. Furthermore, the fall report lacked documentation that the allegation of abuse was investigated further or reported to the State Agency (SA - a state governmental agency that provides oversight for the Centers for Medicare & Medicaid Services [CMS - the federal government agency that administers the nation's major healthcare programs]) or local law enforcement, by Administrative Staff A or investigated by Administrative Nurse B. 4. Review of the unsigned and unnotarized witness statement photograph, provided by the facility that the facility claimed was from CNA C, dated March 13 of an unknown year, documented CNA C was providing 1:1 supervision of R19 in the lounge room where R19 had been trying to stand up from her wheelchair. The document further included that at an unknown time, CNA C became hungry and went to the other side of the room to retrieve a snack from her personal bag. CNA C turned around and discovered R19 had stood up unassisted. CNA C then walked swiftly towards R19 and witnessed R19 fall to the ground. CNA C documented that R19 claimed CNA C hit her, but that staff knew that to not be true because there was no handprint on R19 and R19 had developed a knot on her forehead. The document further noted for the remainder of her shift CNA C performed 1:1 supervision of R19 in a chair seated right next to R19 and did not leave until another staff member was present. During an interview on 04/24/24 at 12:26 PM, Administrative Staff A and Consultant Nurse E stated they were previously unaware of R19's allegation of abuse and stated they expected staff to report allegations of abuse directly to either Administrative Staff A or Administrative Nurse B. Administrative Staff A and Consultant Nurse E explained the process for abuse allegations included Administrative Staff A or Administrative Nurse B would suspend the individual(s) accused of abuse until a thorough investigation was completed, which included reporting to the SA and local law enforcement. Administrative Staff A and Consultant Nurse E confirmed this had not been completed regarding the 03/19/24 incident involving R19 and CNA C and stated Administrative Nurse B and CNA C were now suspended related to an unreported and uninvestigated allegation of abuse. On 04/25/24 at 08:30 AM, Administrative Nurse F stated all staff completed a training check list that must be completed during orientation and was usually started by Administrative Nurse F on their first day of employment. On 04/25/24 at 07:00 PM, Administrative Staff A stated that she was unable to locate or provide training records and that the facility was in the process of transitioning from a paper-based training system to an online training system and that the process was incomplete, and records could not be located. (continued on next page)

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F 0726 Level of Harm - Actual harm Residents Affected - Many	The facility's' undated Staff Competency policy documented that all nursing staff would demonstrate competency in skills and techniques necessary to care for the residents needs that included regularly scheduled in-service training classes based upon the facility assessment. Records would be maintained by the facility in the employee's education file. Further documented that competencies would be demonstrated through written tests, skills list and return demonstrations. The facility failed to ensure staff possessed the appropriate competencies to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial wellbeing. These deficient practices had the potential have negative physical, mental and psychosocial affects to all the residents in the facility. - Resident (R)35's Electronic Health Record (EHR) revealed diagnoses of insomnia (inability to sleep), generalized anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), cerebral palsy (a progressive disorder of movement, muscle tone or posture caused by injury or abnormal development in the immature brain, most often before birth), and dysphasia (a condition that affects the ability to produce and understand spoken language). The Admission Minimum Data Set (MDS) dated [DATE], documented a Brief Interview for Mental Status (BIMS) could not be completed due to R35 was rarely or never understood. The staff assessment documented R35 had memory problems with severely impaired cognition. The MDS documented other behavioral symptoms and wandering occurred daily, during the seven-day look-back period, and R35 was dependent on staff for all cares. The Care Area Assessment (CAA) dated 04/09/24, lacked appropriate documentation in the analysis of findings pane of the triggered areas. The 04/22/24 Care Plan lacked instructions for staff related to ADL (activities of daily living such as walking, grooming, toileting, dressing and eating), transfers, or safety related to resident's preference to sit on the floor in random places/patterns. The 04/22/24 Physician Orders lacked orders specific to transfers or ADL cares. During a dining observation on 04/24/24 at 06:25 PM, two members of the survey team observed Certified Nurse Aide (CNA) G walk up behind R35, who sat cross-legged on the floor, grabbed R35 under his armpits and lifted his buttocks off the floor with R35's heels remaining on the floor, and drug the resident backwards approximately five feet. Consultant Nurse E witnessed the incident and intervened with CNA G. Consultant Nurse E instructed CNA G to stop and to go wait in Administrative Staff A's office. On 04/24/24 at 06:30 PM, Administrative Nurse E performed an initial assessment on R35 and found no gross injuries. Two other CNA staff assisted R35 to a standing position and into his wheelchair. On 04/24/24 at 06:30 PM, Administrative Nurse E performed a complete head-to-toe assessment of R35, which included a skin assessment and found no alterations from his baseline assessment. (continued on next page)

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F 0726 Level of Harm - Actual harm Residents Affected - Many	On 04/24/24 at 06:30 PM, Consultant Nurse E stated that residents should never be dragged except in cases of extreme emergency such as rescuing the resident from further harm, as in the case of a building fire. Consultant Nurse E confirmed R35 was not in any immediate danger of any harm prior to CNA G picking up R35 and dragging him backwards across the floor. On 04/24/24 at 06:35 PM, Administrative Staff A stated CNA G was suspended immediately and until further notice pending a formal investigation. Additionally, Administrative Staff A stated that CNA G was a new-hire, and her onboarding was incomplete. Administrative Staff A stated CNA G had received verbal ANE re-education training prior to the beginning of her shift on 04/24/24 at 06:00 PM. Administrative Staff A stated that a report to the State Agency and local law enforcement would be made as soon as possible. On 04/25/24 at 11:00 AM, Administrative Nurse F stated CNA G had received initial verbal ANE training on her date of hire which was 04/17/24 and confirmed that her training lacked education related to safe transfers. On 04/25/24 at 08:30 AM, Administrative Nurse F stated all staff completed a training check list that must be completed during orientation and was usually started by Administrative Nurse F on their first day of employment. On 04/25/24 at 07:00 PM, Administrative Staff A stated that she was unable to locate or provide training records and that the facility was in the process of transitioning from a paper-based training system to an online training system and that the process was incomplete, and records could not be located. The facility's' undated Staff Competency policy documented that all nursing staff would demonstrate competency in skills and techniques necessary to care for the residents needs that included regularly scheduled in-service training classes based upon the facility assessment. Records would be maintained by the facility in the employee's education file. Further documented that competencies would be demonstrated through written tests, skills list and return demonstrations. The facility failed to ensure staff possessed the appropriate competencies to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial wellbeing. These deficient practices had the potential have negative physical, mental and psychosocial affects to all the residents in the facility. - Resident (R)35's Electronic Health Record (EHR) revealed diagnoses of cerebral palsy (a progressive disorder of movement, muscle tone or posture caused by injury or abnormal development in the immature brain, most often before birth), trisomy 21(a genetic disorder), translocation type of downs syndrome (chromosomal abnormality characterized by varying degrees of mental retardation and multiple defects), and congenital esophageal stenosis (intrinsic narrowing of esophagus at birth). The Admission Minimum Data Set (MDS) dated [DATE], documented a Brief Interview for Mental Status (BIMS) could not be completed due to R35 was rarely or never understood. The staff assessment documented R35 had memory problems with severely impaired cognition. The MDS documented R35 had a feeding tube (tube for introducing high calorie fluids into the stomach) and R35 was dependent on staff for all cares. (continued on next page)

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F 0726 Level of Harm - Actual harm Residents Affected - Many	The Feeding Tube Care Area Assessment CAA dated 04/09/24, lacked analysis of findings documented. The documentation was computer triggered to assist staff in completion of the CAA's. The Nutritional Status CAA dated 04/09/24 lacked analysis of findings documented. The documentation was computer triggered to assist staff in completion of the CAA's. The Dehydration/Fluid Maintenance CAA dated 04/09/24 lacked analysis of findings documented. The documentation was computer triggered to assist staff in completion of the CAA's. The 04/22/24 Care Plan lacked instructions for nursing staff on how to assess a feeding tube prior to feeding tube being used for administration of fluids and medications. The Physician's Order, dated 04/18/24, documented staff were to administer enteral nutrition via gravity or bolus: Jevity (a liquid nutrition product), 237 milliliter (ml), five times a day, per feeding tube. The physician's order lacked direction to assess placement of feeding tube prior to administering feeding. Review of the Progress Notes and Standard Assessment from 03/28/24 to 04/25/24 revealed the following: On 03/28/24 at 02:34 PM, staff documented R35 arrived at the facility via transportation. R35 was NPO (nothing by mouth). On 03/29/24 at 07:17 AM, staff documented R35 tolerated the feeding well, and the percutaneous endoscopic gastrostomy (PEG) tube placement verified per auscultation (listening to sounds with a stethoscope). On 04/22/24 11:51 AM, Licensed Nurse (LN) D failed to check the placement of feeding tube prior to water administration thru the PEG tube. LN D agreed that staff should check placement prior to administering water, medications or feeding. On 4/22/24 12:15 PM, Administrative Nurse B reported staff should assess for placement of the feeding tube prior to any type of administration. On 04/25/24 at 08:30 AM, Administrative Nurse F stated all staff completed a training check list that must be completed during orientation and was usually started by Administrative Nurse F on their first day of employment. On 04/25/24 at 07:00 PM, Administrative Staff A stated that she was unable to locate or provide training records and that the facility was in the process of transitioning from a paper-based training system to an online training system and that the process was incomplete, and records could not be located. The facility's' undated Staff Competency policy documented that all nursing staff would demonstrate competency in skills and techniques necessary to care for the residents needs that included regularly scheduled in-service training classes based upon the facility assessment. Records would be maintained by the facility in the employee's education file. Further documented that competencies would be demonstrated through written tests, skills list and return demonstrations. (continued on next page)

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F 0726 Level of Harm - Actual harm Residents Affected - Many	The facility failed to ensure staff possessed the appropriate competencies to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial wellbeing. These deficient practices had the potential have negative physical, mental and psychosocial affects to all the residents in the facility. - Review of the Electronic Medical Record (EMR) for R3 revealed the resident had the following diagnoses: abnormalities of gait and mobility and morbid obesity (severely overweight) due to excess calories. Review of the Quarterly Minimum Data Set (MDS) dated [DATE] revealed the resident had a Brief Interview for Mental Status (BIMS) Score of 15, which indicated intact cognition. The resident had no impairment of range of motion of the upper or lower extremities and used a wheelchair for mobility. The resident required partial/moderate assistance for rolling left and right in bed. The resident required substantial/maximal assistance of staff for sitting to laying and laying to sitting in bed. Review of the Annual MDS dated [DATE] revealed the resident had a BIMS score of 15, which indicated intact cognition. The resident required partial/moderate assistance of staff for toileting hygiene, showering/bathing. The resident required substantial/maximal assistance of staff for upper and lower body dressing. R3 required partial/moderate assistance from staff for moving from sitting on the side of a bed to lying flat on the bed, lying to sitting on the side of the bed, sitting to standing, transferring to the toilet. The resident required supervision or touching assistance to roll to the left and right in bed. Review of the ADL Functional/Rehabilitation Potential Care Area assessment dated [DATE] lacked any further development or additional information indicating the resident required assistance with bed mobility. Review of the Care Plan dated 09/18/23 lacked any direction to staff regarding the ADL assistance R3 required until 04/23/24 (6 days after X-Ray verified the resident's right shoulder was dislocated, with suspected fracture). Review of the 04/18/24 at 04:08 PM Nurse Note revealed the resident reported that overnight a nursing staff member pulled on the resident's sore arm while assisting her into bed. Resident reports she feels like it was abuse. The writer informed the resident's physician of the resident's complaint, and she ordered an X-Ray of the right shoulder. Review of the 04/18/24 at 06:03 PM Nurse Note revealed X-Ray results revealed the resident had a dislocation and there was concern of an associated Hill Sachs (dent in the humerus caused by a dislocated shoulder) fracture. The resident would be sent out to the local Emergency Department to be evaluated and treated for injury. Review of the 04/18/24 at 10:42 PM Nurse Note revealed return to facility order to follow up with her provider within one two days. The resident had an arm sling in place, however there was no mention of a sling in the hospital discharge instructions. The hospital reported they were unable to determine the age of dislocation and further stated they were not going to attempt relocation. (continued on next page)

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F 0726 Level of Harm - Actual harm Residents Affected - Many	During an interview with the resident on 04/18/24 at 03:46 PM stated a nurse got her up and pulled her on her right arm. The resident held her right arm close to her side and held her right hand to her chest with her left hand. The resident felt like the staff member was mean and stated she did not deserve that. Observation on 04/23/24 at 10:47 AM revealed CNA AA and Certified Medication Aide (CMA) BB and CMA Q, transferred the resident to the toilet. R3 requested the third staff member for assistance. The resident sat in her wheelchair with a sling on her right arm. R3 stated she could only push herself up using her left hand. R3 told the staff she would need them to pull her pants down. Staff assisted the resident to stand and pivot to toilet. Staff removed the resident's brief and stated she was normally wet when toileting, it was part of their routine to toilet every two hours but stated she did not tell them when she had to go. With the use of a gait belt the resident stood from the toilet and pivoted with three staff assistance to sit. On 04/25/24 at 08:30 AM, Administrative Nurse F stated all staff completed a training check list that must be completed during orientation and was usually started by Administrative Nurse F on their first day of employment. On 04/25/24 at 07:00 PM, Administrative Staff A stated that she was unable to locate or provide training records and that the facility was in the process of transitioning from a paper-based training system to an online training system and that the process was incomplete, and records could not be located. The facility's' undated Staff Competency policy documented that all nursing staff would demonstrate competency in skills and techniques necessary to care for the residents needs that included regularly scheduled in-service training classes based upon the facility assessment. Records would be maintained by the facility in the employee's education file. Further documented that competencies would be demonstrated through written tests, skills list and return demonstrations. The facility failed to ensure staff possessed the appropriate competencies to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial wellbeing. These deficient practices had the potential have negative physical, mental and psychosocial affects to all the residents in the facility. - Review of Resident (R)32's undated Physician Orders, documentation included diagnoses of acute respiratory failure, dependence on supplemental oxygen, chronic obstructive pulmonary disease with acute exacerbation (COPD is a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), pneumonia (inflammation of the lungs), and tobacco use. The Admission Minimum Data Set, dated dated [DATE], documentation included the resident with a Brief Interview for Mental Status, (BIMS) score of 15, indicating cognitively intact. He had functional limitation in range of motion on one side of upper and lower extremities. The resident smoked and exhibited shortness of breath on exertion. He received oxygen as a special treatment. The Care Area Assessment (CAA), dated 02/13/24, documentation lacked address of the resident's oxygen use. (continued on next page)

