Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175454	A. Building B. Wing	06/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clearwater Nursing & Rehabilitation Center	620 E Wood Street Clearwater, KS 67026

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 46960 The facility reported a census of 43 residents. Based on observation, interview, and record review, the facility failed to ensure dignity in resident dining when the facility served seven residents their meals in Styrofoam containers, due to a lack of plates, cups, and flatware, for residents who chose to eat in their room. Findings included: - On 05/30/24 at 09:02 AM, observation revealed dietary staff delivered a multi-tiered cart with Styrofoam containers of food to each hall. The Certified Nurse Aides (CNAs) on each hall then delivered each tray with styrofoam containers to the seven residents who chose to dine in their room. On 06/03/24 at 10:00 AM, Dietary Manager O stated that Styrofoam containers were used to deliver meals to the room prior to her hire, and she was in the process of ordering more plates, cups, and silverware to be able to provide actual plates and flatware to the residents who chose to eat in their rooms. Dietary Manager O stated there was an unknown supply chain problem with her supplier and they were having trouble obtaining enough plates for all of the residents in the facility. Dietary Manager O stated there was not enough tableware and silverware for all of the residents in the facility. On 06/06/24 at 01:50 PM, Administrative Nurse B stated that only residents who were under isolation precautions or were taking meals to-go (for example, leaving the facility with family on an outing) should be served with disposable containers and flatware. Administrative Nurse B stated she was unaware of the regulatory requirement that residents should be served regularly with non-disposable flatware and utensils. The facility failed to provide a policy related to disposable flatware and utensils as requested on 06/03/24. The facility failed to ensure dignity in resident dining when the facility served seven residents their meals in Styrofoam containers, due to a lack of plates, cups, and flatware, for residents who chose to eat in their room.

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50659 The facility reported a census of 43 residents with 15 residents sampled. Based on observation, interview, and record review, the facility failed to ensure the right of R22's representative to be informed of changes, when the resident had an increase in behaviors and staff placed R22 on one-to-one observation due to his behaviors. Findings included: - Review of Resident (R)22's Electronic Medical Record (EMR) revealed a diagnosis of dementia (progressive mental disorder characterized by failing memory, confusion) with behaviors. The Significant Change Minimum Data Set (MDS), dated [DATE], documented the staff assessment for cognition revealed R22 had severe cognitive impairment. The resident was independent with ambulation. The Cognitive Loss/Dementia Care Area Assessment (CAA), dated 02/16/24, documented the resident had cognitive loss related to dementia. The Behavioral CAA, dated 02/16/24, documented the resident had behavioral symptoms related to daily wandering. The Quarterly MDS, dated [DATE], documented the staff assessment for cognition revealed R22 had severe cognitive impairment. The MDS documented R22 had behaviors of hitting other residents. The Care Plan dated 05/26/23, revised on 12/29/23, documented R22 had impaired cognitive function, dementia, or impaired thought processes. The Care Plan instructed staff to provide a homelike environment and noted R22 liked to carry a baby doll to bring comfort. The Care Plan lacked interventions for staff related to resident-to-resident altercations. Review of the resident's EMR, dated 05/20/24, documented the resident hit another resident in the face with a closed fist. Staff immediately removed the resident and placed him one on one. The resident remained one on one with staff until bedtime on 05/22/24. The EMR lacked documentation of the resident's Durable Power of Attorney (DPOA) being notified of the behavior or the need to place him one on one with staff. Observation on 05/29/24 at 01:11 PM, revealed the resident sat with a staff member having a glass of lemonade. On 05/28/24 at 12:11 PM, the resident's DPOA stated she had not been notified of the resident's inappropriate interaction with another resident and had not been notified of the need to place him one-on-one with staff. On 05/28/24 at 03:00 PM, Licensed Nurse (LN) H stated when there was an altercation between two residents, staff would need to notify the DPOA right away. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/30/24 at 10:10 AM, Administrative Nurse E stated she expected the nurse to notify fthe resident's family or responsible party of new orders and incidents if a resident had impaired cognition. The facility's policy for Change in a Resident's Condition or Status, dated October 2021 documented the facility shall promptly notify the resident, his or her attending physician, and representative of changes in resident's medical or mental condition and or status. The nurse will notify if an accident or incident involved the resident. The facility failed to notify the resident respresentative of cognitively impaired R22's behaviors which resulted in staff placing the resident on one-to-one supervision.

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F 0584

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Many

Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.

46960

The facility reported a census of 43 residents. Based on observation, interview and record review, the facility failed to maintain a clean, comfortable and homelike environment throughout the facility for all residents of the facility, regarding four Residents (R)7, R 26, R 35 and R 145, who had no means to control the temperature of their rooms.

Findings included:

- During an environmental tour on 05/28/24 at 12:56 PM, four Residents (R)7, R26, R35 and R145, rooms were noted to have blankets laying over their vents. Additionally, the door to R145's room was being held open with a gait belt (a wide belt, usually made from canvas threads or rigid plastic, used to help transfer or stabilize a resident during activity) that was tied to the doorknob and to a handle on a dresser drawer.

On 05/28/24 at 12:56 PM, Resident (R)26 stated he had to cover the vent to his room because he was unable to control the temperature of his room. A resident in a neighboring room had the thermostat in their room and it was too warm for R 26.

On 05/29/24 at 08:30 AM, an observation of R135's room revealed that the door was being held open with a gait belt tied to the doorknob and to a handle on a dresser drawer.

On 06/03/24 at 11:47 AM, an observation of R135's room revealed that the door was being held open with a gait belt tied to the doorknob and to a handle on a dresser drawer.

On 06/03/24 at 11:52 AM, Maintenance staff R and Maintenance Staff Q stated there was a thermostat in every third resident room which controlled the temperatures of multiple residents' rooms. Further, confirmed the finding above related to the door of R135's room blocked open. Additionally stated some residents would put blankets over the floor vents to block the heat or cold from coming into their rooms. Maintenance Staff Q further confirmed that one resident controlling the environmental conditions for their neighbors was not conducive to a home-like environment for the residents. Maintenance staff Q confirmed that R135 not being able to close his door could prevent R135 from having privacy.

The facility lacked a policy for resident room temperatures.

The facility failed to maintain a clean, comfortable and home-like environment throughout the facility for all residents of the facility regarding room temperatures and the inability for R145 to close the door to his room. These deficient practices had the potential to negatively affect the psychosocial well-being of the residents in the facility.