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F 0726 Level of Harm - Actual harm Residents Affected - Many	The Care Plan, dated 02/01/24, directed staff the resident received oxygen therapy related to ineffective gas exchange. Administer medications as ordered by the physician. Monitor/document side effects and effectiveness. Monitor the resident for signs and symptoms of respiratory distress and report to the physician as needed. The care plan lacked address of sanitation, storage, and instructions for maintenance of oxygen and breathing treatment equipment for the resident. The Physician Order documentation related to respiratory care included the following orders: 1. Nebulizer: Change tubing and mouthpiece. Change filter and clean the nebulizer with sanitation wipe, every bedtime on Sundays, ordered 02/11/24. 2. Ipratropium-Albuterol Inhalation Solution, 0.5-2.5 (3.0) milligrams (MG)/3.0 milliliters (ML)(Ipratropium-Albuterol), every four hours as needed for COPD, ordered 04/18/24. Observation on 04/18/24 at 12:46 PM, revealed R32's nebulizer on the bedside table with an unknown clear liquid that remained in the medication chamber. The nebulizer cannula lacked a date to indicate when staff changed the tubing. Observation on 04/24/24 at 02:52 PM, revealed R32's nebulizer on the bedside table with an unknown clear liquid that remained in the medication chamber. On 04/18/24 at 12:46 PM, R32 stated staff did not disassemble the medication chamber, clean, or leave to air dry after each breathing treatment. Interview on 04/24/24 at 03:02 PM, Certified Medication Aide (CMA) FF reported at the completion of each breathing treatment, staff should disassemble the nebulizer mask and medication chamber, rinse with tap water, leave it on a paper towel to air dry to prevent infection. Interview on 04/24/24 at 03:03 PM, with Licensed Nurse (LN) D and LN S, both reported and agreed at the completion of a breathing treatment, staff should disassemble the nebulizer mask and medication chamber, and the parts should be cleaned with tap water, placed on a paper towel to air dry, then approximately 30 minutes later, staff should go back and reassemble the nebulizer and place it in a clear plastic bag until the next breathing treatment to prevent infection. On 04/25/24 at 08:30 AM, Administrative Nurse F stated all staff completed a training check list that must be completed during orientation and was usually started by Administrative Nurse F on their first day of employment. On 04/25/24 at 07:00 PM, Administrative Staff A stated that she was unable to locate or provide training records and that the facility was in the process of transitioning from a paper-based training system to an online training system and that the process was incomplete, and records could not be located. The facility's' undated Staff Competency policy documented that all nursing staff would demonstrate competency in skills and techniques necessary to care for the residents needs that included regularly scheduled in-service training classes based upon the facility assessment. Records would be maintained by the facility in the employee's education file. Further documented that competencies would be demonstrated through written tests, skills list and return demonstrations. (continued on next page)

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F 0726 Level of Harm - Actual harm Residents Affected - Many	The facility failed to ensure staff possessed the appropriate competencies to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial wellbeing. These deficient practices had the potential have negative physical, mental and psychosocial affects to all the residents in the facility. 31078 - Resident (R)89's Electronic Medical Record (EMR) dated 04/04/24 revealed the following diagnoses: heart failure (heart disease), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), essential (primary) hypertension (elevated blood pressure), edema (swelling resulting from an excessive accumulation of fluid in the body tissues), lymphedema (swelling caused by accumulation of lymph), alcohol abuse, other stimulant abuse, atrial fibrillation (rapid irregular heart beat), acute kidney failure (inability of the kidneys to excrete wastes, concentrate urine and conserve electrolytes), hypomagnesemia (less than normal magnesium levels in the blood), hyperkalemia (greater than normal amount of potassium in the blood), major depressive disorder (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness and hopelessness) severe with psychotic features (any major mental disorder characterized by a gross impairment in reality testing), systolic (congestive) heart failure (a condition with low heart output and the body becomes congested with fluid), chronic pain, morbid (severe) obesity due to excess calories (the state or condition of being very fat or overweight), hypothyroidism (condition characterized by decreased activity of the thyroid gland), cellulitis of right lower limb (skin infection caused by bacteria characterized by heat, redness and swelling), and hyponatremia (lower than normal sodium blood level). R89's Annual Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The resident was occasionally incontinent of urine. R89 had two stage two pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, because of pressure, or pressure in combination with shear and/or friction) on his buttock. Medications R89 received included antipsychotic (class of medications used to treat major mental conditions which cause a break from reality), antidepressant (class of medications used to treat mood disorders), diuretic (medication to promote the formation and excretion of urine), and opioid pain medications daily during the look-back period. The Quarterly MDS dated [DATE], revealed a BIMS score of 15, indicating intact cognition. The resident had no skin breakdown documented on the assessment. Medications R89 received included antipsychotic, antidepressant, antibiotic, opioid pain medication and antiplatelet (medication to prevent blood clots) daily during the look-back period. The Care Area Assessment (CAA) dated 12/22/23 revealed: The Functional Abilities CAA documented R89's was independent with daily cares, required supervision at times, and was continent of bowel and bladder. He triggered for fall risk, but gait was steady, and R89 could ambulate as he wanted to, without the use of an assistive device. R89 required medications that could increase his risk for falls, with no recent history of falls. He triggered on nutrition due to his high body mass index (BMI) and documented he triggered for pain and had medications for comfort. (continued on next page)

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F 0726 Level of Harm - Actual harm Residents Affected - Many	The Pressure Ulcer CAA revealed R89 had pain and required medication for pain relief. He had a history of pressure ulcers/ulcers to lower extremities. On 12/21/23, R89 had

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36881 The facility reported a census of 35 residents with 20 residents sampled for review, which included one resident, Resident (R)23, reviewed for provision of medically related social services. Based on observation, interview, and record review, the facility failed to provide sufficient and appropriate medically related social services (services provided by the facility's staff to assist residents in attaining or maintaining their mental and psychosocial health) to meet resident's (R)23's psychosocial needs related to alcohol use disorder. Findings included: - Review of Resident (R)23's undated Physician Orders revealed diagnoses which included alcohol use with unspecified alcohol induced disorder, and major depression disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). The Admission Minimum Data Set (MDS), dated [DATE], documented the resident admitted to the facility on [DATE] and had a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. She did not exhibit any behaviors. The resident was independent with activities of daily living (ADL) which included bed mobility, transfers, and walking. The resident received antidepressants (class of medications used to treat mood disorders) for five days of the look back period. She did not receive special treatments, procedures, and programs. The Quarterly MDS dated [DATE], included the following changes from the above assessment: R23 had a BIMS score of 15, indicating intact cognition. The Activities of Daily Living (ADL) Functional/Rehabilitation Potential Care Area Assessment, (CAA) dated 09/17/23, documentation included the resident recently admitted to the facility following an inpatient stay at the hospital behavioral unit with diagnoses of alcohol use disorder and major depressive disorder. She was alert and oriented, able to make her needs known, and desired to go home. The resident was independent with ADL completion. She currently had a court appointed guardian that reported the resident could not safely care for herself due to the above diagnoses. The Care Plan, initiated 09/27/23, directed staff the resident had depression and staff were to monitor for signs of depression including hopelessness, insomnia, anxiety, sadness, verbalizing statements, repetitive anxious or health related complaints, and/or tearfulness. Discuss with the resident/family/caregivers any concerns, fears issues regarding health or other subjects as often as resident desires. The Care Plan did not address and lacked any interventions to mitigate risk factors or provide treatment/support to the resident regarding her alcoholism/alcohol use disorder. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Per the Mayo Clinic online (mayoclinic.org) information, regarding alcohol use disorder, treatment can include detox and withdrawal, learning new skills and making a treatment plan, psychological counseling, oral or injected medication, continuing support, treatment for psychological problems, medical treatment for health conditions, and spiritual practice. The information included under Residential Treatment Programs noted most residential treatment programs included individual and group therapy, support groups, educational lectures, family involvement, and activity therapy. The information further noted residential treatment programs typically include licensed alcohol and drug counselors, social workers, nurses, doctors, and other with expertise and experience in treating alcohol use disorder. The website documented the treatment may involve a brief intervention, individual or group counseling, and outpatient program, or a residential inpatient stay. Working to stop alcohol use to improve quality of life is the main treatment goal. Observation on 04/22/24 at 09:56 AM revealed R23 sat in a chair in her room. She stood from her chair at the bedside, reached for her walker, and sat down independently. She was alert and oriented and readily engaged in conversation. During an interview on 04/22/24 at 09:56 AM, R23 stated she was a retired nurse. She reported she drank to much when she retired. The resident checked herself into the hospital to get some help for her alcoholism, and then she was sent to the facility for rehabilitation. The counselor told her to stay for a month for alcohol rehabilitation and R23 reported she admitted to this facility around eight months ago and did not want to stay. She stated she was not getting any help or support such as Alcohol Anonymous (AA) and was now paying privately to stay, while not getting any help with her alcoholism. She reported the guardian was not helpful and she did not want to live her life out at the facility. R23 stated her alcoholism is not addressed at the facility and the facility does not discuss discharge planning or a treatment plan for alcoholism. R23 stated there is no communication. During an interview on 04/23/24 at 09:32 AM, Social Services Designee (SSD) L confirmed the resident admitted from the hospital behavioral unit following a hospital stay for alcoholism. SSD L stated she was aware the resident had a history of alcoholism on admission. SSD L said the resident was alert and oriented and had not received alcohol rehabilitation treatment and/or services. SSD L stated she did not think the resident needed the services, since R23 was not drinking. SSD L reported she had not received training in alcohol or substance abuse and the facility did not offer AA or Alcohol treatment services until a month ago. She stated the facility had not offered services to the resident to provide for her care and/or treatment of psychosocial needs related to alcoholism since her admission. Additionally, SSD L reported the resident had expressed the desire to attend AA meetings. SSD L confirmed the resident's care plan did not address the resident's psychosocial needs related to her alcoholism. On 04/23/23 at 03:30 PM, Administrative Nurse B, Administrative Nurse F, and Consultant Nurse Q, agreed the resident's primary diagnosis for admission was related to her alcoholism. They verified the facility failed to provide the care, treatment, service for supportive care as the primary focus related to the resident's alcoholism. The undated facility policy Social Services, Provision of F745 and Qualifications of F850, documentation included the community provides medically related social services to assist each resident to attain or maintain his/her highest practicable physical, mental, or psychosocial well-being. Medically related social services is provided to maintain or improve each resident's ability to control everyday physical needs, mental and psychosocial needs which included coping abilities. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The undated facility policy F689 Accidents-Substance Use Disorder (SUD), documentation included residents with substance use disorder will receive necessary care and services once admitted to the community. Interventions may include providing substance use treatment services, such as Alcohol anonymous meetings. The facility failed to provide sufficient and appropriate medically related social services to meet resident's (R)23's psychosocial needs related to alcohol use disorder.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 46960 The facility reported a census of 35 residents with 20 residents included in the sample. Based on observation, interview, and record review the facility failed to ensure an effective pharmacy system in place to ensure the accurate accounting, reconciliation, and destruction of controlled/narcotic medications. This deficient practiced affected Resident (R) 40, R39, R41, R24, R89, R35, R15, R18, and R10, and placed any resident who received controlled medications at risk for staff diversion of their medication and potential untreated symptoms management that could negatively affect their physical, mental, and psychosocial well-being. Findings included: - During the onsite health resurvey and complaint investigations revealed a concern regarding staff misappropriation of resident narcotic/controlled medication and drug diversion. Review of the facility reported incident (FRI) history for the facility revealed two FRI investigations regarding drug diversions. FRI#3574 was investigated with a prior complaint survey (92M411) on 10/25/23. The FRI investigation revealed Administrative Nurse B reported a drug diversion regarding discontinued medications for R39 and R41. The facility investigation revealed on 10/18/23 at approximately 06:30PM Administrative Nurse B and LN RR noticed a narcotic card of R39's Oxycodone (opioid narcotic medication used to treat severe pain) 5/325 mg looked suspicious, and the back side of the card appeared to have tape covering 4 torn open holes. Upon further investigation another card of Oxycodone HCL ER oral Tablet 12HR for R41 appeared to be missing one original pill as the color and size were slightly different and was also taped in the bubble pack. Administrative Nurse B's undated and signed witness statement into the 10/18/23 issue revealed R39's Oxycodone 5/325 mg card with the four taped over areas and R41's Oxycontin 5mg IR card with the 1 taped over area, did not have a matching imprint for the medication, and turned out to be Hydralazine (vasodilator medication, used to lower blood pressure), in their place. Administrative Nurse B's witness statement included the facility conducted on the spot re-education, and any discontinued/discharged narcotics must be given to Administrative Nurse B for safe secured storage within 24 hours of the resident medication being discontinued/resident discharged . The narcotics in question were stored in a double locked area of the medication cart until they could be destroyed by the pharmacist since the Oxycodone they discovered belonged to R39, who discharged from the facility on 09/27/23 and the oxycodone HCl ER Oral Tablet ER 12HR was prescribed to R41, but was discontinued on 10/13/23. The facility was unable to determine when these medications were taken and was not able to determine who has taken them. The facilty determined that no resident missed any scheduled doses of their pain medication related to this incident. The investigation included an addendum which documented LN RR, employed at the facility from 10/11/23 to 10/27/23, was terminated and turned into the State Board of Nursing for erratic behavior and suspected. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Corrective Actions for FRI #3574 included Administrative Nurse B would audit narcotic counts and verify cards have not been tampered with twice weekly for four weeks, then once a week for four weeks, then monthly as needed. Any non-compliance would immediately be addressed with reeducation and taken to the facility QAPI team. All CMAs and LNs received additional education on 10/24/23 on the process of narcotic administration, narcotic counts and documentation of controlled narcotics. All CMAs and LNs including agency staff who have not been educated would have face-to-face education prior to working their next shift. QAPI Ad Hoc meeting held on 10/19/23. The Facility Reported Incident (FRI) #5420 investigation revealed the facility discovered a drug diversion regarding discontinued controlled substances for R40, R39, R41, R24, and R89. Per the report, during the monthly pharmacy narcotic destruction on 01/23/24 at approximately 10:15 AM, the consultant Pharmacist and Administrative Nurse F discovered a potential medication diversion of narcotics with previously discharged resident medications. The FRI revealed the pharmacist noted the narcotic count sheets could potentially be copies of the original narcotic count sheets; however, per the facility report they concluded the narcotic sheets were the originals. The FRI noted on 01/23/24 all discontinued controlled medication present in the narcotic waste cabinet were destroyed per policy. The FRI identified potential missing medication cards and could not account for the missing cards of medications. On 01/24/24 at approximately 11:00 AM, the facility reviewed clinical records with the Pharmacy records and discovered the missing medication cards were not destroyed during the previous narcotic destruction. At approximately 11:30 AM the nursing leadership performed a controlled substance count and noted all controlled medications in the medication carts, along with count sheets were reviewed and no discrepancies in the count or cards were identified. For R40: The facility reported 96 tabs of 7.5 milligram (mg) Norco were unaccounted for/missing for R40. The onsite surveyor investigation revealed R40 had a diagnosis of chronic pain, was care planned for his mixed acute and chronic pain related to pelvic fracture and previous hip fracture. The Care Plan for R40 included the resident's pain was alleviated/relieved by pain medication regimen, the staff were to anticipate the resident need for pain relief and respond immediately to any complaint of pain, monitor for non-verbal indicators of pain, and included the resident preferred to have pain controlled by: Oxycontin as prescribed. R40 passed away on 10/26/23, almost three months prior. For R39: The facility reported 97 tabs of 5/325 mg Oxycodone were unaccounted for/missing for R39. The onsite surveyor investigation revealed R39 admitted to the facility after surgery (amputation) of toes on both feet, then discharged to the hospital on 09/27/23 where she passed away (almost four months prior). For R41 (also listed in FRI 3574): The facility reported 44 tabs of 20 mg Oxycodone and 46 tabs of 10 mg Oxycodone were unaccounted for/missing for R41. The onsite surveyor investigation revealed R41 discharged from the facility on 11/08/23 (2.5 months prior). For R24 (also listed in FRI 3574): The facility reported 2 tabs of 5mg Oxycodone were unaccounted for/missing for R24. The onsite surveyor investigation revealed R24 was a current resident of the facility and had diagnoses which included spinal stenosis, pain her right knee, chronic obstructive pulmonary disease, and right thigh bone fracture. For R89: The facility reported 33 half tabs of 5 mg Oxycodone were unaccounted for/missing for R89. The onsite surveyor investigation revealed R89 had a diagnosis of chronic pain. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility reported the incident to the State Agency and informed the state agency the interventions they put in place to prevent the incident from happening in the future included: A process change to all discontinued narcotics. All narcotics were placed in a double locked file cabinet in the Director of Nursing office. The facility began staff education on narcotic diversion, and initiated nursing education on the proper removing of medications from the medication carts. Observation during the onsite survey on 04/18/24 at 10:05 AM revealed the following concerns: The narcotic sheet for R18 noted a PRN Oxycodone was removed and signed out but did not contain the date staff signed it out for administration. The medication cart contained R10's Ativan 0.5 mg tablets in a blister pack with 27 pills, prescribed to R10. The label on the pack instructed to administer one tabled by mouth every three hours as needed (PRN), for anxiety. The surveyor noted three of the pills were wasted. The narcotic sheet did not contain a date entry for two of the wasted Ativan, and the one wasted Ativan was dated 02/09/24. All three were signed off by two staff members the Ativan were wasted. Surveyor investigation revealed R10 did not have an order for Ativan since the 11/07/23 end date. Observation on 04/18/24 at 10:42 AM revealed R35's Narcotic sheet did not contain a prescription number to be able to compare to the Narcotic card for R35's 5 mg Diazepam or R35's 10 mg Diazepam. Further observation revealed R15's as needed Ativan for anxiety, in the PRN section of the Narcotic Book, with the last dose documented on 11/21/23. The surveyor investigation revealed R15's Ativan order was discontinued on 03/19/24 (almost 4 months prior). During an interview on 04/18/24 at 10:35 AM, CMA CC stated when a narcotic medication was discontinued CMAs let the LN know, then the LN pulled the medication from the cart and destroyed it. CMA CC said she thought there was a destroy box in the medication room, but she was not sure. When asked what she does with her narcotic keys when she leaves the facility grounds to go to lunch, CMA CC stated she gave her keys to the LN if she left the facility grounds. When asked if she performed a narcotic medication count when she leaves the keys with the LN, CMA CC said no. During an interview on 04/18/24 at 10:38 AM, LN T stated the discontinued narcotic medications were picked up by Administrative Nurse F and Administrative Nurse B pick up the discontinued narcotics and lock them in a triple locked cabinet in Administrative Nurse B's office. During an interview on 04/18/24 at 11:00 AM, Administrative Nurse F stated the narcotics stayed in the med cart to be counted until both her and Administrative Nurse B were in the building together to collect the discontinued narcotic medications. Administrative Nurse F said they check every morning for discontinued narcotics and pull them out of the Narcotics drawer. Administrative Nurse F reported that each have their own key for the different locks on the cabinets and when asked what happens when one of the staff with a key go on vacations, Administrative Nurse F stated, not sure probably give our key to Administrative Staff A or Social Services Staff L. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/23/24 at 11:15 AM with Administrative Nurse B, Administrative Nurse F, and Consultant Nurse E revealed the narcotic medications that are discontinued remained in the medication car and were counted until both Administrative Nurse B and Administrative Nurse F can pull them the next day from the medication cart to lock up. When asked about the keys for the Narcotics lock box, Administrative Nurse B said she and Administrative Nurse F have their own keys on their key rings, they do not share keys or hand their keys off to no one. Administrative Nurse B further stated when they are not in the facility together or on vacation, they expected the discontinued narcotic medications to remain in the medication carts and be counted until they are removed by the two of them. When asked if they knew there were two residents with discontinued medications in the narcotic box on the medication cart, they both answered no. Administrative Nurse B stated the procedure for narcotic keys when a CMA left the facility included the charge nurse and CMA complete a narcotic count with every key release. The facility policy named Medication Errors dated 2023 revealed it is the policy of the facility to provide protections for the health, welfare, and rights of each resident by ensuring residents receive care and services safely in an environment free of significant medication errors. A significant medication error means one which causes the resident discomfort or jeopardizes his health and safety. The facility shall ensure medications will be administered according to physician orders. The undated Discontinued Medications F755 Policy revealed staff shall destroy medications or shall return them to the dispensing pharmacy in accordance with facility policy and state law. A practitioner's order to discontinue a resident's medication must be documented in the resident's clinical record and on the medication administration record (MAR). The nurse receiving the order to discontinue a medication is responsible for recording that information and notifying the dispensing pharmacy of the discontinuation. The facility failed to ensure an effective pharmacy system in place to ensure the accurate accounting, reconciliation, and destruction of controlled/narcotic medications. This deficient practiced affected Resident (R) 40, R39, R41, R24, R89, R35, R15, R18, and R10, and placed any resident who received controlled medications at risk for staff diversion of their medication and potential untreated symptoms management that could negatively affect their physical, mental, and psychosocial well-being.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36881 The facility census totaled 35 residents with 20 included in the sample and five reviewed for medications. Based on observation, interview, and record review the facility failed to ensure three of the five residents reviewed remained free of unnecessary medications by the failure to ensure the Consulting Pharmacist identified and reported medication irregularities by not having Monthly Medication Reviews Reviews from 01/01/24 to 04/25/24 for Resident (R)28, R19, and R3. Findings included: - Review of Resident (R)3's Physician Orders dated 04/21/24 revealed diagnoses which included Schizophrenia (mental disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought), insomnia (inability to sleep), abnormalities of gait and immobility, and need for assistance with personal care. The Admission Minimum Data Set (MDS), dated [DATE], documented the resident admitted ,d+[DATE] 1/23. A Brief Interview for Mental Status (BIMS) score of 15 indicated she was cognitively intact. The resident did not exhibit behaviors nor mood indicators. She reported no pain and did not receive scheduled nor as needed (PRN) pain medication. The resident received antipsychotics, antidepressants, and antibiotics for seven days of the look back period. The physician did not document contraindications of gradual dose reductions (GDR) and none had been attempted. The Quarterly MDS, dated [DATE] revealed the resident had a BIMS of 15, which indicated intact cognition. She received antipsychotic, antianxiety, antidepressant, anticoagulant, and antibiotic medication during the look back period. The resident continued to deny pain on interview and did not receive scheduled or PRN pain medication. The Psychotropic Drug (medication that affects brain activities associated with mental processes and behavior) Use Care Area Assessment, dated 08/13/23 , documentation included the resident recently admitted to facility from another nursing facility. The resident was alert and able to make her needs known. She understood others and made herself understood. The resident currently received medications, which included antibiotic medications, antidepressant medications, and antipsychotic medications. The Care Plan (CP), dated 04/17/24 lacked addressing the use of psychotropic medications and care directives associated with medication side effects. Review of the Physician Orders, dated 04/21/24, revealed the resident had orders for the following psychoactive medications: 1. Quetiapine Fumarate/Seroquel (antipsychotic medication), Oral Tablet 25 milligrams (mg), give 12.5 mg by mouth two times a day for schizophrenia, ordered 08/02/23. 2. Duloxetine/Cymbalta, (antidepressant medication) Oral Capsule Delayed Release Particles 20 mg, give 1 capsule by mouth one time a day related to major depression disorder, ordered 08/02/23. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Monitor for target behaviors: demanding to staff, yelling out, anxious, delusions related to psychoactive medication use of Seroquel and duloxetine, ordered 08/03/24. The facility failed to provide Medication Regimen Review (MRR) for any residents prior to 01/01/24 and was unable to locate any facility or provider responses to pharmacy MRR reports after 01/01/24. On 04/25/24 at 12:36 PM, Consultant Nurse E stated that the facility was unable to locate any Medication Regimen Review (MRR) for any residents prior to 01/01/24 and was unable to locate any facility or provider responses to pharmacy MRR reports after 01/01/24. Additionally stated that her expectation was for Administrative Nurse B to respond to the pharmacy's MRR within seven days by either addressing the concern internally or forwarding to the provider for them to address. Consultant Nurse E further stated that the maximum time that should be allowed for the facility or the provider to respond would be no more than 21 days and confirmed the facility and provider's failure to respond to MRR reports from the pharmacy was unacceptable. The undated facility policy titled Medication Regimen Reviews F756, documentation included the consultant pharmacist shall review the medication regimen per state and federal guidelines. The facility failed to prevent the use of unnecessary medications for R3 when the facility failed to track, monitor, and/or respond to pharmacist's monthly recommendations and identification of irregularities for the resident related to the facility's failure to provide monthly medication regimen and responses reviews prior to 01/01/24 and was unable to locate any facility or provider responses to pharmacy MRR reports after 01/01/24. 