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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** 50659 The facility reported a census of 43 residents with 15 residents sampled, which included two residents reviewed for behaviors and resident-to-resident abuse. Based on observation, interview, and record review, the facility failed to ensure staff identified and responded appropriately to all allegations of abuse, to include resident-to-resident abuse, when Resident (R)22, who had a history of hitting other residents, continued to hit residents in the facility on multiple occasions. On 12/20/22, R22 grabbed R195's sweatshirt by the collar and pushed her wheelchair backwards. R22 let go and then grabbed her nose between his index and middle finger. He continued to pull on her nose, which according to R195, caused pain. On 01/01/23, R22 hit R 196. On 02/06/23, R22, with a closed fist, hit R196 to the back of the head. On 06/04/23, R22 hit his spouse and then hit R30 which knocked R30 out of his chair. On 06/11/23, R22 swung a baby doll, and hit R13 twice on the face across her glasses. On 05/12/24, R22 punched R17 on the left side of R17's jaw. On 05/20/24, R22 raised his closed fist to R2 and made contact with R2's face. These continued incidents of resident-to-resident abuse and lack of supervision and interventions to prevent abuse, placed the residents in immediate jeopardy for continued abuse. In addition, on 01/19/24, R16 who had a history of sexual behaviors and physical aggression, hit an unknown resident after the unknown resident bumped R16's wheelchair. On 01/24/24, R16 grabbed the breast of R12 through her shirt. On 01/25/24, R16 masturbated in a public area. Findings Included: - Resident (R) 22's Electronic Health Record (EHR) revealed diagnoses included vascular dementia (a progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain), major depressive disorder (major mood disorder which causes persistent feelings of sadness), and senile degeneration of brain. The Significant Change Minimum Data Set (MDS) dated [DATE], documented R22 had severely impaired cognition. R22 required total assistance with activities of daily living (ADL) cares such as oral care, toileting, footwear, and personal hygiene; required maximal assistance with dressing, eating, and bathing; and was independent with ambulation. R22 was always incontinent of bladder and bowel. The Quarterly MDS dated [DATE], documented R22 had severely impaired cognition. R22 had physical behavioral symptoms directed toward others. R22 was independent with ambulation. The Cognitive Loss/Dementia CAA dated 02/16/24, documented R22 had an actual problem of cognition loss related to dementia. The Behavioral CAA dated 02/16/24, documented R22 had an actual problem with behavioral symptoms related to wandering. The 05/28/24 Care Plan dated 05/26/23, revised on 12/29/23, documented R22 had impaired cognitive function, dementia, or impaired thought processes. Staff instructed to provide a homelike environment and noted R22 liked to carry a baby doll to bring comfort. The care plan lacked interventions for staff related to resident-to-resident altercations. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The Physician's Order dated 05/28/24, included the following orders: Divalproex (medication used to treat bipolar disorder [major mental illness that caused people to have episodes of severe high and low moods]) use and staff were to monitor for tearfulness or crying, aggression, agitation as well as adverse effects every day and night. The staff were to note the number of episodes of target behavior and a redirection code: 0=did not occur; 1=easily altered; 2=difficult to redirect, ordered 12/24/22. Trazodone HCl (antidepressant medication), 50 milligrams (mg), give 1 tablet by mouth at bedtime, related to unspecified dementia, ordered 06/22/23. Divalproex Sodium Delayed Release Sprinkle, 125 mg, give 250 mg by mouth, three times a day, related to major depressive disorder, ordered 03/08/24. Ativan (antianxiety medication) use, and staff were to monitor the resident for anxiety and anger every day and night shift for behavior monitoring. The staff were to note the number of episodes of target behavior and a redirection code: 0=did not occur; 1=easily altered; 2=difficult to redirect, ordered 04/04/24. Ativan, 0.5 milligram (mg), give 0.5 mg by mouth, every four hours as needed, for anxiety/restlessness related to terminal diagnosis, end of life for six months, ordered 04/25/24. Review of the Progress Notes from 12/01/22 to 05/28/24 documented the following resident-to-resident concerns: Review of the Progress Notes revealed on 12/20/22 at 02:20 PM, R22 grabbed resident 195's sweatshirt by the collar and pushed her wheelchair backwards. R195 stated she did not react because she knows residents with dementia don't know any different. R22 let go and then grabbed her nose between his index and middle finger. He continued to pull on her nose, which R195 said caused her pain, and she told him to stop and pushed his hand away. Review of the Progress Notes revealed on 01/01/23 at 06:50 PM R22 hit R196 on the chest with a closed fist. Review of a Facility Reported Incident called into the state agency revealed on 02/06/23 R22, with his closed fist, hit R196 to the back of his head. The EHR for R22 lacked documentation of the 02/06/23 resident-to-resident physical abuse. Review of the Progress Notes revealed the following: On 06/04/23 at 06:42 PM, R22 hit his spouse and then hit R30, which knocked R30 out of his chair. [R30 had impaired cognition per the 05/22/23 MDS.] On 06/11/23 at 05:21 PM, R22 swung a baby doll, hitting R13 twice on the face across her glasses. [R13 had intact cognition per the 06/01/23 MDS.] On 06/13/23 at 06:00 AM, R22 transferred to a behavior unit. (continued on next page)

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F 0600

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Many

On 06/22/23 at 01:00 PM, R22 returned from a behavior unit.

On 07/30/23 the CNA reported she asked the resident to stand up and go to the restroom and the resident slapped her in the face. The CNA walked away from the resident.

The record lacked any other Progress Notes regarding resident-to-resident altercations between 07/30/23 and 03/04/24.

Review of the 03/04/24 behavior note at 07:00 PM revealed the dayshift nurse reported R22 sat at the nurse's station and got up to go to his room and his roommate told him to stop and when R22 and the nurse aide walked by him, R22 grabbed his roommate's shoulder and pulled him back toward him. The residents were separated.

Review of the Progress Notes revealed the following:

On 05/12/24 at 04:45 PM, R22 punched R17 in the jaw. [R17 had impaired cognition per the 03/14/24 MDS.]

On 05/20/24 at 03:38 PM, R22 raised his closed fist to R2 and made contact with R2's face. On 05/28/24 at 12:11 PM, R22's family member reported the resident had a resident-to-resident altercation on 05/20/24, and the family member stated the facility did not notify the family they placed R22 on one-on-one. [R2 had impaired cognition per the 02/23/24 MDS.]