46960 - Resident (R)19's Electronic Health Record (EHR) revealed diagnoses of generalized anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), obsessive-compulsive disorder (OCD is an anxiety disorder characterized by recurrent and persistent thoughts, ideas and feelings of obsessions severe to cause marked distress, consume considerable time or significantly interfere with the resident's occupational, social or interpersonal functioning), cognitive communication deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness), and major depressive disorder with psychotic symptoms (a major mood disorder which causes persistent feelings of sadness with a gross impairment in reality perception). The Admission Minimum Data Set (MDS) dated [DATE], documented a Brief Interview for Mental Status (BIMS) could not be completed due to R19 was rarely or never understood. The staff assessment documented R19 had memory problems with severely impaired cognition. The MDS documented R19 had hallucinations (sensing things while awake that appear to be real, but the mind created) and lacked documentation of any behaviors toward self or others. The resident received antianxiety (a class of medications that calm and relax people) and antidepressant (a class of medications used to treat mood disorders. The Quarterly MDS dated [DATE], documented R19 had a BIMS of 13, which indicated intact cognition and received antianxiety and antidepressant medications. The Physician Orders revealed the following: (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Hydroxyzine, (an antihistamine [a class of medication used to counteract the physiological effects of histamine production in allergic reactions or can be used to treat psychological conditions such as anxiety), 10 milligrams (mg), one tablet, by mouth or via peg tube (a tube that was surgically inserted through the abdominal wall and into the stomach for the purposes of feeding and/or administration of medications) every eight hours as needed (PRN), ordered on 11/7/23, and discontinued by the physician on 03/19/24. Memantine (Namenda - a medication that is used to treat moderate to severe dementia), 10 mg, to give one and a half tablets by mouth or via peg tube, one time per day for Neurological agent, ordered on 11/29/23 and discontinued by the physician on 03/08/24. Memantine, 10 mg tablet, to be given by mouth, two times per day, for Neurological agent, ordered 03/08/24. Review of pharmacist medication regimen review (MRR) reports revealed the following: 1. On 12/18/23, the pharmacist requested the physician clarify the indication (reason for a person to take a medication) for memantine. The facility failed to provide a provider or facility response to this request. 2. On 01/19/24, the pharmacist requested a stop date for hydroxyzine that was ordered on a PRN basis in order to remain within compliance of federal regulations. The facility failed to provide a provider or facility response to this request. 3. On 02/17/24, the pharmacist MRR report documented that no significant irregularities were identified and referred to nursing and physician recommendations. The facility failed to provide a provider or facility response to this request. 4. On 03/27/24, the pharmacist MRR report documented that no significant irregularities were identified and referred to nursing and physician recommendations. The facility failed to provide a provider or facility response to this request. 5. On 04/17/24, in response to a fall review request from the facility, the pharmacist MRR report documented that no significant irregularities were identified and referred to nursing and physician recommendations. The facility failed to provide a provider or facility response to this request. 6. On 04/23/24, the pharmacist MRR report documented that no significant irregularities were identified and referred to nursing and physician recommendations. The facility failed to provide a provider or facility response to this request. Review of the electronic medication administration record (eMAR) 11/27/23 to 04/22/24 revealed that the resident had received 13 doses of hydroxyzine from when the pharmacist identified the irregularity on 01/19/24 and when the provider discontinued the order on 03/19/24. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/25/24 at 12:36 PM, Consultant Nurse E stated that the facility was unable to locate any MRR data for any residents prior to 01/01/24 and was unable to locate any facility or provider responses to pharmacy MRR reports after 01/01/24. Additionally stated that her expectation was for Administrative Nurse B to respond to the pharmacy's MRR within 7 days by either addressing the concern internally or forwarding to the provider for them to address. Further, stated that the maximum time that should be allowed for the facility or the provider to respond would be no more than 21 days. Confirmed the facility's and provider's failure to respond to MRR reports from the pharmacy for two months was an unacceptable practice. The undated facility policy Medication Regimen Reviews documented that a consultant pharmacist would review the medication regimen following state and federal guidelines. Further documented that the Director of Nursing (DON - Administrative Nurse B) would agree on the process and steps to be taken to resolve any identified irregularities. Additionally documented that the focus of the pharmacist review would include unnecessary medications that further included psychotropic medications for a review for specific conditions as diagnosed . Further documented that a review of the resident's PRN psychotropic medications would be limited to 14 days, and that if required for more than 14 days then a physician would document a rational in the EHR. The facility failed to prevent the use of unnecessary medications for R19 when the facility failed to respond to pharmacist recommendations for an appropriate indication for use, and the failure to respond to pharmacist recommendation for an end date or appropriate rationale for continued use. These deficient practices caused R19 to receive an unnecessary medication for 13 doses over two months after the pharmacist initially identified the deficient practice. - R28's Electronic Health Record (EHR) revealed diagnoses of intellectual disabilities (characterized both by a significantly below-average score on a test of mental ability or intelligence and by limitations in the ability to function in areas of daily life, such as communication, self-care, getting along in social situations and school activities), psychosis (any major mental disorder characterized by a gross impairment in reality perception) and need for assistance with personal care. Review of the 08/25/23 Admission Minimum Data Set revealed the resident had a Brief Interview for Mental Status (BIMS) score of 13, which indicated intact cognition. The resident required extensive assistance of one to two staff for bed mobility, transfers, dressing, toilet use and personal hygiene. The resident had no falls in the last month prior to admission/entry. The resident had a fall in the last 2-6 months prior to admission/entry or reentry and a fracture in the 6 months prior to admission/reentry. Review of the Falls Care Area assessment dated [DATE] revealed R28 admitted to the facility from another long-term care facility. The resident had a history of falls with a neck fracture noted among others. R28 required extensive staff assistance with activities of daily living including, dressing, restroom usage, peri-care, grooming, transfers, and mobility. Review of the 02/21/24 Quarterly Minimum Data Set revealed the resident had a Brief Interview for Mental Status (BIMS) score of 11, which indicated moderately impaired cognition. The resident had impairment of both the upper and lower extremities on both sides and he used a wheelchair for mobility. The resident had no falls identified since the prior assessment. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 04/22/24 Care Plan documented R28 had a diagnosis of psychosis and instructed staff with the following interventions: 1. On 11/29/23, staff were to administer medications as ordered. 2. On 11/29/23, staff had psychological services in place as ordered by the physician. 3. On 11/29/23, staff were to reapproach resident whenever he was displaying behaviors. The Care Plan lacked information related to the use of psychotropic medications or Black Box Warning (BBW- highest safety-related warning that medications can have assigned by the Food and Drug Administration) The Physician's Orders documented the following: 1. Abilify (Aripiprazole - an antipsychotic medication) 20 milligrams (mg), to be given orally once per day for mood stabilizer on 02/21/24. 2. Buspirone (an antianxiety medication), 10 mg, to be given orally three times per day for behaviors and anxiety on 12/01/23. 3. Buspirone, 10mg to be given orally every 12 hours as needed (PRN) for nausea or vomiting. Review of pharmacist medication regimen review (MRR) reports revealed the following: 1. On 10/30/23, the pharmacist documented that a MRR had been performed, however the facility failed to produce the document for review upon request on 04/24/24. 2. On 11/24/23, the pharmacist documented that a MRR had been performed, however the facility failed to produce the document for review upon request on 04/24/24. 3. On 12/18/23 the pharmacist documented that a MRR had been performed, however the facility failed to produce the document for review upon request on 04/24/24. 4. On 01/19/24, the pharmacist documented a requested clarification from the facility or physician for the inappropriate indication for PRN buspar of nausea or vomiting. The facility failed to provide a response from the facility or physician as requested on 04/24/24. 5. On 02/17/24, the pharmacist documented that a MRR had been performed, however the facility failed to produce the document for review upon request on 04/24/24. 6. On 03/27/24, the pharmacist documented that a MRR had been performed, however the facility failed to produce the document for review upon request on 04/24/24. 7. On 04/17/24 the pharmacist documented that a MRR had been performed, however the facility failed to produce the document for review upon request on 04/24/24 (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/18/24 at 03:56 PM, R28 observed self-propelling in wheelchair with anti-rollback brakes installed with an interrupted forward and backward motions that lacked a discernable pattern in common area. On 04/22/24 at 09:55 AM, R28 observed self-propelling backward in wheelchair with anti-rollback brakes installed and nearly hit R35 who was sitting on the floor when an unknown staff member called out to R28 who then resumed interrupted forward and backward motions in a random pattern in the common area. On 04/25/24 at 12:36 PM, Consultant Nurse E stated that the facility was unable to locate any MRR data for any residents prior to 01/01/24 and was unable to locate any facility or provider responses to pharmacy MRR reports after 01/01/24. Additionally stated that her expectation was for Administrative Nurse B to respond to the pharmacy's MRR within 7 days by either addressing the concern internally or forwarding to the provider for them to address. Further, stated that the maximum time that should be allowed for the facility or the provider to respond would be no more than 21 days. Confirmed the facility's and provider's failure to respond to MRR reports from the pharmacy for two months was an unacceptable practice. The undated facility policy Medication Regimen Reviews documented that a consultant pharmacist would review the medication regimen following state and federal guidelines. Further documented that the Director of Nursing (DON - Administrative Nurse B) would agree on the process and steps to be taken to resolve any identified irregularities. Additionally documented that the focus of the pharmacist review would include unnecessary medications that further included psychotropic medications for a review for specific conditions as diagnosed . Further documented that a review of the resident's PRN psychotropic medications would be limited to 14 days, and that if required for more than 14 days then a physician would document a rational in the EHR. The facility failed to prevent the use of unnecessary medications for R28 when the facility failed to respond to pharmacist recommendations for an appropriate indication for use, and the failure to respond to pharmacist recommendations.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46960 The facility reported a census of 35 residents. The sample included 20 residents with five residents (R) reviewed for unnecessary medications. Based on observation, interview, and record review, the facility failed to prevent the use of unnecessary medications when staff failed to enter R89's 04/04/24 re-admission medication orders into the Electronic Medication Administration Record (eMAR) for five days, this failure resulted in staff incorrectly administering medications from a prior order, with some at incorrect dosages and omitted medications that were ordered in R89's treatment after return from the hospital causing the resident to be sent back to the hospital with renal failure. Furthermore, the facility failed to ensure that R19's medication regimen was free of unnecessary medications when the facility failed to respond to pharmacist recommendations on 12/18/23, 01/19/24, 02/17/24, 03/27/24, 04/17/24 and 04/23/24. Findings Included: - Resident (R)89's electronic medical record (EMR) dated 04/04/24 revealed the following diagnoses that included heart failure (heart disease), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), essential (primary) hypertension (elevated blood pressure), edema , lymphedema (swelling caused by accumulation of lymph), alcohol abuse, other stimulant abuse, atrial fibrillation (rapid irregular heart beat), acute kidney failure (inability of the kidneys to excrete wastes, concentrate urine and conserve electrolytes), hypomagnesemia (, hyperkalemia (greater than normal amount of potassium in the blood), major depressive disorder (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness and hopelessness), severe with psychotic features (any major mental disorder characterized by a gross impairment in reality testing), systolic (congestive) heart failure (a condition with low heart output and the body becomes congested with fluid) , chronic pain, morbid (severe) obesity due to excess calories (the state or condition of being very fat or overweight), hypothyroidism (condition characterized by decreased activity of the thyroid gland), cellulitis of right lower limb (skin infection caused by bacteria characterized by heat, redness and swelling), hyponatremia (low sodium level). R89's Annual Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The resident was occasionally incontinent of urine. R89 had two stage 2 pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, because of pressure, or pressure in combination with shear and/or friction) on his buttock. Medications included antipsychotic (class of medications used to treat major mental conditions which cause a break from reality), antidepressant (class of medications used to treat mood disorders), diuretic (medication to promote the formation and excretion of urine), and opioid pain medications daily. The Quarterly Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. The resident had no skin breakdown documented on the assessment. Medications included antipsychotic, antidepressant, antibiotic, opioid pain medication and antiplatelet (medication that prevent blood clots from forming) medications daily. The Care Area Assessment (CAA) dated 12/22/23 revealed: (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Functional Abilities CAA- R89 received medications that increase his risk for falls, with no recent history of falls. He does trigger for pain and has medications for comfort. The baseline care plan dated 04/04/24 revealed R89 received psychotropics, diuretics, and opioid pain medications. Review of R89's readmission orders from the hospital dated 04/04/24 revealed the resident was to receive the following medications as ordered: Gabapentin, 200 mg, three times a day (TID), (antiseizure and nerve pain relief). Bumex, 2 mg, every day, (diuretic). Metolazone, 2.5 mg, three times a week, (diuretic). Multivitamin, every day, (supplement). Oxycodone, 5 mg, every 6 hours as needed (PRN), (opioid pain medication). Nitroglycerin, 0.4 mg, sublingual (under the tongue), PRN, (chest pain). Protonix, 20 mg, every day, (gastric acid reducer). Senna, 8.6 mg, daily, (laxative). Spironolactone, 50 mg, every day, (diuretic). Review of the electronic Medication Administration Record (eMAR) for 04/01/24 thru 04/30/24, revealed the resident received the following medications from 04/04/24 thru 04/09/24 from orders prior to hospitalization with readmit on 04/04/24. Amiodarone, HCl Tablet, 200 mg, give one 1 tablet by mouth, one time a day, (Heart medication). Aspirin Tablet Delayed Release, 81 mg, give one tablet by mouth, one time a day, (anticoagulant). Famotidine, 20 mg, every day, (acid blocker). Glucosamine, 500 mg, three capsules, daily, (supplement). Levothyroxine, 100 micrograms (mcg), daily, (Hormone for thyroid). Lipitor, 10 mg, daily, (to reduce cholesterol in blood). Metolazone, 2.5 mg, three times a week, (diuretic). Sodium Chloride, One Gm (gram), daily, (supplement). Coreg, 12.5 mg, twice a day (BID), (cardiac medication). (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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Entresto, 49-51 mg, BID, (cardiac medication). Mag-oxide, 800 mg, BID, supplement). Spironolactone, 50 mg, BID, (diuretic). Topamax, 25 mg, tab 2 (50 mg), BID, (Antiseizure). Gabapentin, 450 mg, TID, (nerve pain). Percocet, 5-325 mg, TID, (opioid pain medication). On 04/15/24 at 11:30 AM Administrative Nurse B reported there were medication errors due to the admitting nurse did not process the resident's admission orders on return from the hospital, so the resident received the same medications from his prior admission. the previous medication cards were still in the medication cart to be passed. On 04/15/24 at 01:30 PM, Administrative Nurse B reported that the resident returned to the facility on [DATE] at about 04:35 PM. LN T checked the resident in and passed report to LN W and Administrative Nurse B stated she told LN W it was her responsibility to readmit the resident and gave her the admission packet. The nurse did not check any of his orders or update his medications and as a result, the resident received all his previous medications and did not receive the new medications in the discharge orders. It was not discovered until the admitting hospital started questioning and comparing his orders from the facility against his discharge orders he had when he left the hospital on the 04/04/24. The discrepancy in medications was discovered and reported to the state agency. On 04/15/24 at 03:45 PM, Physician U reported she could not find the admission orders in the resident's EMR. The resident was on diuretics prior to and after hospitalization . She was concerned about the cardiac and hypertensives the resident received. when she got report it was for him having low urine and thought the resident was voiding some just not much. It was a worry that the nurses did not follow the discharge orders, but they do not have to call her for her approval or signature since she was not the physician who ordered the medications. The undated facility policy Medication Regimen Reviews documented that a consultant pharmacist would review the medication regimen following state and federal guidelines. Further documented that the Director of Nursing (DON - Administrative Nurse B) would agree on the process and steps to be taken to resolve any identified irregularities. Additionally documented that the focus of the pharmacist review would include unnecessary medications that further included psychotropic medications for a review for specific conditions as diagnosed . Further documented that a review of the resident's PRN psychotropic medications would be limited to 14 days, and that if required for more than 14 days then a physician would document a rational in the EHR. The facility failed to prevent the use of unnecessary medications for R89 when staff did not enter R89's 04/04/24 re-admission medication orders into the Electronic Medication Administration Record (eMAR) for five days. This failure resulted in staff incorrectly administering medications from a prior order, with some at incorrect dosages and omitted medications that were ordered in R89's treatment after return from the hospital causing the resident to be sent back to the hospital with renal failure. (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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Resident (R)19's Electronic Health Record (EHR) revealed diagnoses of generalized anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), obsessive-compulsive disorder (OCD is an anxiety disorder characterized by recurrent and persistent thoughts, ideas and feelings of obsessions severe to cause marked distress, consume considerable time or significantly interfere with the resident's occupational, social or interpersonal functioning), cognitive communication deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness), and major depressive disorder with psychotic symptoms (a major mood disorder which causes persistent feelings of sadness with a gross impairment in reality perception). The Admission Minimum Data Set (MDS) dated [DATE], documented a Brief Interview for Mental Status (BIMS) could not be completed due to R19 was rarely or never understood. The staff assessment documented R19 had memory problems with severely impaired cognition. The MDS documented R19 had hallucinations (sensing things while awake that appear to be real, but the mind created) and lacked documentation of any behaviors toward self or others. The resident received antianxiety (a class of medications that calm and relax people) and antidepressant (a class of medications used to treat mood disorders. The Quarterly MDS dated [DATE], documented R19 had a BIMS of 13, which indicated intact cognition and received antianxiety and antidepressant medications. The Physician Orders revealed the following: Hydroxyzine, (an antihistamine [a class of medication used to counteract the physiological effects of histamine production in allergic reactions or can be used to treat psychological conditions such as anxiety), 10 milligrams (mg), one tablet, by mouth or via peg tube (a tube that was surgically inserted through the abdominal wall and into the stomach for the purposes of feeding and/or administration of medications) every eight hours as needed (PRN), ordered on 11/7/23, and discontinued by the physician on 03/19/24. Memantine (Namenda - a medication that is used to treat moderate to severe dementia), 10mg, to give one and a half tablets by mouth or via peg tube, one time per day for Neurological agent, ordered on 11/29/23 and discontinued by the physician on 03/08/24. Memantine, 10mg tablet, to be given by mouth, two times per day, for Neurological agent, ordered 03/08/24. Review of pharmacist medication regimen review (MRR) reports revealed the following: 1. On 12/18/23, the pharmacist requested the physician clarify the indication (reason for a person to take a medication) for memantine. The facility failed to provide a provider or facility response to this request. 2. On 01/19/24, the pharmacist requested a stop date for hydroxyzine that was ordered on a PRN basis in order to remain within compliance of federal regulations. The facility failed to provide a provider or facility response to this request. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. On 02/17/24, the pharmacist MRR report documented that no significant irregularities were identified and referred to nursing and physician recommendations. The facility failed to provide a provider or facility response to this request. 4. On 03/27/24, the pharmacist MRR report documented that no significant irregularities were identified and referred to nursing and physician recommendations. The facility failed to provide a provider or facility response to this request. 5. On 04/17/24, in response to a fall review request from the facility, the pharmacist MRR report documented that no significant irregularities were identified and referred to nursing and physician recommendations. The facility failed to provide a provider or facility response to this request. 6. On 04/23/24, the pharmacist MRR report documented that no significant irregularities were identified and referred to nursing and physician recommendations. The facility failed to provide a provider or facility response to this request. Review of the electronic medication administration record (eMAR) 11/27/23 to 04/22/24 revealed that the resident had received 13 doses of hydroxyzine from when the pharmacist identified the irregularity on 01/19/24 and when the provider discontinued the order on 03/19/24. On 04/25/24 at 12:36 PM, Consultant Nurse E stated that the facility was unable to locate any MRR data for any residents prior to 01/01/24 and was unable to locate any facility or provider responses to pharmacy MRR reports after 01/01/24. Additionally stated that her expectation was for Administrative Nurse B to respond to the pharmacy's MRR within 7 days by either addressing the concern internally or forwarding to the provider for them to address. Further, stated that the maximum time that should be allowed for the facility or the provider to respond would be no more than 21 days. Confirmed the facility's and provider's failure to respond to MRR reports from the pharmacy for two months was an unacceptable practice. The undated facility policy Medication Regimen Reviews documented that a consultant pharmacist would review the medication regimen following state and federal guidelines. Further documented that the Director of Nursing (DON - Administrative Nurse B) would agree on the process and steps to be taken to resolve any identified irregularities. Additionally documented that the focus of the pharmacist review would include unnecessary medications that further included psychotropic medications for a review for specific conditions as diagnosed . Further documented that a review of the resident's PRN psychotropic medications would be limited to 14 days, and that if required for more than 14 days then a physician would document a rational in the EHR. The facility failed to prevent the use of unnecessary medications for R19 when the facility failed to respond to pharmacist recommendations for an appropriate indication for use, and the failure to respond to pharmacist recommendation for an end date or appropriate rationale for continued use. These deficient practices caused R19 to receive an unnecessary medication for 13 doses over two months after the pharmacist initially identified the deficient practice.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36881 The facility census totaled 35 residents with 20 included in the sample and five reviewed for medications. Based on observation, interview, and record review the facility failed to ensure residents remained free of unnecessary psychotroic medications by the failure to have Consulting pharmacist Monthly Regimen Review reports from 01/01/24 to 04/25/24 including gradual dose reduction (GDR) and psychotropic monitoring for three of five residents reviewed, which included Resident (R)28, R19, and R3. Findings included: - Review of Resident (R) 3's Physician Orders dated 04/21/24 revealed diagnoses which included schizophrenia (mental disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought), insomnia (inability to sleep), abnormalities of gait and immobility, and need for assistance with personal care. The Admission Minimum Data Set (MDS), dated [DATE], documented the resident admitted ,d+[DATE] 1/23. The resident had a Brief Interview for Mental Status (BIMS) score of 15, which indicated no cognitive impairment. The resident did not exhibit behaviors nor mood indicators. She reported no pain and did not receive scheduled or as needed (PRN) pain medications. The resident received antipsychotics, antidepressants, and antibiotics for seven days of the look back period. The physician did not document contraindications of gradual dose reductions (GDR) and none had been attempted. The Quarterly MDS, dated [DATE] revealed the resident received antipsychotic, antianxiety, antidepressant, anticoagulant, and antibiotic medication during the look back period. The resident continued to deny pain on interview and did not receive scheduled or PRN pain medications. The Psychotropic Drug (medication that affects brain activities associated with mental processes and behavior) Use Care Area Assessment, dated 08/13/23, documentation included the resident recently admitted to facility from another nursing facility. She was alert and able to make her needs known. She understood and made herself understood. The resident currently received medications, which included antibiotics, antidepressants, and antipsychotics. The Care Plan dated 04/17/24 lacked any interventions related to the use of psychotropic drugs and/or care directives associated with side effects related to the medications. Review of the Physician Orders, dated 04/21/24, revealed orders for the following psychoactive medications and related orders: 1. Quetiapine Fumarate/Seroquel (antipsychotic medication), oral tablet 25 milligrams (mg). Staff were to give the resident 12.5 mg, by mouth two times a day for schizophrenia, ordered 08/02/23. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Duloxetine/Cymbalta (antidepressant medication), oral capsule (delayed release particles) 20 mg. Staff were to give 1 capsule by mouth one time a day related to major depression disorder, ordered 08/02/23. 3. Staff were to monitor for target behaviors such as being demanding to staff, yelling out, being anxious, and delusions related to the use of psychoactive medication, ordered 08/03/24. The facility failed to provide Medication Regimen Review (MRR) for any residents prior to 01/01/24 and was unable to locate any facility or provider responses to pharmacy MRR reports after 01/01/24. On 04/25/24 at 12:36 PM, Consultant Nurse E stated the facility was unable to locate any Medication Regimen Review (MRR) for any residents prior to 01/01/24 and was unable to locate any facility or provider responses to pharmacy MRR reports after 01/01/24. Additionally, Consultant Nurse E stated her expectation was for Administrative Nurse B to respond to the pharmacy's MRR within 7 days by either addressing the concern internally or forwarding to the provider for them to address. Further, she stated that the maximum time that should be allowed for the facility or the provider to respond to MMR reports would be no more than 21 days. Consultant Nurse E confirmed the facility and provider's failure to respond to MRR reports from the pharmacy was unacceptable. The undated facility policy titled Medication Regimen Reviews F756, documentation included the consultant pharmacist shall review the medication regimen per state and federal guidelines. The facility failed to prevent the use of unnecessary medications for R3 when the facility failed to track, monitor, and/or respond to pharmacist's monthly recommendations and identification of medication irregularities. The facility failed to ensure the physician documented contraindications for a gradual dose reduction, which was not attempted or monitored by the facility when the facility failed to provide MMRs and responses/reviews prior to 01/01/24 and was unable to locate any facility or provider responses to pharmacy MRR reports after 01/01/24. 46960 - R19's Electronic Health Record (EHR) revealed diagnoses of generalized anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), obsessive-compulsive disorder (OCD is an anxiety disorder characterized by recurrent and persistent thoughts, ideas and feelings of obsessions severe to cause marked distress, consume considerable time or significantly interfere with the resident's occupational, social or interpersonal functioning), cognitive communication deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness), and major depressive disorder with psychotic symptoms (a major mood disorder which causes persistent feelings of sadness with a gross impairment in reality perception). The Admission Minimum Data Set (MDS) dated [DATE], documented a Brief Interview for Mental Status (BIMS) could not be completed due to R19 was rarely or never understood. The staff assessment documented R19 had memory problems with severely impaired cognition. The MDS documented R19 had hallucinations (sensing things while awake that appear to be real, but the mind created) and lacked documentation of any behaviors toward self or others. The resident received antianxiety (a class of medications that calm and relax people) and antidepressant (a class of medications used to treat mood disorders. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Quarterly MDS dated [DATE], documented R19 had a BIMS of 13, which indicated intact cognition and received antianxiety and antidepressant medications. The Physician Orders revealed the following: Hydroxyzine, (an antihistamine [a class of medication used to counteract the physiological effects of histamine production in allergic reactions or can be used to treat psychological conditions such as anxiety), 10 milligrams (mg), one tablet, by mouth or via peg tube (a tube that was surgically inserted through the abdominal wall and into the stomach for the purposes of feeding and/or administration of medications) every eight hours as needed (PRN), ordered on 11/7/23, and discontinued by the physician on 03/19/24. Memantine (Namenda - a medication that is used to treat moderate to severe dementia), 10mg, to give one and a half tablets by mouth or via peg tube, one time per day for Neurological agent, ordered on 11/29/23 and discontinued by the physician on 03/08/24. Memantine, 10mg tablet, to be given by mouth, two times per day, for Neurological agent, ordered 03/08/24. Review of pharmacist medication regimen review (MRR) reports revealed the following: 1. On 12/18/23, the pharmacist requested the physician clarify the indication (reason for a person to take a medication) for memantine. The facility failed to provide a provider or facility response to this request. 2. On 01/19/24, the pharmacist requested a stop date for hydroxyzine that was ordered on a PRN basis in order to remain within compliance of federal regulations. The facility failed to provide a provider or facility response to this request. 3. On 02/17/24, the pharmacist MRR report documented that no significant irregularities were identified and referred to nursing and physician recommendations. The facility failed to provide a provider or facility response to this request. 4. On 03/27/24, the pharmacist MRR report documented that no significant irregularities were identified and referred to nursing and physician recommendations. The facility failed to provide a provider or facility response to this request. 5. On 04/17/24, in response to a fall review request from the facility, the pharmacist MRR report documented that no significant irregularities were identified and referred to nursing and physician recommendations. The facility failed to provide a provider or facility response to this request. 6. On 04/23/24, the pharmacist MRR report documented that no significant irregularities were identified and referred to nursing and physician recommendations. The facility failed to provide a provider or facility response to this request. Review of the electronic medication administration record (eMAR) 11/27/23 to 04/22/24 revealed that the resident had received 13 doses of hydroxyzine from when the pharmacist identified the irregularity on 01/19/24 and when the provider discontinued the order on 03/19/24. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/25/24 at 12:36 PM, Consultant Nurse E stated that the facility was unable to locate any MRR data for any residents prior to 01/01/24 and was unable to locate any facility or provider responses to pharmacy MRR reports after 01/01/24. Additionally stated that her expectation was for Administrative Nurse B to respond to the pharmacy's MRR within 7 days by either addressing the concern internally or forwarding to the provider for them to address. Further, stated that the maximum time that should be allowed for the facility or the provider to respond would be no more than 21 days. Confirmed the facility's and provider's failure to respond to MRR reports from the pharmacy for two months was an unacceptable practice. The undated facility policy Medication Regimen Reviews documented that a consultant pharmacist would review the medication regimen following state and federal guidelines. Further documented that the Director of Nursing (DON - Administrative Nurse B) would agree on the process and steps to be taken to resolve any identified irregularities. Additionally documented that the focus of the pharmacist review would include unnecessary medications that further included psychotropic medications for a review for specific conditions as diagnosed . Further documented that a review of the resident's PRN psychotropic medications would be limited to 14 days, and that if required for more than 14 days then a physician would document a rational in the EHR. The facility failed to prevent the use of unnecessary medications for R19 when the facility failed to respond to pharmacist recommendations for an appropriate indication for use, and the failure to respond to pharmacist recommendation for an end date or appropriate rationale for continued use. These deficient practices caused R19 to receive an unnecessary medication for 13 doses over two months after the pharmacist initially identified the deficient practice. - R28's Electronic Health Record (EHR) revealed diagnoses of intellectual disabilities (characterized both by a significantly below-average score on a test of mental ability or intelligence and by limitations in the ability to function in areas of daily life, such as communication, self-care, getting along in social situations and school activities), psychosis (any major mental disorder characterized by a gross impairment in reality perception) and need for assistance with personal care. Review of the 08/25/23 Admission Minimum Data Set revealed the resident had a Brief Interview for Mental Status (BIMS) score of 13, which indicated intact cognition. The resident required extensive assistance of one to two staff for bed mobility, transfers, dressing, toilet use and personal hygiene. The resident had no falls in the last month prior to admission/entry. The resident had a fall in the last 2-6 months prior to admission/entry or reentry and a fracture in the 6 months prior to admission/reentry. Review of the Falls Care Area assessment dated [DATE] revealed R28 admitted to the facility from another long-term care facility. The resident had a history of falls with a neck fracture noted among others. R28 required extensive staff assistance with activities of daily living including, dressing, restroom usage, peri-care, grooming, transfers, and mobility. Review of the 02/21/24 Quarterly Minimum Data Set revealed the resident had a Brief Interview for Mental Status (BIMS) score of 11, which indicated moderately impaired cognition. The resident had impairment of both the upper and lower extremities on both sides and he used a wheelchair for mobility. The resident had no falls identified since the prior assessment. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 04/22/24 Care Plan documented R28 had a diagnosis of psychosis and instructed staff with the following interventions: 1. On 11/29/23, staff were to administer medications as ordered. 2. On 11/29/23, staff had psychological services in place as ordered by the physician. 3. On 11/29/23, staff were to reapproach resident whenever he was displaying behaviors. The Care Plan lacked information related to the use of psychotropic medications or Black Box Warning (BBW- highest safety-related warning that medications can have assigned by the Food and Drug Administration) The Physician's Orders documented the following: 1. Abilify (Aripiprazole - an antipsychotic medication) 20 milligrams (mg), to be given orally once per day for mood stabilizer on 02/21/24. 2. Buspirone (an antianxiety medication), 10mg, to be given orally three times per day for behaviors and anxiety on 12/01/23. 3. Buspirone, 10mg to be given orally every 12 hours as needed (PRN) for nausea or vomiting. Review of pharmacist medication regimen review (MRR) reports revealed the following: 1. On 10/30/23, the pharmacist documented that a MRR had been performed, however the facility failed to produce the document for review upon request on 04/24/24. 2. On 11/24/23, the pharmacist documented that a MRR had been performed, however the facility failed to produce the document for review upon request on 04/24/24. 3. On 12/18/23 the pharmacist documented that a MRR had been performed, however the facility failed to produce the document for review upon request on 04/24/24. 4. On 01/19/24, the pharmacist documented a requested clarification from the facility or physician for the inappropriate indication for PRN buspar of nausea or vomiting. The facility failed to provide a response from the facility or physician as requested on 04/24/24. 5. On 02/17/24, the pharmacist documented that a MRR had been performed, however the facility failed to produce the document for review upon request on 04/24/24. 6. On 03/27/24, the pharmacist documented that a MRR had been performed, however the facility failed to produce the document for review upon request on 04/24/24. 7. On 04/17/24 the pharmacist documented that a MRR had been performed, however the facility failed to produce the document for review upon request on 04/24/24 (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/18/24 at 03:56 PM, R28 observed self-propelling in wheelchair with anti-rollback brakes installed with an interrupted forward and backward motions that lacked a discernable pattern in common area. On 04/22/24 at 09:55 AM, R28 observed self-propelling backward in wheelchair with anti-rollback brakes installed and nearly hit R35 who was sitting on the floor when an unknown staff member called out to R28 who then resumed interrupted forward and backward motions in a random pattern in the common area. On 04/25/24 at 12:36 PM, Consultant Nurse E stated that the facility was unable to locate any MRR data for any residents prior to 01/01/24 and was unable to locate any facility or provider responses to pharmacy MRR reports after 01/01/24. Additionally stated that her expectation was for Administrative Nurse B to respond to the pharmacy's MRR within 7 days by either addressing the concern internally or forwarding to the provider for them to address. Further, stated that the maximum time that should be allowed for the facility or the provider to respond would be no more than 21 days. Confirmed the facility's and provider's failure to respond to MRR reports from the pharmacy for two months was an unacceptable practice. The undated facility policy Medication Regimen Reviews documented that a consultant pharmacist would review the medication regimen following state and federal guidelines. Further documented that the Director of Nursing (DON - Administrative Nurse B) would agree on the process and steps to be taken to resolve any identified irregularities. Additionally documented that the focus of the pharmacist review would include unnecessary medications that further included psychotropic medications for a review for specific conditions as diagnosed . Further documented that a review of the resident's PRN psychotropic medications would be limited to 14 days, and that if required for more than 14 days then a physician would document a rational in the EHR. The facility failed to prevent the use of unnecessary medications for R28 when the facility failed to respond to pharmacist recommendations for an appropriate indication for use, and the failure to respond to pharmacist recommendations.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure medication error rates are not 5 percent or greater. 50659 The facility had a census of 35 residents. The sample included 20 residents. Based on observation, interview, and record review the facility failed to ensure Resident (R) 35 and R6, reviewed during the medication administration pass, remained free of medication errors. Thirty one medication opportunities were observed/ two medication errors occurred. This placed the resident at risk for adverse reactions from the medications and resulted in a medication error rate of 6.45%. Findings Included: - Resident 35's medical diagnoses included congenital stenosis and stricture of esophagus (a rare birth defect characterized by the narrowing of the esophagus (the tube that connects the mouth to the stomach)), cerebral palsy (a group of disorders that affect movement, muscle tone, balance, and posture) and aphasia. The Electronic Health Record (EHR) revealed an order for enteral nutrition via bolus: Jevity 1.5, 237 milliliters (ml) five times per day via Gastrostomy (G) Tube (surgical creation of an artificial opening into the stomach thru the abdominal wall). Hold if greater than 100 ml residual. Give 30 cubic centimeters (cc) free water prior to and after feeding. The EHR revealed a 03/29/24 order for diazepam (anti-anxiety medication) 5 milligrams (mg), three times a day via G-tube for anxiety and restlessness. Observation on 04/22/24 at 11:51 AM, Licensed Nurse D did not check for placement of the G Tube prior to administering the 30 cc of water and medications. Observation on 04/23/23 at 04:30 PM, Certified Medication Aide (CMA) CC began medication preparation for oral medication for R6, stopped preparing the oral medications, donned gloves, administered eye drops to R6, doffed gloves, and resumed preparation and administration of oral medications without performing hand hygiene. Interview on 04/22/24 at 11:51 AM, LN D confirmed she should check placement prior to medication administration in the G Tube. Interview on 04/23/23 at 04:30 PM, MCA CC confirmed the lack of hand hygiene when she switched from oral medication pass to administration of eye drops and the lack of hand hygiene after doffing gloves and stated that she should have used the hand sanitizer prior to donning gloves and after doffing gloves. On 04/22/24 at 12:15 PM, Administrative Nurse B reported staff should assess for placement of the feeding tube prior to any type of administration. On 04/23/24 at 04:45 PM Administrative B reported staff should wash hands before applying gloves and administering eye drops and after removing gloves, hands should be washed with hand sanitizer or washed with soap and water. (continued on next page)