During an interview on 05/28/24 at 02:57 PM, Certified Nurse Aide (CNA) C stated R22 was aggressive and would hit other residents and staff. CNA C stated she redirected R22 away from others if R22 was in a bad mood. CNA C stated R22 would have a mad expression on his face. CNA C stated that she would report resident-to-resident abuse to the charge nurse or the Director of Nursing.

During an interview on 05/28/24 at 03:00 PM, Licensed Nurse (LN) H stated she was told R22 could be agitated and had placed his hands on other residents. LN H reviewed how to report any type of abuse alleged or witnessed to the Director of Nursing, Administrator, provider, family member and hospice if needed.

On 05/28/24 at 03:08 PM, LN D stated was not aware R22 struck R17. LN C stated R22 hit R2 on the side of R2's face in the dining room and staff were busy at the time of the incident. CNA J witnessed the incident and reported to LN D. LN D stated she did not know why R22 hit R2, she stated that she reported the incident to the Assistant Director of Nursing, Director of Nursing, provider, hospice, and family member. LN D stated a risk management completed in EHR. LN D agreed that a progress note was not completed on R2.

On 05/28/24 at 03:13 PM, Administrative Staff B revealed that neither incident on 05/12/24 or 05/20/24 were reported to state agency or reported to law enforcement and stated there was no physical injury that occurred with either incident.

On 05/28/24 at 03:15 PM, Administrative Staff A stated staff notified her of both incidents (05/12/24 and 05/20/24) the same date they occurred.

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The facility's policy for Abuse Investigation and Reporting, dated October 2021 documented all allegations of resident abuse (including physical, mental, emotional, verbal, and or sexual abuse). Any reasonable suspicion of a crime shall be promptly reported to local, state, and federal agencies and thoroughly investigated by facility management. The facility failed to ensure staff identified and responded appropriately to all allegations of abuse, to include resident-to-resident abuse. These continued incidents placed the residents in immediate jeopardy for continued abuse. On 05/28/24 at 04:50 PM, Administrative Staff A was provided the Immediate Jeopardy (IJ) template for failure to provide to ensure staff identified and responded appropriately to all allegations of abuse, to include resident-to-resident abuse. The facility submitted an acceptable plan for removal of the immediate jeopardy on 05/29/24 at 05:15 PM which included the following: 1. Staff in-serviced on the facility's Abuse Neglect and Exploitation policy and procedure. (ANE) and would be completed by 05/28/24. Staff will not be allowed to work until signatures received. 2. Inter-Disciplinary Team was in-serviced on 05/28/2024 for ANE reporting. 3. Staff placed R22 on a one on one at 05:00 PM on 05/28/2024 and would remain a one on one until deemed no longer a threat or discharged from the facility. 4. Referrals would be sent to Behavior Units for temporary placement. 5. Hospice and Medical Director to complete a medication review. 6. Quality Assurance Performance Improvement (QAPI) meeting on 05/29/24. The surveyor verified the facility implemented the above corrective measures on-site on 05/29/24 at 05:15 PM. The deficient practice remained at a scope and severity level of an E, following the implementation of the removal plan. The facility failed to ensure staff identified and responded appropriately to all allegations of abuse, to include resident-to-resident abuse. These continued incidents place the residents in immediate jeopardy for continued abuse. - R16's Electronic Health Record (EHR) revealed diagnoses of Intermittent Explosive Disorder (an impulse disorder marked by frequent anger outbursts or aggression, which are out of proportion to the cause and create significant distress to the person. The anger episodes can be mild or severe and may involve hurting someone badly enough to require medical attention or even cause death [per the Cleveland Clinic website]), bipolar disorder (major mental illness that caused people to have episodes of severe high and low moods), dementia (progressive mental disorder characterized by failing memory, confusion), and sexual dysfunction. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The Significant Change Minimum Data Set (MDS) dated [DATE], documented staff completed an interview to determine the resident's cognition, which indicated he had moderately impaired cognition. No behaviors were noted on the assessment. R16 required extensive assistance with Activities of Daily Living (ADL - such as bed mobility, toileting, and hygiene) and was independent for eating. R16 was always incontinent of bladder. The Quarterly MDS dated [DATE], documented the resident had a BIMS of seven, which indicated severe cognitive impairment. The resident had no behaviors. R16 required maximal to total dependence with ADL and required set-up assistance for eating. The Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) dated 06/27/23, documented the resident had an increased need for assistance with ADL. The Cognitive Loss/Dementia CAA dated 06/27/23, documented the resident had a BIMS score of less than 13. The 05/29/24 Care Plan with an intervention dated 03/22/21, revealed R16 had cognitive functions, and mood and behavior. Staff were instructed to provide R16 privacy in his room with the door shut and reminded R16 to sit down when masturbating. On 09/13/23, an intervention revealed R16 had a potential for behavioral problems and staff were to administer medications as ordered and monitored for effectiveness. Staff were instructed to intervene as needed to protect the rights and safety of others and to divert the resident's attention. Staff were to remove the resident from the situation and take him to an alternate location as needed. The Physician's Order dated 05/29/24, documented on 12/01/22, staff were to monitor the resident for targeted behaviors associated with Depakote ([Divalproex]an anticonvulsant drug that treats seizures, migraines, and bipolar disorder) as well as monitor for potential adverse effects, which included: being anxious, refusing cares, and being tearful/crying. The Physician Order also included the following: Divalproex Sodium Oral Capsule Delayed Release Sprinkle, 125 milligrams, 4 capsules by mouth, two times a day, related to bipolar disorder, ordered 01/24/24. Paxil (an anti-depressant to treat depression), 30 milligrams by mouth, one time a day, for sexual dysfunction, ordered 03/25/24. Review of the Progress Notes from 12/01/23 to 05/28/24 documented the following: On 01/19/2024 at 03:07 PM, the resident was seated in the doorway of the dining room when an unidentified resident in an electric wheelchair bumped into R16's wheelchair. The unidentified resident yelled at R16 to get out of the way. When the unidentified resident moved close to R16's side, R16 punched the unidentified resident in the arm and yelled at the unidentified resident. On 01/24/24 at 12:37 PM, Licensed Nurse (LN) D documented Certified Nurse Aide (CNA) G observed R16 grab the breast of R12 through her shirt. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 01/25/24 at 01:04 PM, LN D documented Activity Director K notified LN D that R16 was in the dining room with his penis out and masturbated in front of residents. R16 was told to stop and removed from the dining room. R16 was to see psychologist provider in two weeks. On 01/25/24 at 06:48 PM, Administrative Staff L documented the internal investigation completed regarding incidents involving R16 on 01/24/24 and 01/25/24 concluded and R16 had not intentionally touched R12's breast. R16 was provided one on one. Provider adjusted R16's medications. On 02/22/24 at 11:39 AM, documented R16 was overheard saying sexually inappropriate statements to staff. R16 stated staff made sexual comments to him. R16 was educated that the interaction was witnessed, and staff made no inappropriate comments and that he could not continue to talk to staff in that manner. On 05/30/24 at 08:28 AM, Licensed Nurse (LN) D stated that her progress notes charted in R16's EHR on 01/24/24 and 01/25/24 were accurate as to what was told to her by staff who reported what they had seen. LN D stated, Administrative Staff L investigated the two incidents that were documented and did not request a statement from her. LN D stated she did not know anything further about the investigation. LN D verified the initials in the progress note on 01/24/24 was identified as R12. LN D stated that she received Abuse, Neglect and Exploitation (ANE) education this week prior to working and last week at the facility skills fair. On 05/30/24 at 09:01 AM, CNA F stated R16 had a history of hitting others, but she has not witnessed that. CNA F stated R16 did masturbate when and where he wanted to, and that staff were to re-direct the resident to a private area. CNA F stated that ANE education was completed on 05/29/24 before work and last week at the skills fair. On 06/03/24 at 10:39 AM, Activity Staff K stated on 01/24/24, she did not know about the incident when R16 grabbed another resident. Activity Staff K stated on 01/25/24, staff was notified that R16 was in dining room and had masturbated in front of other residents. Administrative Staff L did not request for Activity Staff K to write a statement for Administrative Staff L for either of the dates in January of 2024. On 06/03/24 at 12:00 PM, Administrative Staff A and Administrative B were questioned about R16's incidents on 01/19/24 and 01/25/24 and she stated she would look for investigations and update when found. On 06/03/24 at 01:20 PM, Administrative Staff A provided a copy of the 01/24/24 facility investigation. Stated that it was not called into police or reported to the state agency. Administrative staff A was not able to locate any incident from 01/19/24 for R16. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175454	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/03/2024
NAME OF PROVIDER OR SUPPLIER Clearwater Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 620 E Wood Street Clearwater, KS 67026	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 06/03/24 at 02:00 PM review of the facility's undated investigation provided by Administrative Staff L revealed a signature sheet with 22 staff members signatures, and an undated, non-witnessed complaint investigation witness statement of facts with a written statement from CNA G that documented R16 appeared to be touching another resident's breast. The undated investigation by Administrative Staff L further contained an undated Training: Abuse and Neglect form that documented the definition of abuse as: a willful infliction of injury, unreasonable confinement, intimidation, or punishment resulting in physical harm, pain, or mental anguish. Staff were instructed that each employee was responsible to report any signs of abuse to their direct supervisor or department director as soon as possible. If staff were unsure about the signs of abuse, they were to speak with the Director of Nursing or Administrator. When in doubt staff were instructed to report the potential abuse. Review of the Abuse Prevention Program dated 10/2021 documented: Our residents have the right to be free from abuse, neglect, neglect, misappropriation of property and exploitation. The facility would develop and implement policies and procedures to aid in preventing abuse and investigate and report any allegations of abuse within timeframes as required by federal requirements. The facility's policy for Abuse Investigation and Reporting, dated October 2021 documented all allegations of resident abuse (including physical, mental, emotional, verbal, and or sexual abuse). Any reasonable suspicion of a crime shall be promptly reported to local, state, and federal agencies and thoroughly investigated by facility management. The role of the Administrator is to assign an investigation to an appropriate individual, to prevent any further abuse. The role of the Investigator is to review completed forms, medical records, witnesses, and review all events leading up to the alleged incident. The facility would notify the Ombudsmen and ensure reporting of all alleged violations involving abuse etc. to state licensing/certification agency. The facility would notify the Ombudsman, adult protective services, and law enforcement within 2 hours if the alleged violation involved serious bodily injury, or 24 hours if not resulted in a serious bodily injury. The facility failed to ensure staff identified and responded appropriately to all allegations of abuse, to include resident-to-resident abuse regarding R16.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175454	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/03/2024

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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 50659

The facility reported a census of 43 residents with 15 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. The facility failed to report two allegations of resident-to-resident abuse, when on 05/12/24 at 04:45 PM, R22, who had a history of hitting others, punched R17 on the left side of R17's jaw. On 05/20/24, R22 raised his closed fist to R2 and made contact with R2's face. Both notes from the electronic records revealed the staff notified management, however niether of the instances were reported to the state agency, as required. These continued incidents of resident-to-resident abuse and lack of supervision and interventions to prevent abuse, and falls placed the residents in immediate jeopardy for continued abuse.Furthermore, on 01/19/24, R16, who had a history of sexual behaviors and physical aggression, hit an unknown resident after the unknown resident bumped R16's wheelchair. On 01/24/24, R16 grabbed the breast of R12 through her shirt.

Findings Included:

- Resident (R) 22's Electronic Health Record (EHR) revealed diagnoses included vascular dementia (a progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain), major depressive disorder (major mood disorder which causes persistent feelings of sadness) and senile degeneration of brain.

The Significant Change Minimum Data Set (MDS) dated [DATE], documented R22 had severely impaired cognition. R22 required total assistance with activities of daily living (ADL) cares such as oral care, toileting, footwear and personal hygiene; required maximal assistance with dressing, eating, and bathing; and was independent with ambulation. R22 was always incontinent of bladder and bowel.

The Quarterly MDS dated [DATE], documented R22 had severely impaired cognition. R22 had physical behavioral symptoms directed toward others. R22 was independent with ambulation.

The Cognitive Loss/Dementia CAA dated 02/16/24, documented R22 had an actual problem of cognition loss related to dementia.

The Behavioral CAA dated 02/16/24, documented R22 had an actual problem with behavioral symptoms related to wandering.