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	175450	A. Building B. Wing	04/25/2024

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The undated facility policy Medication Errors documented that the facility would ensure the residents would receive care and services in an environment free of medication errors. Further defined a medication error to be observed or identified administration of medications which is not in accordance with accepted professional standards and principles. Additionally documented that the facility must ensure that the medication error rate was below five percent (5%). The facility failed to ensure that R35's medications were not given without checking for proper placement of his G Tube. Furthermore, the facility failed to ensure that the overall medication error rate was below 5%. These deficient practices had the potential to have a negative affect on the overall physical and psychosocial well-being of all the residents in the facility.

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31078 The facility census totaled 35 residents, with 20 in the sample, and five residents reviewed for unnecessary medications. Based on interview and record review the facility failed to prevent significant medication errors for R89 when staff did not enter R89's 04/04/24 re-admission medication orders into the Electronic Medication Administration Record (eMAR) for five days. This failure resulted in staff incorrectly administering medications from a prior order, with some at incorrect dosages and omitted medications that were ordered in R89's treatment after return from the hospital. Findings Included: - Resident (R)89's Electronic Medical Record (EMR) dated 04/04/24 revealed the following diagnoses: heart failure (heart disease), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), essential (primary) hypertension (elevated blood pressure), edema (swelling resulting from an excessive accumulation of fluid in the body tissues), lymphedema (swelling caused by accumulation of lymph), alcohol abuse, other stimulant abuse, atrial fibrillation (rapid irregular heart beat), acute kidney failure (inability of the kidneys to excrete wastes, concentrate urine and conserve electrolytes), hypomagnesemia (less than normal magnesium levels in the blood), hyperkalemia (greater than normal amount of potassium in the blood), major depressive disorder (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness and hopelessness) severe with psychotic features (any major mental disorder characterized by a gross impairment in reality testing), systolic (congestive) heart failure (a condition with low heart output and the body becomes congested with fluid), chronic pain, morbid (severe) obesity due to excess calories (the state or condition of being very fat or overweight), hypothyroidism (condition characterized by decreased activity of the thyroid gland), cellulitis of right lower limb (skin infection caused by bacteria characterized by heat, redness and swelling), and hyponatremia (lower than normal sodium blood level). R89's Annual Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The resident was occasionally incontinent of urine. R89 had two stage two pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, because of pressure, or pressure in combination with shear and/or friction) on his buttock. Medications R89 received included antipsychotic (class of medications used to treat major mental conditions which cause a break from reality), antidepressant (class of medications used to treat mood disorders), diuretic (medication to promote the formation and excretion of urine), and opioid pain medications daily during the look-back period. The Quarterly MDS dated [DATE], revealed a BIMS score of 15, indicating intact cognition. The resident had no skin breakdown documented on the assessment. Medications R89 received included antipsychotic, antidepressant, antibiotic, opioid pain medication and antiplatelet (medication to prevent blood clots) daily during the look-back period. The Care Area Assessment (CAA) dated 12/22/23 revealed: (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	The Functional Abilities CAA documented R89's was independent with daily cares, required supervision at times, and was continent of bowel and bladder. He triggered for fall risk, but gait was steady, and R89 could ambulate as he wanted to, without the use of an assistive device. R89 required medications that could increase his risk for falls, with no recent history of falls. He triggered on nutrition due to his high body mass index (BMI) and documented he triggered for pain and had medications for comfort. The Pressure Ulcer CAA revealed R89 had pain and required medication for pain relief. He had a history of pressure ulcers/ulcers to lower extremities. On 12/21/23, R89 had one open area to his left buttock and two open areas to his right buttock. The Baseline Care Plan dated 04/04/24 revealed the resident was alert and could communicate with staff. The resident was independent with eating, personal hygiene, and toileting. R89 was frequently incontinent of urine, used a walker and a wheelchair for mobility, and received psychotropics, diuretics, and opioid pain medications. Review of the EMR revealed R89 transferred to the hospital on 03/18/24 and returned 17 days later on 04/04/24. Review of R89's hospital discharge orders revealed during the 17-day hospital stay to treat R89's sepsis, R89 received multiple intravenous antibiotics and placement of a urinary catheter (generally necessary to assist in bladder emptying, until someone cannot empty their bladder). The urinary catheter was removed prior to R89's discharge to the facility on [DATE]. The Nurse Note dated 04/04/24 at 05:39 PM, revealed the resident returned to the facility at 04:35 PM via facility transportation from a local hospital. R89 had cellulitis on both lower legs as well as dry skin. The resident required assistance of one to two staff with a gait belt and used a walker for mobility. He used a urinal for bladder and could use the toilet for bowel. Review of R89's readmission orders from the hospital dated 04/04/24 revealed the resident was to receive the following medications as ordered: Duloxetine, 30 milligrams (mg), PO (by mouth), daily, as an antidepressant. Gabapentin, 200 mg, three times a day (TID), for antiseizure and nerve pain relief. Bumex, 2 mg, daily, for diuretic. Metolazone, 2.5 mg, three times a week, for diuretic. Multivitamin tab, daily, for supplement. Oxycodone, 5 mg, every 6 hours, as needed (PRN). Nitroglycerin, 0.4 mg, sublingual (under the tongue), PRN, for chest pain. Protonix, 20 mg, daily, for gastric acid reducer. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Risperidone, 1 mg, daily, for depression with psychosis. Senna, 8.6 mg, daily, as a laxative. Spironolactone, 50 mg, daily, as a diuretic. Review of the electronic Medication Administration Record (eMAR) from 04/01/24 through 04/30/24 revealed the resident received the following medications from 04/04/24 to 04/09/24, five days. (These were the medication orders in the facility system from prior to R89's 03/18/24 hospitalization). Amiodarone HCl (medication used for heart irregularities), 200 mg, one 1 tablet by mouth, one time a day. Aspirin tablet delayed release, 81 mg, one tablet by mouth, one time a day (anticoagulant). Duloxetine (antidepressant medication), 90 mg, PO, every day. Famotidine (medication used as an acid blocker), 20 mg, daily. Glucosamine (supplement), 500 mg, three capsules, daily. Levothyroxine (hormone for thyroid), 100 micrograms (mcg), daily. Lipitor medication used to reduce blood cholesterol),10 mg, daily. Metolazone (diuretic medication), 2.5 mg, three times a week. Risperidone (antipsychotic medication), 3 mg, at bedtime (HS). Sodium Chloride (supplement), 1 gm (gram), daily. Trazadone, (antidepressant medication), 100 mg, give 150 mg, at HS. Coreg (cardiac medication), 12.5 mg twice a day (BID). Entresto (cardiac medication), 49-51 mg, BID. Mag-oxide (supplement) 800 mg, BID. Spironolactone (diuretic medication) 50 mg, BID. Topamax, medication used for seizures), 25 mg, 2 tabs (50 mg), BID. Gabapentin (medication used for nerve pain) 450 mg, three times a day (TID). Percocet (opioid pain medication), 5-325 mg, TID. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	During an interview on 04/15/24 at 11:30 AM, Administrative Nurse B reported the resident had a long history of kidney disease. There were medication errors for R89, because the facility's admitting nurse did not process the resident's admission orders on return from the hospital (on 04/04/24), so the resident received the same medications from his prior facility admission. Administrative Nurse B stated R89's (prior) medication cards were still in the medication cart to be passed. During an interview on 04/15/24 at 01:30 PM, Administrative Nurse B reported that the resident returned to the facility on [DATE] at approximately 04:35 PM. Administrative Nurse B said LN T checked the resident in and passed report to LN W. Administrative Nurse B stated she told LN W it was her responsibility to readmit the resident and gave her the admission packet. Administrative Nurse B said the nurse did not check any of his orders or update his medications and as a result, the resident received all his previous medications and did not receive the new medications in the hospital discharge orders. Administrative Nurse B said it was not discovered until the resident was readmitting to the hospital on 04/09/24 and the admitting hospital nurse questioned and compared his orders from the facility against his discharge orders he had when he left the hospital on 04/04/24. The discrepancy in medications was discovered and reported to the state (agency). During an interview on 04/15/24 at 03:45 PM, Physician U, who also serves as the facility medical director, reported she could not find the admission orders in the resident's EMR. The resident received diuretic medications prior to and after hospitalization . Physician U said she was concerned about the cardiac and hypertensive medications the resident received in error. Physician U also reported when she got report it was for R89 having low urine and she thought the resident was voiding some, just not much. Physician U said it is a worry that the nurses did not follow the discharge orders, but they do not have to call her for her approval or signature, since she was not the physician who ordered the medications. The facility policy named Medication Errors dated 2023 revealed it was the policy of the facility to provide protections for the health, welfare, and rights of each resident by ensuring residents receive care and services safely in an environment free of significant medication errors. A significant medication error means one which causes the resident discomfort or jeopardizes his health and safety. The facility shall ensure medications will be administered according to physician orders. The facility failed to prevent medication errors for R89 when staff did not enter R89's 04/04/24 re-admission medication orders into the Electronic Medication Administration Record (eMAR) for five days, this failure resulted in staff incorrectly administering medications from a prior order, with some at incorrect dosages and omitted medications that were ordered in R89's treatment after return from the hospital.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 50659 The facility reported a census of 35 residents. The facility had one medication room and two medication carts. Based on observation, interview, and record review the facility failed to remove medications from circulation when no longer in use for R10 and R15. This deficient practice placed the affected residents at risk for receiving medications that were not ordered by a physician. Findings included: - Observation during the onsite survey on 04/18/24 at 10:05 AM revealed the following concerns: The narcotic sheet for R18 noted a PRN Oxycodone was removed and signed out but did not contain the date staff signed it out for administration. The medication cart contained R10's Ativan 0.5 mg tablets in a blister pack with 27 pills, prescribed to R10. The label on the pack instructed to administer one tabled by mouth every three hours as needed (PRN), for anxiety. The surveyor noted three of the pills were wasted. The narcotic sheet did not contain a date entry for two of the wasted Ativan, and the one wasted Ativan was dated 02/09/24. All three were signed off by two staff members the Ativan were wasted. Surveyor investigation revealed R10 did not have an order for Ativan since the 11/07/23 end date. Observation on 04/18/24 at 10:42 AM revealed R35's Narcotic sheet did not contain a prescription number to be able to compare to the Narcotic card for R35's 5 mg Diazepam or R35's 10 mg Diazepam. Further observation revealed R15's as needed Ativan for anxiety, in the PRN section of the Narcotic Book, with the last dose documented on 11/21/23. The surveyor investigation revealed R15's Ativan order was discontinued on 03/19/24 (almost 4 months prior). Interview on 04/18/24 at 10:45 AM with CMA CC revealed the facility nurses pulled the discontinued narcotics from the medication cart so they could be destroyed. Interview on 4/18/24 at 10:47 with Licensed Nurse T revealed the CMAs did not have keys access to the medication room where narcotics were stored. Interview on 04/18/24 at 11:00 AM, Administrative Nurse F revealed discontinued narcotics stayed in the medication carts until her and Administrative Nurse B were both in the facility to collect the discontinued narcotics. Administrative Nurse F revealed the narcotics were checked daily and discontinued narcotics were pulled out of the narcotic drawer. She revealed her and Administrative Nurse B had different keys for the locked narcotic storage cabinet. Interview on 04/23/24 at 11:15 AM with Administrative Nurse B revealed the narcotics that were discontinued were to remain in the medication cart until counted by Administrative Nurse F and herself the next day and they could be moved to the lock up. Administrative Nurse B was not aware of the discontinued medications for R 10 and R15. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The undated Controlled Substances F 755 Policy revealed controlled substances will be disposed of in a secure and safe method, per state and federal guidelines. The undated Discontinued Medications F755 Policy revealed staff shall destroy medications or shall return them to the dispensing pharmacy in accordance with facility policy and state law. A practitioner ' s order to discontinue a resident ' s medication must be documented in the resident ' s clinical record and on the medication administration record (MAR). The nurse receiving the order to discontinue a medication is responsible for recording that information and notifying the dispensing pharmacy of the discontinuation. The facility failed to remove discontinued medications from the narcotic lock box on 2 of 2 medications carts for R 10 and R15.

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46960 The facility reported a census of 35 residents with 20 residents sampled, which included one resident sampled for feeding assistance. Based on observation, interview, and record review, the facility failed to provide person-centered feeding assistance to Resident (R) 8 as directed on his care plan. This deficient practice had the potential to negatively impact the nutritional intake and psychosocial well-being of this resident. Findings Included: - R8's Electronic Health Record (EHR) documented the pertinent medical diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), dyspepsia (indigestion), dysphagia (difficulty swallowing) and schizophrenia (a mental disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought). R8's Annual Minimum Data Set (MDS), dated [DATE] documented a Brief Interview for Mental Status score of six, which indicated severe cognitive impairment and documented that R8 was independent with eating. R8 had a documented weight loss of five percent (5%) or more in the look-back period and was not on a prescribed weight loss regimen. R8's ADL (activities of daily living, activities such as eating, bathing, grooming, dressing, toileting and walking) Functional / Rehabilitation Potential Care Area Assessment (CAA), dated 03/01/24 lacked analysis of findings documented. The documentation was computer triggered to assist staff in completion of the CAA's. R8's Nutritional Status CAA, dated 03/01/24 lacked analysis of findings documented. The documentation was computer triggered to assist staff in completion of the CAA's. R8's Quarterly MDS, dated [DATE] documented a BIMS score of six, which indicated severely impaired cognition and documented that R8 required supervision assistance with eating. R8 had a documented weight loss of five percent (5%) or more in the look-back period and was not on a prescribed weight loss regimen. The Care Plan documented on 04/06/22 and revised on 01/08/24 that R8 had significant weight loss and provided the instruction for staff to provide R8 with a divided plate and built-up silver wear for meals and a mug with a lid. The Physician's Orders lacked documentation specific for feeding assistance. On 04/18/24 at 08:30 AM, R8 sat in his wheelchair by the main entrance with an over-the-bed table in front of him with a standard plate of food and standard silver wear on the table. R8 appeared to experience difficulty as he attempted to consume the food. On 04/23/24 at 12:47 PM, R8 sat in his wheelchair by the main entrance eating mid-day meal and lacked built-up silverware. His fruit cup was sealed. (continued on next page)

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/25/24 at 05:40 PM Certified Medication Aide (CMA) FF stated that during mealtimes, all staff were to be present in the dining area to provide assistance to residents as needed which included providing built up utensils if needed. On 04/25/24 at 06:20 PM, Consultant Nurse E was made aware of surveyor observations and confirmed that R8 had not eaten any of his food. Stated that the expectation was for staff to offer assistance if needed, which included built up utensils and provide additional food choices if a resident does not like the food that was served. The facility's undated policy Quality of Life - Activities of Daily Living documented that staff behaviors were directed toward assisting the residents in maintaining independent functioning, dignity and well-being. The facility failed to provide person-centered feeding assistance to R8 as directed on his care plan when appropriate. This deficient practice had the potential to negatively impact the nutritional intake and psychosocial well-being of this resident.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31078 The facility reported a census of 35 residents. Based on observation, interview, and record review the facility failed to prepare and serve food under sanitary conditions to all residents in the facility to prevent the potential for foodborne bacteria. Findings included: - During initial kitchen tour on 04/18/24 at 09:00 AM the following areas of concern were identified: The refrigerator had a large bag of shredded cheese that was opened and undated. Certified Dietary Manager J disposed of the bag. Dietary Staff Z prepared to wash the breakfast dishes in the dishwasher. When asked about test strips, Dietary Staff Z was unable to locate testing strips. Interview on 04/18/24 at 09:00 AM Certified Dietary Manager J stated she had ordered the wrong strips on 04/16/24 and the correct strips were ordered 04/18/24. She confirmed that the three-compartment sink would be utilized to wash dishes until the sanitizing strips arrived. Record review of the dishwasher log on 04/18/24 revealed the machine was tested on [DATE] after the evening meal and the dishes were completed at that time. The follow up kitchen tour was conducted on 04/22/24 at 10:00 AM the dishwasher machine was tested at 100 parts per million (ppm) by CDM J. On 04/24/24 at 11:25 AM, Dietary Staff (DS) Z removed a container of onions from the refrigerator with gloved hands. She removed the lid, removed a handful of onions, and placed them in a second bowl. She then put the lid back on the bowl and placed the onions back in the refrigerator with the same gloved hands. While wearing the same gloves DS Z removed a bag of lettuce, a tomato, and cheese from the refrigerator and placed them on the prep table. She retrieved a cutting board and a knife from the cabinet and placed them on the prep table. She then used the knife with the same gloved hands to chop lettuce to place in the bowl with the onions, then proceeded to cut up the tomato and placed it in the same bowl. She then reached into the bag of cheese retrieved a handful of cheese and placed it on the lettuce. She then covered the bowl with plastic wrap and placed it in the refrigerator to be used for taco salad for the facility residents. She then removed her gloves and washed her hands. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 04/24/24 at 11:30 AM, Dietary Staff Y put gloves on and took chicken out of the oven. She placed it on the counter and retrieved a large pan and two smaller pans from under the counter and a knife from a drawer. With the same gloved hands, she began to prepare the chicken. She used tongs to pick up the hot chicken and placed the pieces on the cutting board. She used a knife to cut the chicken into small pieces and used her glove hand to place the chicken in the pans. With the same gloved hands, she placed chicken in the food processor to shred it for mechanical soft diets. Dietary Staff Y stated she was not aware she needed to remove her gloves and wash her and after touching food items. An interview on 04/25/24 at 12:00 PM CDM J reported the dietary aides did not have regular training on food handling. The facility policy named Date Marking for Food Safety dated 2024 revealed the facility adheres to a date marking system to ensure the safety of ready-to-eat, time/temperature control for food safety. The facility failed to prepare and serve food under sanitary conditions for the residents of the facility to prevent the potential of foodborne bacteria.