The 05/28/24 Care Plan dated 05/26/23, revised on 12/29/23, documented R22 had impaired cognitive function, dementia, or impaired thought processes. Staff instructed to provide a homelike environment and noted R22 liked to carry a baby doll to bring comfort. The care plan lacked interventions for staff related to resident-to-resident altercations.

The Physician's Order dated 05/28/24, included the following orders:

(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 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Divalproex (medication used to treat bipolar disorder [major mental illness that caused people to have episodes of severe high and low moods]) use and staff were to monitor for tearfulness or crying, aggression, agitation as well as adverse effects every day and night. The staff were to note the number of episodes of target behavior and a redirection code: 0=did not occur; 1=easily altered; 2=difficult to redirect, ordered 12/24/22. Trazodone HCl (antidepressant medication), 50 milligrams (mg), give 1 tablet by mouth at bedtime, related to unspecified dementia, ordered 06/22/23. Divalproex Sodium Delayed Release Sprinkle, 125 mg, give 250 mg by mouth, three times a day, related to major depressive disorder, ordered 03/08/24. Ativan (antianxiety medication) use, and staff were to monitor the resident for anxiety and anger every day and night shift for behavior monitoring. The staff were to note the number of episodes of target behavior and a redirection code: 0=did not occur; 1=easily altered; 2=difficult to redirect, ordered 04/04/24. Ativan, 0.5 milligram (mg), give 0.5 mg by mouth, every four hours as needed, for anxiety/restlessness related to terminal diagnosis, end of life for six months, ordered 04/25/24. Review of the Progress Notes from 12/01/24 to 05/28/24 documented the following resident-to-resident concerns: Review of the 03/04/24 behavior note at 07:00 PM revealed the dayshift nurse reported R22 sat at the nurse's station and got up to go to his room and his roommate told him to stop and when R22 and the nurse aide walked by him, R22 grabbed his roommate's shoulder and pulled him back toward him. The residents were separated. Review of the Progress Notes revealed the following: On 05/12/24 at 04:45 PM, R22 punched R17 in the jaw. [R17 had impaired cognition per the 03/14/24 MDS.] On 05/20/24 at 03:38 PM, R22 raised his closed fist to R2 and made contact with their face. On 05/28/24 at 12:11 PM, R22's family member reported the resident had a resident-to-resident altercation on 05/20/24, and the family member stated the facility did not notify the family they placed R22 on one-on-one. [R2 had impaired cognition per the 02/23/24 MDS.] On 05/20/24 at 03:38 PM, R22 raised his closed fist to R2 and made contact with their face. On 05/28/24 at 12:11 PM, R22's family member reported the resident had a resident-to-resident altercation on 05/20/24, and the family member stated the facility did not notify the family they placed R22 on one-on-one. On 05/28/24 at 02:57 PM, Certified Nurse Aide (CNA) C stated R22 is aggressive and would hit other residents and staff. CNA C stated she redirected R22 away from others if R22 was in a bad mood. CNA C stated R22 would have a mad expression on his face. CNA C stated that she would report resident-to-resident abuse to the charge nurse or the Director of Nursing. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 05/28/24 at 03:00 PM, Licensed Nurse (LN) H stated she was told R22 could be agitated and had placed his hands on other residents. LN H reviewed how to report any type of abuse alleged or witnessed to the Director of Nursing, Administrator, provider, family member and hospice if needed. On 05/28/24 at 03:08 PM, LN D stated was not aware R22 struck R17. LN C stated R22 hit R2 on the side of R2's face in the dining room and staff were busy at the time of the incident. CNA J witnessed the incident and reported to LN D. LN D stated she did not know why R22 hit R2, she stated that she reported the incident to the Assistant Director of Nursing, Director of Nursing, provider, hospice and family member. LN D stated a risk management completed in EHR. LN D agreed that a progress note was not completed on R2. On 05/28/24 at 03:13 PM, Administrative Staff B revealed that neither incident on 05/12/24 or 05/20/24 were reported to state agency or reported to law enforcement and stated there was no physical injury that occurred with either incident. On 05/28/24 at 03:15 PM, Administrative Staff A stated staff notified her of both incidents (05/12/24 and 05/20/24) the same date they occurred. The facility's policy for Abuse Investigation and Reporting, dated October 2021 documented all allegations of resident abuse (including physical, mental, emotional, verbal, and or sexual abuse). Any reasonable suspicion of a crime shall be promptly reported to local, state and federal agencies and thoroughly investigated by facility management. The facility failed to ensure staff reported the alleged abuse to the State Agency or local law enforcement, as required for resident-to-resident abuse. These continued incidents placed the residents in immediate jeopardy for continued abuse. On 05/28/24 at 04:50 PM, Administrative Staff A was provided the Immediate Jeopardy (IJ) template and notified 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 for resident-to-resident abuse, which placed the residents in immediate jeopardy. The facility submitted an acceptable plan for removal of the immediate jeopardy on 05/29/24 at 05:15 PM which included the following: 1. Staff in-serviced on the facility's Abuse Neglect and Exploitation policy and procedure. (ANE), and would be completed by 05/28/24. Staff will not be allowed to work until signatures received. 2. Inter-Disciplinary Team was in-serviced on 05/28/24 for ANE reporting. 3. Staff placed R22 on a one-on-one at 05:00 PM on 05/28/24 and would remain a one-on-one until deemed no longer a threat or discharged from the facility. 4. Referrals would be sent to Behavior Units for temporary placement. 5. Hospice and Medical Director to complete a medication review. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	6. Quality Assurance Performance Improvement (QAPI) meeting on 05/29/24. The surveyor verified the facility implemented the above corrective measures on-site on 05/29/24 at 05:15 PM. The deficient practice remained at a scope and severity level of an F, following the implementation of the removal plan. - R16's Electronic Health Record (EHR) revealed diagnoses of intermittent explosive disorder, bipolar disorder (major mental illness that caused people to have episodes of severe high and low moods), dementia (progressive mental disorder characterized by failing memory, confusion), and sexual dysfunction. The Significant Change Minimum Data Set (MDS) dated [DATE], documented staff completed an interview to determine the resident's cognition, which indicated he had moderately impaired cognition. No behaviors were noted on the assessment. R16 required extensive assistance with activities of daily living (ADLs - such as bed mobility, toileting, and hygiene) and was independent for eating. R16 was always incontinent of bladder. The Quarterly MDS dated [DATE], documented the resident had a BIMS of seven, which indicated severe cognitive impairment. The resident had no behaviors. R16 required maximal to total dependence with ADLs and required set-up assistance for eating. The Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) dated 06/27/23, documented the resident had an increased need for assistance with ADLs. The Cognitive Loss/Dementia CAA dated 06/27/23, documented the resident had a BIMS score of less than 13. The 05/29/24 Care Plan with an intervention dated 03/22/21, revealed R16 had cognitive functions, and mood and behavior. Staff were instructed to provide R16 privacy in his room with the door shut and reminded R16 to sit down when masturbating. On 09/13/23, an intervention revealed R16 had a potential for behavioral problems and staff were to administer medications as ordered and monitored for effectiveness. Staff were instructed to intervene as needed to protect the rights and safety of others and to divert the resident's attention. Staff were to remove the resident from the situation and take him to an alternate location as needed. Review of the Progress Notes on 01/19/24 at 03:07 PM revealed the resident was seated in the doorway of the dining room when an unidentified resident in an electric wheelchair bumped into R16's wheelchair. The unidentified resident yelled at R16 to get out of the way. When the unidentified resident moved close to R16's side, R16 punched the unidentified resident in the arm and yelled at the unidentified resident. The facility did not notify the state agency regarding this resident-to-resident abuse incident. Review of the Progress Notes on 01/24/24 at 12:37 PM, Licensed Nurse (LN) D documented Certified Nurse Aide (CNA) G observed R16 grab the breast of R12 through her shirt. The facility did not notify the state agency regarding the resident-to-resident abuse. On 05/30/24 at 08:45 AM, R16 seated in wheelchair in dining room for breakfast. Did not want to talk to anyone. R16 did not react when R10 took his breakfast plate that was full of his food away. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview on 05/30/24 at 09:01 AM, CNA F stated R16 had a history of hitting others, but she had not witnessed that. During an interview on 06/03/24 at 10:39 AM, Activity Staff K stated on 01/24/24, she did not know about the incident when R16 grabbed another resident. During an interview on 06/03/24 at 01:20 PM, Administrative Staff A stated the incident was not called into police or reported to the state agency. Administrative Staff A was not able to locate any incident information from 01/19/24 for R16. The facility's policy for Abuse Investigation and Reporting, dated October 2021 documented all allegations of resident abuse (including physical, mental, emotional, verbal, and or sexual abuse). Any reasonable suspicion of a crime shall be promptly reported to local, state and federal agencies and thoroughly investigated by facility management. The facility failed to report all allegations of abuse, to include resident-to-resident abuse regarding R16.