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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. 46960 The facility identified a census of 35 residents. Based on observations, record reviews, and interviews the facility failed to have an effective administration to identify and develop corrective action plans for potential quality deficiencies as found on the current survey. This deficient practice placed the residents at risk for decreased quality of care, quality of treatment, and sense of well-being. Findings Included: - During the current survey the facility failed to have an effective quality assessment and performance improvement (QAPI) program as evidenced by the number of deficient practices, elevated scope and severity, and substandard quality of care found onsite as followed: The facility failed to protect the privacy and dignity of Residents (R)24 and R25. This deficient practice led to R24 being disturbed in her room on multiple occasions by another resident with wandering behaviors, and R25 being seated in the dining area wearing a shirt and an incontinence brief with his lap partially covered with a blanket. This practice had the potential to lead to negative psychosocial effects related to dignity (See F550). The facility failed to promote and facilitate resident self-determination through support of resident's choice when Resident (R)25 was not given a choice about the meals he ate. This deficient practice had the potential to have a negative effect on R25's psychosocial well-being (See 561). The facility failed to ensure an environment free from neglect and alleged abuse, which had the potential to negatively affect all residents of the facility (See F600). The facility failed to ensure an effective system in place to prevent the misappropriation of resident property when staff diverted controlled medications and could not account for numerous controlled/missing narcotic medications affecting five residents of the facility. This deficient practiced affected Resident (R) 40, R39, R41, R24, and R89 and placed any resident who received controlled medications at risk for staff diversion of their medication and potential untreated symptoms management that could negatively affect their physical, mental, and psychosocial well-being (See F602). (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	04/25/2024

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	The timely reporting of alleged abuse to the State Agency (SA - a state governmental agency that provides oversight for the Centers for Medicare & Medicaid Services [CMS - the federal government agency that administers the nation's major healthcare programs]) or local law enforcement, as required. On 03/19/24 at around 10:00 AM, CNA C was on one-on-one observation in a closed-door room with just herself and cognitively impaired R19, due to the resident was yelling and screaming since 05:00 AM. CNA C reported that R19 allegedly fell out of her wheelchair to the floor obtaining a knot on her forehead, bruising, and abrasion to her eye. R19 repeatedly stated CNA C hit her. The Licensed Nurse reported the incident to the Director of Nursing, however the facility failed to report the allegation of abuse to the Administrator, State Agency, and local law enforcement regarding R19 repeatedly stating CNA C hit her. CNA C remained in a chair next to R19 for the remainder of her shift and continued to work at the facility with residents. The facility did not report the incident until 04/24/24, during the onsite survey, 36 days after the allegation. This deficient practice placed R19 immediate jeopardy and all residents at risk for abuse (See F609). The facility failed to thoroughly investigate incidents of alleged abuse and failed to protect residents from further abuse. On 03/19/24, cognitively impaired R19 obtained a knot on her forehead, and a scuffed and bruised right eye while under the one-on-one supervision of Certified Nurse Aide (CNA) C, while in a closed-door room with no other witnesses. R19 had been yelling and screaming since 05:00 AM and at around 10:00 AM CNA C reported to Licensed Nurse (LN) D that R19 fell on to the floor when CNA C went to get something out of her purse. The LN documented that upon assessment R19 repeatedly stated CNA C hit her in the face and was yelling it out. The facility did not investigate the allegation of abuse or protect R19 from potential further abuse, which allowed CNA C to continue to sit in the chair right beside R19 in one-on-one observation and CNA C continued to work in the facility until her suspension on 04/24/24, 36 days after the allegation, when the facility started the investigation into the 03/19/24 allegation of abuse. This deficient practice placed R19 in immediate jeopardy and placed all residents at risk for abuse (See F610). The facility failed to provide a copy of the facility bed hold policy to Resident (R) 18 and R21 and/or their representative with a written notice specifying the duration and cost of the bed hold policy, at the time of the residents' transfer to the hospital (See F623). The facility failed to provide a copy of the facility bed hold policy to Resident (R) 18 and R21 and/or their representative with a written notice specifying the duration and cost of the bed hold policy, at the time of the residents' transfer to the hospital (See 625). The facility failed to complete or complete an analysis of the Care Area Assessments (CAAs) triggered on the residents Minimum Data Set (MDS) for four residents that included Resident (R) 25, R18, R21, and R22 (See F636). The facility failed to accurately complete the Minimum Data Set (MDS) for sampled residents, Residents (R)3 and R23 related to inaccurate documentation of restraints, R24 related to use of wheelchair and Oxygen usage, R25 related to inaccurate documentation of falls, urinary catheter (a flexible tube inserted through a narrow opening into a body cavity, particularly the bladder, for removing fluid) and contracture (abnormal permanent fixation of a joint or muscle) to R25's left hand, R28 related to inaccurate documentation of falls and R32 related to no CAA development. These deficient practices had the potential to lead to uncommunicated need for care and services to meet each individual residents' needs (See F641). (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	The facility failed to accurately complete comprehensive care plan for four of the sampled residents, Resident (R)32, R22, and R3, and R 35. These deficient practices had the potential to lead to uncommunicated need for care and services to meet each individual residents' needs (See F656). The facility failed to revise a care plan for Resident (R) 25, related to falls (See F657) The facility failed to provide services to meet professional standards of care when staff failed to assess Resident (R)35's feeding tube for proper placement before administering water and medications. This deficient practice had the potential to have a negative effect on R35's physical well-being (F658). The facility failed to provide appropriate ADL care to Resident (R)3, when staff hurt this resident's shoulder. This failure resulted in actual harm when on 04/18/24 Certified Nurse Aide (CNA) HH pulled on R3's sore arm while assisting her in bed, R3 transported to the local Emergency Department (ED) where she was diagnosed with a right shoulder dislocation and suspicion of a Hill Sachs Fracture (dent in the humerus caused by a dislocated shoulder). Additionally, the facility failed to provide assistance for dependent residents during meals for R8. Furthermore, the facility failed to provide grooming assistance for R25 (See F677). The facility failed to have a clear system in place to document resident's choice regarding code status (indicates the type of resuscitation procedures for a resident, if any, when/if the resident heart stops beating). This failure had the ability to negatively affect the mental, physical, and psychosocial well-being of Resident (R)11, R13, R26, R29, R32, R16 and R18 (See 678). The facility failed to provide needed care and services that were resident centered, in accordance with the resident's preferences, goals for care and professional standards of practice that would meet resident's physical, mental, and psychosocial needs related to treatment for alcoholism for R23 (See F684). The facility failed to provide Resident (R) 25 with hand splint (rigid or flexible material used to protect, immobilize, or restrict motion in a body part) to assist in maintaining anatomical alignment of the resident's hand (See F688) The facility failed to provide an environment as free of accident hazards as possible for all four residents reviewed. The facility failed to place effective and timely fall interventions for R28 who had multiple falls. This failure caused actual harm when R28 fell from his wheelchair on 03/05/24, required transport to the local emergency department, and placement of two staples to the resident's head. The facility failed to identify causal factors for two falls experienced by R19, a dependent resident with repeated falls, to prevent further falls. The facility failed to appropriately monitor for safety for R35, a resident with wandering when the staff pushed R35 in his wheelchair and allowed his feet to drag the floor. These deficient practices led to actual harm for R19 and R28 and at risk for further injury that could negatively affect the overall health and well-being of the residents in the facility. Furthermore, these deficient practices had the potential to have a negative psychosocial impact on the affected residents (See F689). (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	The facility failed to provide appropriate respiratory care in maintaining respiratory equipment to prevent the spread of infection, consistent with standards of practice and person-centered care plan for one Resident (R)32 related to an unknown clear liquid left in the nebulizer chamber (See F695). The facility failed to ensure staff possessed the appropriate competencies to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial wellbeing. These deficient practices had the potential have negative physical, mental and psychosocial affects to all the residents in the facility (See F726). The facility failed to ensure an effective pharmacy system in place to ensure the accurate accounting, reconciliation, and destruction of controlled/narcotic medications. This deficient practiced affected Resident (R) 40, R39, R41, R24, R89, R35, R15, R18, and R10, and placed any resident who received controlled medications at risk for staff diversion of their medication and potential untreated symptoms management that could negatively affect their physical, mental, and psychosocial well-being (See F745). The facility failed to ensure an effective pharmacy system in place to ensure the accurate accounting, reconciliation, and destruction of controlled/narcotic medications. This deficient practiced affected Resident (R) 40, R39, R41, R24, R89, R35, R15, R18, and R10, and placed any resident who received controlled medications at risk for staff diversion of their medication and potential untreated symptoms management that could negatively affect their physical, mental, and psychosocial well-being (See F755). The facility failed to ensure three of the five residents reviewed remained free of unnecessary medications by the failure to ensure the Consulting Pharmacist identified and reported medication irregularities by not having Monthly Medication Reviews from 01/01/24 to 04/25/24 for Resident (R)28, R19 R3 (See F756). The facility failed to ensure residents remained free of unnecessary psychotropic medications by the failure to have Consulting pharmacist Monthly Regimen Review reports from 01/01/24 to 04/25/24 including gradual dose reduction (GDR) and psychotropic monitoring for three of five residents reviewed, which included Resident (R)28, R19, and R3 (See F758). The facility failed to ensure Resident (R) 35 and R6, reviewed during the medication administration pass, remained free of medication errors. Thirty one medication opportunities were observed/ two medication errors occurred. This placed the resident at risk for adverse reactions from the medications and resulted in a medication error rate of 6.45%. (F759). The facility failed to prevent significant medication errors for R89 when staff did not enter R89's 04/04/24 re-admission medication orders into the Electronic Medication Administration Record (eMAR) for five days. This failure resulted in staff incorrectly administering medications from a prior order, with some at incorrect dosages and omitted medications that were ordered in R89's treatment after return from the hospital (See F760). The facility failed to provide person-centered feeding assistance to Resident (R) 8 as directed on his care plan. This deficient practice had the potential to negatively impact the nutritional intake and psychosocial well-being of this resident (F810). (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	The facility failed to prepare and serve food under sanitary conditions to all residents in the facility to prevent the potential for food borne bacteria (F812). The facility failed to maintain an effective quality assurance and performance improvement (QAPI) program to develop corrective actions plans and monitor them to correct identified quality deficiencies prior to survey. This deficient practice placed the residents at risk for ineffective care. (F867). The facility failed to maintain an in-service training program for nurses' aides that was appropriate and effective to ensure the continuing competence of nurse aides. The facility identified eleven Certified Nurse Aides (CNAs) had been employed over one year. Of the eleven, five were reviewed, and five of the five CNAs lacked the required 12 hours of in-service training to include dementia and abuse training, to ensure the continuing competence of nurse aides and appropriate care and services to all residents of the facility (See F880). The facility failed to maintain an in-service training program for nurses' aides that was appropriate and effective to ensure the continuing competence of nurse aides. The facility identified eleven Certified Nurse Aides (CNAs) had been employed over one year. Of the eleven, five were reviewed, and five of the five CNAs lacked the required 12 hours of in-service training to include dementia and abuse training, to ensure the continuing competence of nurse aides and appropriate care and services to all residents of the facility (See F883). The facility failed to maintain an in-service training program for nurses' aides that was appropriate and effective to ensure the continuing competence of nurse aides. The facility identified eleven Certified Nurse Aides (CNAs) had been employed over one year. Of the eleven, five were reviewed, and five of the five CNAs lacked the required 12 hours of in-service training to include dementia and abuse training, to ensure the continuing competence of nurse aides and appropriate care and services to all residents of the facility (See F947). The facility failed to have an effective administration to identify and develop corrective action plans for potential quality deficiencies as found on the current survey. This deficient practice placed the residents at risk for decreased quality of care, quality of treatment, and sense of well-being.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. 46960 The facility identified a census of 35 residents. Based on observations, record reviews, and interviews, the facility failed to maintain an effective quality assurance and performance improvement (QAPI) program to develop corrective actions plans and monitor them to correct identified quality deficiencies prior to survey. This deficient practice placed the residents at risk for ineffective care. Findings Included: - During the current survey the facility failed to have an effective quality assessment and performance improvement (QAPI) program as evidenced by the number of deficient practices, elevated scope and severity, and substandard quality of care found onsite as followed: The facility failed to protect the privacy and dignity of Residents (R)24 and R25. This deficient practice led to R24 being disturbed in her room on multiple occasions by another resident with wandering behaviors, and R25 being seated in the dining area wearing a shirt and an incontinence brief with his lap partially covered with a blanket. This practice had the potential to lead to negative psychosocial effects related to dignity (See F550). The facility failed to promote and facilitate resident self-determination through support of resident's choice when Resident (R)25 was not given a choice about the meals he ate. This deficient practice had the potential to have a negative effect on R25's psychosocial well-being (See 561). The facility failed to ensure an environment free from neglect and alleged abuse, which had the potential to negatively affect all residents of the facility (See F600). The facility failed to ensure an effective system in place to prevent the misappropriation of resident property when staff diverted controlled medications and could not account for numerous controlled/missing narcotic medications affecting five residents of the facility. This deficient practiced affected Resident (R) 40, R39, R41, R24, and R89 and placed any resident who received controlled medications at risk for staff diversion of their medication and potential untreated symptoms management that could negatively affect their physical, mental, and psychosocial well-being (See F602). (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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The timely reporting of alleged abuse to the State Agency (SA - a state governmental agency that provides oversight for the Centers for Medicare & Medicaid Services [CMS - the federal government agency that administers the nation's major healthcare programs]) or local law enforcement, as required. On 03/19/24 at around 10:00 AM, CNA C was on one-on-one observation in a closed-door room with just herself and cognitively impaired R19, due to the resident was yelling and screaming since 05:00 AM. CNA C reported that R19 allegedly fell out of her wheelchair to the floor obtaining a knot on her forehead, bruising, and abrasion to her eye. R19 repeatedly stated CNA C hit her. The Licensed Nurse reported the incident to the Director of Nursing, however the facility failed to report the allegation of abuse to the Administrator, State Agency, and local law enforcement regarding R19 repeatedly stating CNA C hit her. CNA C remained in a chair next to R19 for the remainder of her shift and continued to work at the facility with residents. The facility did not report the incident until 04/24/24, during the onsite survey, 36 days after the allegation. This deficient practice placed R19 immediate jeopardy and all residents at risk for abuse (See F609). The facility failed to thoroughly investigate incidents of alleged abuse and failed to protect residents from further abuse. On 03/19/24, cognitively impaired R19 obtained a knot on her forehead, and a scuffed and bruised right eye while under the one-on-one supervision of Certified Nurse Aide (CNA) C, while in a closed-door room with no other witnesses. R19 had been yelling and screaming since 05:00 AM and at around 10:00 AM CNA C reported to Licensed Nurse (LN) D that R19 fell on to the floor when CNA C went to get something out of her purse. The LN documented that upon assessment R19 repeatedly stated CNA C hit her in the face and was yelling it out. The facility did not investigate the allegation of abuse or protect R19 from potential further abuse, which allowed CNA C to continue to sit in the chair right beside R19 in one-on-one observation and CNA C continued to work in the facility until her suspension on 04/24/24, 36 days after the allegation, when the facility started the investigation into the 03/19/24 allegation of abuse. This deficient practice placed R19 in immediate jeopardy and placed all residents at risk for abuse (See F610). The facility failed to provide a copy of the facility bed hold policy to Resident (R) 18 and R21 and/or their representative with a written notice specifying the duration and cost of the bed hold policy, at the time of the residents' transfer to the hospital (See F623). The facility failed to provide a copy of the facility bed hold policy to Resident (R) 18 and R21 and/or their representative with a written notice specifying the duration and cost of the bed hold policy, at the time of the residents' transfer to the hospital (See 625). The facility failed to complete or complete an analysis of the Care Area Assessments (CAAs) triggered on the residents Minimum Data Set (MDS) for four residents that included Resident (R) 25, R18, R21, and R22 (See F636). The facility failed to accurately complete the Minimum Data Set (MDS) for sampled residents, Residents (R)3 and R23 related to inaccurate documentation of restraints, R24 related to use of wheelchair and Oxygen usage, R25 related to inaccurate documentation of falls, urinary catheter (a flexible tube inserted through a narrow opening into a body cavity, particularly the bladder, for removing fluid) and contracture (abnormal permanent fixation of a joint or muscle) to R25's left hand, R28 related to inaccurate documentation of falls and R32 related to no CAA development. These deficient practices had the potential to lead to uncommunicated need for care and services to meet each individual residents' needs (See F641). (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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility failed to accurately complete comprehensive care plan for four of the sampled residents, Resident (R)32, R22, and R3, and R 35. These deficient practices had the potential to lead to uncommunicated need for care and services to meet each individual residents' needs (See F656). The facility failed to revise a care plan for Resident (R) 25, related to falls (See F657) The facility failed to provide services to meet professional standards of care when staff failed to assess Resident (R)35's feeding tube for proper placement before administering water and medications. This deficient practice had the potential to have a negative effect on R35's physical well-being (F658). The facility failed to provide appropriate ADL care to Resident (R)3, when staff hurt this resident's shoulder. This failure resulted in actual harm when on 04/18/24 Certified Nurse Aide (CNA) HH pulled on R3's sore arm while assisting her in bed, R3 transported to the local Emergency Department (ED) where she was diagnosed with a right shoulder dislocation and suspicion of a Hill Sachs Fracture (dent in the humerus caused by a dislocated shoulder). Additionally, the facility failed to provide assistance for dependent residents during meals for R8. Furthermore, the facility failed to provide grooming assistance for R25 (See F677). The facility failed to have a clear system in place to document resident's choice regarding code status (indicates the type of resuscitation procedures for a resident, if any, when/if the resident heart stops beating). This failure had the ability to negatively affect the mental, physical, and psychosocial well-being of Resident (R)11, R13, R26, R29, R32, R16 and R18 (See 678). The facility failed to provide needed care and services that were resident centered, in accordance with the resident's preferences, goals for care and professional standards of practice that would meet resident's physical, mental, and psychosocial needs related to treatment for alcoholism for R23 (See F684). The facility failed to provide Resident (R) 25 with hand splint (rigid or flexible material used to protect, immobilize, or restrict motion in a body part) to assist in maintaining anatomical alignment of the resident's hand (See F688) The facility failed to provide an environment as free of accident hazards as possible for all four residents reviewed. The facility failed to place effective and timely fall interventions for R28 who had multiple falls. This failure caused actual harm when R28 fell from his wheelchair on 03/05/24, required transport to the local emergency department, and placement of two staples to the resident's head. The facility failed to identify causal factors for two falls experienced by R19, a dependent resident with repeated falls, to prevent further falls. The facility failed to appropriately monitor for safety for R35, a resident with wandering when the staff pushed R35 in his wheelchair and allowed his feet to drag the floor. These deficient practices led to actual harm for R19 and R28 and at risk for further injury that could negatively affect the overall health and well-being of the residents in the facility. Furthermore, these deficient practices had the potential to have a negative psychosocial impact on the affected residents (See F689). (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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility failed to provide appropriate respiratory care in maintaining respiratory equipment to prevent the spread of infection, consistent with standards of practice and person-centered care plan for one Resident (R)32 related to an unknown clear liquid left in the nebulizer chamber (See F695). The facility failed to ensure staff possessed the appropriate competencies to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial wellbeing. These deficient practices had the potential have negative physical, mental and psychosocial affects to all the residents in the facility (See F726). The facility failed to ensure an effective pharmacy system in place to ensure the accurate accounting, reconciliation, and destruction of controlled/narcotic medications. This deficient practiced affected Resident (R) 40, R39, R41, R24, R89, R35, R15, R18, and R10, and placed any resident who received controlled medications at risk for staff diversion of their medication and potential untreated symptoms management that could negatively affect their physical, mental, and psychosocial well-being (See F745). The facility failed to ensure an effective pharmacy system in place to ensure the accurate accounting, reconciliation, and destruction of controlled/narcotic medications. This deficient practiced affected Resident (R) 40, R39, R41, R24, R89, R35, R15, R18, and R10, and placed any resident who received controlled medications at risk for staff diversion of their medication and potential untreated symptoms management that could negatively affect their physical, mental, and psychosocial well-being (See F755). The facility failed to ensure three of the five residents reviewed remained free of unnecessary medications by the failure to ensure the Consulting Pharmacist identified and reported medication irregularities by not having Monthly Medication Reviews from 01/01/24 to 04/25/24 for Resident (R)28, R19 R3 (See F756). The facility failed to ensure residents remained free of unnecessary psychotropic medications by the failure to have Consulting pharmacist Monthly Regimen Review reports from 01/01/24 to 04/25/24 including gradual dose reduction (GDR) and psychotropic monitoring for three of five residents reviewed, which included Resident (R)28, R19, and R3 (See F758). The facility failed to ensure Resident (R) 35 and R6, reviewed during the medication administration pass, remained free of medication errors. Thirty one medication opportunities were observed/ two medication errors occurred. This placed the resident at risk for adverse reactions from the medications and resulted in a medication error rate of 6.45%. (F759). The facility failed to prevent significant medication errors for R89 when staff did not enter R89's 04/04/24 re-admission medication orders into the Electronic Medication Administration Record (eMAR) for five days. This failure resulted in staff incorrectly administering medications from a prior order, with some at incorrect dosages and omitted medications that were ordered in R89's treatment after return from the hospital (See F760). The facility failed to provide person-centered feeding assistance to Resident (R) 8 as directed on his care plan. This deficient practice had the potential to negatively impact the nutritional intake and psychosocial well-being of this resident (F810). (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility failed to prepare and serve food under sanitary conditions to all residents in the facility to prevent the potential for food borne bacteria (F812). The facility failed to ensure an effective administration to develop corrective actions plans and monitor them to correct identified quality deficiencies prior to survey. This deficient practice placed the residents at risk for ineffective care (F835). The facility failed to maintain an in-service training program for nurses' aides that was appropriate and effective to ensure the continuing competence of nurse aides. The facility identified eleven Certified Nurse Aides (CNAs) had been employed over one year. Of the eleven, five were reviewed, and five of the five CNAs lacked the required 12 hours of in-service training to include dementia and abuse training, to ensure the continuing competence of nurse aides and appropriate care and services to all residents of the facility (See F880). The facility failed to maintain an in-service training program for nurses' aides that was appropriate and effective to ensure the continuing competence of nurse aides. The facility identified eleven Certified Nurse Aides (CNAs) had been employed over one year. Of the eleven, five were reviewed, and five of the five CNAs lacked the required 12 hours of in-service training to include dementia and abuse training, to ensure the continuing competence of nurse aides and appropriate care and services to all residents of the facility (See F883). The facility failed to maintain an in-service training program for nurses' aides that was appropriate and effective to ensure the continuing competence of nurse aides. The facility identified eleven Certified Nurse Aides (CNAs) had been employed over one year. Of the eleven, five were reviewed, and five of the five CNAs lacked the required 12 hours of in-service training to include dementia and abuse training, to ensure the continuing competence of nurse aides and appropriate care and services to all residents of the facility (See F947). The facility failed to identify and develop corrective action plans for potential quality deficiencies through the QAPI plan to correct identified quality issues. This deficient practice placed the residents at risk for ineffective care.

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	175450	A. Building B. Wing	04/25/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 50659 The facility reported a census of 35 residents. The sample included 20 residents. Based on observation, interview, and record review, the facility failed to maintain an effective infection control program related to improper cleaning of respiratory equipment, lacked proper hand hygiene during medication administration, and cleaning of glucometers to prevent the spread of possible infections to the residents in the facility. Findings included: - On 04/18/24 at 11:38 AM, Certified Medication Aide (CMA) CC failed to perform hand hygiene; CMA CC applied gloves to hands without hand hygiene. Completed the blood sugar reading, utilized the glucometer (instrument used to calculate blood glucose) on Resident (R) 33. CMA CC removed gloves from hands, walked out of R33's room, reached into pocket, retrieved keys to the medication cart. CMA CC removed a sanitizer wipe and wiped off the glucometer with an ungloved hand. CMA CC did not wash hands when the task completed. On 04/18/24 at 11:48 AM, CMA CC failed to wash hands prior to the next glucometer reading on R25. CMA CC was stopped by surveyor. CMA CC reported hands should be washed, stated normally wash hands with hallway sanitizer stations on the walls. CMA CC completed glucometer reading on R25, removed gloves, picked up the glucometer and walked out of R25's room. CMA CC retrieved keys from the uniform pocket, opened several medication cart drawers, found sanitizer wipes and cleaned the glucometer with no gloved hands. CMA CC failed to perform hand hygiene after glove removal and prior to cleaning the glucometer. CMA CC reported hand hygiene should be completed after removing gloves every time. CMA CC stated the glucometer should be washed off wearing gloves if blood was visible. On 04/23/24 at 04:30 PM, CMA CC failed to wash hands after removal of gloves. CMA CC prepared oral medications pills for R6 during a medication observation. CMA CC prepared three oral tablets into a medication cup, then proceeded to apply gloves, open the top drawer of the medication cart, removed an eye drop single administration vial of refresh eye drops. CMA CC applied an eye drop to each eye. CMA CC removed gloves, then finished preparing oral medication of two more tablets, a nasal spray and an inhaler. Staff administered medications. CMA CC stated that eye drops should have been prepared last and given last, that hands should have been washed prior to gloves applied and after gloves removed. CMA CC pointed to a hand sanitizer on medication cart. On 04/23/24 at 04:45 PM, Administrative Staff B reported staff should wash hands prior to applying gloves and giving care. Hands hygiene should be completed after gloves were removed with hand sanitizer or washing hands with soap and water. In addition, observation on 04/18/24 at 12:46 PM, revealed R32's nebulizer (device which changes liquid medication into a mist easily inhaled into the lungs) on the bedside table with an unknown clear liquid that remained in the medication chamber. The nebulizer cannula lacked a date to indicate when staff changed the tubing. Observation on 04/24/24 at 02:52 PM, revealed R32's nebulizer on the bedside table with an unknown clear liquid that remained in the medication chamber. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/18/24 at 12:46 PM, R32 stated staff did not disassemble the medication chamber, clean, or leave to air dry after each breathing treatment. Interview on 04/24/24 at 03:02 PM, Certified Medication Aide (CMA) FF reported at the completion of each breathing treatment, staff should disassemble the nebulizer mask and medication chamber, rinse with tap water, leave it on a paper towel to air dry to prevent infection. Interview on 04/24/24 at 03:03 PM, with Licensed Nurse (LN) D and LN S, both reported and agreed at the completion of a breathing treatment, staff should disassemble the nebulizer mask and medication chamber, and the parts should be cleaned with tap water, placed on a paper towel to air dry, then approximately 30 minutes later, staff should go back and reassemble the nebulizer and place it in a clear plastic bag until the next breathing treatment to prevent infection. Interview on 04/24/24 at 03:45 PM, Consultant Nurse E stated at the completion of a breathing treatment, staff should disassemble the nebulizer mask and medication chamber, cleanse and rinse the mask and chamber and staff should place the parts on a paper towel to air dry. After a period of time, staff should reassemble the equipment and place it in a plastic bag to prevent infection. The undated facility policy Infection Prevention and Control Program F880 lacked the hand hygiene component. The facility failed to give a policy related to hand hygiene as requested. The undated facility policy Glucometer Disinfection documented the purpose of the procedure is to provide guidelines for staff to disinfect device to prevent transmission of blood borne diseases to residents and employees. Staff provided direction to wash hands, apply gloves, obtain the blood sample, remove their gloves, perform hand hygiene prior to exiting the room, reapply gloves if there is visible contamination of the device, or if the resident has hepatitis (inflammatory condition of the liver) or the human immunodeficiency virus (HIV) that attacks the immune system. After cleaning the glucometer, staff are to remove gloves and perform hand hygiene. The undated facility policy Oxygen Administration lacked address of sanitation and storage of nebulizer equipment after each use to prevent infection. The facility failed to maintain an effective infection control program related to improper cleaning of respiratory equipment, lacked proper hand hygiene during medication administration and cleaning of glucometers to prevent cross contamination in the facility.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop and implement policies and procedures for flu and pneumonia vaccinations. 50659 The facility reported a census of 35 residents. The sample included 20 residents with five residents reviewed for immunizations. The facility failed to provide proof of vaccination or declination of vaccines for the 2023-2024 influenza or pneumococcal (vaccines designed to prevent pneumonia [inflammation of the lungs which can be debilitating or lethal in the elderly]) for five of the five residents reviewed. Findings included: - Review of the Electronic Health Record (EHR) for Resident (R)89 lacked documentation of 2022 to 2023 influenza vaccine or declination of the vaccine. It further lacked documentation of any pneumococcal vaccine or declination of the vaccine(s). Review of the EHR for R18 lacked documentation of 2022 to 2023 influenza vaccine or declination of the vaccine. It further lacked documentation of any pneumococcal vaccine or declination of vaccine(s). Review of the EHR for R10 lacked documentation of 2022 to 2023 influenza vaccine or declination of the vaccine. It further lacked documentation of any pneumococcal vaccine or declination of vaccine(s). Review of the EHR for R33 lacked documentation of 2022 to 2023 influenza vaccine or declination of the vaccine. It further lacked documentation of any pneumococcal vaccine or declination of vaccine(s). Review of the EHR for R25 lacked documentation of 2022 to 2023 influenza vaccine or declination of the vaccine. It further lacked documentation of any pneumococcal vaccine or declination of vaccine(s). The facility failed to provide proof of vaccination or declination of vaccines for the 2022-2023 influenza or pneumococcal for these five residents reviewed. On 04/25/24 01:37 PM, Consultant Nurse E was informed influenza and pneumococcal for the five residents were needed. The education for residents/responsible parties, signed consent/ given, or signed declination by residents/responsible party. The facility failed to provide a policy related to wandering/elopement as requested on 04/25/24.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 31078 The facility census totaled 35 residents. Based on interview and record review, the facility failed to maintain an in-service training program for nurses' aides that was appropriate and effective to ensure the continuing competence of nurse aides. The facility identified eleven Certified Nurse Aides (CNAs) had been employed over one year. Of the eleven, five were reviewed, and five of the five CNAs lacked the required 12 hours of in-service training to include dementia and abuse training, to ensure the continuing competence of nurse aides and appropriate care and services to all residents of the facility. Findings Included: - Review of a list of CNAs employment dates revealed eleven CNAs had been employed for at least 12 months. Of the eleven, five were reviewed and none of the five had completed training in abuse, neglect, and exploitation (ANE). None of the five employees had training dealing with dementia residents. On 04/25/24 the training log for CNA II revealed 75 minutes of training the last 12 months and lacked training in abuse, neglect, and exploitation (ANE), or had training dealing with dementia residents. On 04/25/24 the training log for CNA JJ revealed 75 minutes of training in last 12 months and lacked training in abuse, neglect, and exploitation (ANE), or had training dealing with dementia residents. On 04/25/24 the training log for CNA KK revealed 75 minutes of training in last 12 months and lacked training in abuse, neglect, and exploitation (ANE), or had training dealing with dementia residents. On 04/25/24 the training log for CNA AA revealed 120 minutes of training in last 12 months and lacked training in abuse, neglect, and exploitation (ANE). or had training dealing with dementia residents. On 04/25/24 the training log for CNA LL revealed no training in last 12 months. On 04/25/24 at 07:00 PM, Administrative Staff N provided the training records for selected CNAs that had worked for the facility for the last year as documented above. Administrative Staff N stated that she had reviewed all the training's for the previous six months and added up the minutes spent during each training and then confirmed that the CNAs selected for review did not have the required hours nor the required training components. On 04/25/24 at 07:00 PM, Administrative Staff A stated that she was unable to locate or provide training records for the selected CNAs and that the facility was in the process of transitioning from a paper-based training system to an online training system and that the process was incomplete, and records could not be located. (continued on next page)

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility did not provide a policy regarding the required training and in-service of staff, as requested on 04/23/24 at 04:00 PM. The facility failed to maintain an in-service training program for nurse aides that included the required 12 hours of in-service training to include dementia and abuse training, to ensure the continuing competence of nurse aides and appropriate care and services to all residents of the facility.