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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 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50659 The facility reported a census of 43 residents with 15 residents sampled, which included two residents reviewed for abuse. Based on observation, interview, and record review, the facility failed to investigate all allegations of resident-to-resident abuse to protect residents from further incidents of abuse. The facility failed to thoroughly investigate two abuse allegations regarding R22, who had a history of hitting other residents, and continued to hit residents in the facility on multiple occasions. On 12/20/22, R22 grabbed R195's sweatshirt by the collar and pushed her wheelchair backwards. R22 let go and then grabbed her nose between his index and middle finger. He continued to pull on her nose, which caused R195 pain. On 01/01/23, R22 hit R196. On 02/06/23, R22, with a closed fist, hit R196 to the back of the head. On 06/04/23, R22 hit his spouse and then hit R30 which knocked R30 out of his chair. On 06/11/23, R22 swung a baby doll, and hit R13 twice on the face across her glasses. On 05/12/24, R22 punched R17 on the left side of R17's jaw. On 05/20/24, R22 raised his closed fist to R2 and made contact with R2's face. The facility failure to investigate, implement effective interventions and/or provide appropriate supervision to prevent further resident-to-resident abuse, placed the residents in immediate jeopardy for lack of protection. Furthermore, on 01/19/24, Resident (R)16 who had a history of sexual behaviors and physical aggression, hit an unknown resident after the unknown resident bumped R16's wheelchair. On 01/24/24, R16 grabbed the breast of R12 through her shirt. On 01/25/24, R16 masturbated in a public area. The facility did not thoroughly investigate these abuse allegations which allowed continued resident-to-resident abuse incidents. Findings Included: - Resident (R) 22's Electronic Health Record (EHR) revealed diagnoses included vascular dementia (a progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain), major depressive disorder (major mood disorder which causes persistent feelings of sadness), and senile degeneration of brain. The Significant Change Minimum Data Set (MDS) dated [DATE], documented R22 had severely impaired cognition. R22 required total assistance with activities of daily living (ADL) cares such as oral care, toileting, footwear and personal hygiene; required maximal assistance with dressing, eating, and bathing; and was independent with ambulation. R22 was always incontinent of bladder and bowel. The Quarterly MDS dated [DATE], documented R22 had severely impaired cognition. R22 had physical behavioral symptoms directed toward others. R22 was independent with ambulation. The Cognitive Loss/Dementia CAA dated 02/16/24, documented R22 had an actual problem of cognition loss related to dementia. The Behavioral CAA dated 02/16/24, documented R22 had an actual problem with behavioral symptoms related to wandering. (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 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The 05/28/24 Care Plan dated 05/26/23, revised on 12/29/23, documented R22 had impaired cognitive function, dementia, or impaired thought processes. Staff instructed to provide a homelike environment and noted R22 liked to carry a baby doll to bring comfort. The care plan lacked interventions for staff related to resident-to-resident altercations. The Physician's Order dated 05/28/24, included the following orders: Divalproex (medication used to treat bipolar disorder [major mental illness that caused people to have episodes of severe high and low moods]) use and staff were to monitor for tearfulness or crying, aggression, agitation as well as adverse effects every day and night. The staff were to note the number of episodes of target behavior and a redirection code: 0=did not occur; 1=easily altered; 2=difficult to redirect, ordered 12/24/22. Trazodone HCl (antidepressant medication), 50 milligrams (mg), give 1 tablet by mouth at bedtime, related to unspecified dementia, ordered 06/22/23. Divalproex Sodium Delayed Release Sprinkle, 125 mg, give 250 mg by mouth, three times a day, related to major depressive disorder, ordered 03/08/24. Ativan (antianxiety medication) use, and staff were to monitor the resident for anxiety and anger every day and night shift for behavior monitoring. The staff were to note the number of episodes of target behavior and a redirection code: 0=did not occur; 1=easily altered; 2=difficult to redirect, ordered 04/04/24. Ativan, 0.5 milligram (mg), give 0.5 mg by mouth, every four hours as needed, for anxiety/restlessness related to terminal diagnosis, end of life for six months, ordered 04/25/24. Review of the Progress Notes revealed on 12/20/22 at 02:20 PM, R22 grabbed resident 195's sweatshirt by the collar and pushed her wheelchair backwards. R195 stated she did not react because she knows residents with dementia don't know any different. R22 let go and then grabbed R195's nose between his index and middle finger. He continued to pull on her nose, which R195 said caused her pain, and she told him to stop and pushed his hand away. Review of the Progress Notes revealed on 01/01/23 at 06:50 PM R22 hit R196 on the chest with a closed fist. Review of a Facility Reported Incident called into the state agency revealed on 02/06/23 R22, with his closed fist, hit R196 to the back of his head. The EHR for R22 lacked documentation of the 02/06/23 resident-to-resident physical abuse. Review of the Progress Notes revealed the following: On 06/04/23 at 06:42 PM, R22 hit his spouse and then hit R30 which knocked R30 out of his chair. [R30 had impaired cognition per the 05/22/23 MDS.] On 06/11/23 at 05:21 PM, R22 swung a baby doll, hitting R13 twice on the face across her glasses. [R13 had intact cognition per the 06/01/23MDS.] (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 06/13/23 at 06:00 AM, R22 transferred to a behavior unit. On 06/22/23 at 01:00PM, R22 returned from a behavior unit. On 07/30/23 the CNA reported she asked the resident to stand up and go to the restroom and the resident slapped her in the face. The CNA walked away from the resident. The record lacked any other Progress Notes regarding resident-to-resident altercations between 07/30/23 and 03/04/24. Review of the 03/04/24 behavior note at 07:00 PM revealed the dayshift nurse reported R22 sat at the nurse's station and got up to go to his room and his roommate told him to stop and when R22 and the nurse aide walked by him, R22 grabbed his roommate's shoulder and pulled him back toward him. The residents were separated. Review of the Progress Notes and EHR revealed the following: A Progress Note dated 05/12/24 at 04:45 PM, revealed R22 punched R17 in the jaw. The 03/14/24 MDS in R17's EHR revealed R17 had impaired cognition. The facility lacked an investigation into the resident-to-resident altercation on 05/12/24 regarding R22 and R17. R22's Care Plan further lacked an updated interventions to deter R22's resident-to-resident aggression. A Progress Note dated 05/20/24 at 03:38 PM, revealed R22 raised his closed fist to R2 and made contact with R2's face. The 02/23/24 MDS for R2 indicated R2 had impaired cognition. The facility lacked an investigation into the resident-to-resident altercation on 05/20/24 regarding R22 and R2. R22's Care Plan lacked an updated interventions to deter R22's resident-to-resident aggression. On 05/30/24 at 08:45 AM, R22 sat in the dining room for breakfast, with one-on-one observation by staff. During an interview on 05/28/24 at 12:11 PM, R22's family member reported the resident had a resident-to-resident altercation on 05/20/24, and the family member stated the facility did not notify the family they placed R22 on one-on-one. During an interview on 05/28/24 at 02:57 PM, Certified Nurse Aide (CNA) C stated R22 is aggressive and would hit other residents and staff. CNA C stated she redirected R22 away from others if R22 was in a bad mood. CNA C stated R22 would have a mad expression on his face. CNA C stated that she would report resident-to-resident abuse to the charge nurse or the Director of Nursing. During an interview on 05/28/24 at 03:00 PM, Licensed Nurse (LN) H stated she was told R22 could be agitated and had placed his hands on other residents. LN H reviewed how to report any type of abuse alleged or witnessed to the Director of Nursing, Administrator, provider, family member and hospice if needed. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Clearwater Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 620 E Wood Street Clearwater, KS 67026	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview on 05/28/24 at 03:08 PM, LN D stated she was not aware R22 struck R17. LN C stated R22 hit R2 on the side of R2's face in the dining room and staff were busy at the time of the incident. CNA J witnessed the incident and reported to LN D. LN D stated she did not know why R22 hit R2, she stated that she reported the incident to the Assistant Director of Nursing, Director of Nursing, provider, hospice and family member. LN D stated a risk management completed in EHR. LN D agreed that a progress note was not completed on R2. During an interview on 05/28/24 at 03:13 PM, Administrative Staff B revealed that neither incident on 05/12/24 or 05/20/24 were reported to state agency or reported to law enforcement and stated there was no physical injury that occurred with either incident. During an interview on 05/28/24 at 03:15 PM, Administrative Staff A stated staff notified her of both incidents (05/12/24 and 05/20/24) the same date they occurred. The facility's policy for Abuse Investigation and Reporting, dated October 2021 documented all allegations of resident abuse (including physical, mental, emotional, verbal, and or sexual abuse). Any reasonable suspicion of a crime shall be promptly reported to local, state and federal agencies and thoroughly investigated by facility management. On 05/28/24 at 04:50 PM, Administrative Staff A was provided the Immediate Jeopardy (IJ) template and notified that the facility failure to investigate all allegations of abuse to include resident-to-resident abuse, and failure to provide interventions and/or supervision to protect residents from further resident-to-resident abuse, placed the residents in immediate jeopardy. The facility submitted an acceptable plan for removal of the immediate jeopardy on 05/29/24 at 05:15 PM which included the following: 1. Staff in-serviced on the facility's Abuse Neglect and Exploitation policy and procedure. (ANE), and would be completed by 05/28/24. Staff will not be allowed to work until signatures received. 2. Inter-Disciplinary Team was in-serviced on 05/28/2024 for ANE reporting. 3. Staff placed R22 on a one on one at 05:00 PM on 05/28/2024 and would remain a one on one until deemed no longer a threat or discharged from the facility. 4. Referrals would be sent to Behavior Units for temporary placement. 5. Hospice and Medical Director to complete a medication review. 6. Quality Assurance Performance Improvement (QAPI) meeting on 05/29/24. The surveyor verified the facility implemented the above corrective measures on-site on 05/29/24 at 05:15 PM. The deficient practice remained at a scope and severity level of F, following the implementation of the removal plan. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	- R16's Electronic Health Record (EHR) revealed diagnoses of Intermittent Explosive Disorder (an impulse disorder marked by frequent anger outbursts or aggression, which are out of proportion to the cause and create significant distress to the person. The anger episodes can be mild or sever and may involve hurting someone badly enough to require medical attention or even cause death [per the Cleveland Clinic website]), bipolar disorder (major mental illness that caused people to have episodes of severe high and low moods), dementia (progressive mental disorder characterized by failing memory, confusion), and sexual dysfunction. The Significant Change Minimum Data Set (MDS) dated [DATE], documented staff completed an interview to determine the resident's cognition, which indicated he had moderately impaired cognition. No behaviors were noted on the assessment. R16 required extensive assistance with activities of daily living (ADLs - such as bed mobility, toileting, and hygiene) and was independent for eating. R16 was always incontinent of bladder. The Quarterly MDS dated [DATE], documented the resident had a BIMS of seven, which indicated severe cognitive impairment. The resident had no behaviors. R16 required maximal to total dependence with ADLs and required set-up assistance for eating. The Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) dated 06/27/23, documented the resident had an increased need for assistance with ADLs. The Cognitive Loss/Dementia CAA dated 06/27/23, documented the resident had a BIMS score of less than 13. The 05/29/24 Care Plan with an intervention dated 03/22/21, revealed R16 had cognitive functions, and mood and behavior. Staff were instructed to provide R16 privacy in his room with the door shut and reminded R16 to sit down when masturbating. The care plan lacked interventions for staff related to resident-to-resident altercations. On 09/13/23, an intervention revealed R16 had a potential for behavioral problems and staff were to administer medications as ordered and monitored for effectiveness. Staff were instructed to intervene as needed to protect the rights and safety of others and to divert the resident's attention. Staff were to remove the resident from the situation and take him to an alternate location as needed. Review of the Progress Notes from 12/01/23 to 05/28/24 documented the following: On 01/19/2024 at 03:07 PM, the resident was seated in the doorway of the dining room when an unidentified resident in an electric wheelchair bumped into R16's wheelchair. The unidentified resident yelled at R16 to get out of the way. When the unidentified resident moved close to R16's side, R16 punched the unidentified resident in the arm and yelled at the unidentified resident. On 01/24/24 at 12:37 PM, Licensed Nurse (LN) D documented Certified Nurse Aide (CNA) G observed R16 grab the breast of R12 through her shirt. On 01/25/24 at 01:04 PM, LN D documented Activity Director K notified LN D that R16 was in the dining room with his penis out and masturbated in front of residents. R16 was told to stop and removed from the dining room. R16 was to see psychologist provider in two weeks. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 01/25/24 at 06:48 PM, Administrative Staff L documented the internal investigation completed regarding incidents involving R16 on 01/24/24 and 01/25/24 concluded and R16 had not intentionally touched R12's breast. R16 was provided one on one. Provider adjusted R16's medications. On 02/22/24 at 11:39 AM, documented R16 was overheard saying sexually inappropriate statements to staff. R16 stated staff made sexual comments to him. R16 was educated that the interaction was witnessed, and staff made no inappropriate comments and that he could not continue to talk to staff in that manner. During an interview on 05/30/24 at 08:28 AM, Licensed Nurse (LN) D stated that her progress notes charted in R16's EHR on 01/24/24 and 01/25/24 were accurate as to what was told to her by staff who reported what they had seen. LN D stated, Administrative Staff L investigated the two incidents that were documented and did not request a statement from her. LN D stated she did not know anything further about the investigation. LN D verified the initials in the progress note on 01/24/24 was identified as R12. LN D stated that she received Abuse, Neglect and Exploitation (ANE) education this week prior to working and last week at the facility skills fair. During an interview on 05/30/24 at 09:01 AM, CNA F stated R16 had a history of hitting others, but she has not witnessed that. CNA F stated R16 did masturbate when and where he wanted to, and that staff were to re-direct the resident to a private area. CNA F stated that ANE education was completed on 05/29/24 before work and also last week at the skills fair. During an interview on 06/03/24 at 10:39 AM, Activity Staff K stated on 01/24/24, she did not know about the incident when R16 grabbed another resident. Activity Staff K stated on 01/25/24, staff was notified that R16 was in dining room and had masturbated in front of other residents. Administrative Staff L did not request for Activity Staff K to write a statement for Administrative Staff L for either of the dates in January of 2024. During an interview on 06/03/24 at 12:00 PM, Administrative Staff A and Administrative B were questioned about R16's incidents on 01/19/24 and 01/25/24 and she stated she would look for investigations and update when found. During an interview on 06/03/24 at 01:20 PM, Administrative Staff A provided a copy of the 01/24/24 facility investigation. Stated that it was not called into police or reported to the state agency. Administrative staff A was not able to locate any incident from 01/19/24 for R16. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 06/03/24 at 02:00 PM review of the facility's undated investigation provided by Administrative Staff L revealed a signature sheet with 22 staff members signatures, and an undated, non-witnessed complaint investigation witness statement of facts with a written statement from CNA G that R16 appeared to be touching another resident's breast. The undated investigation by Administrative Staff L further contained an undated Training: Abuse and Neglect form that documented the definition of abuse as: a willful infliction of injury, unreasonable confinement, intimidation, or punishment resulting in physical harm, pain or mental anguish. Staff were instructed that each employee was responsible to report any signs of abuse to their direct supervisor or department director as soon as possible. If staff were unsure about the signs of abuse, they were to speak with the Director of Nursing or Administrator. When in doubt staff were instructed to report the potential abuse. Review of the Abuse Prevention Program dated 10/2021 documented: Our residents have the right to be free from abuse, neglect, neglect, misappropriation of property and exploitation. The facility would develop and implement policies and procedures to aid in preventing abuse and investigate and report any allegations of abuse within timeframes as required by federal requirements. The facility's policy for Abuse Investigation and Reporting, dated October 2021 documented all allegations of resident abuse (including physical, mental, emotional, verbal, and or sexual abuse). Any reasonable suspicion of a crime shall be promptly reported to local, state, and federal agencies and thoroughly investigated by facility management. The role of the Administrator is to assign an investigation to an appropriate individual, to prevent any further abuse. The role of the Investigator is to review completed forms, medical records, witnesses, and review all events leading up to the alleged incident. The facility would notify the Ombudsmen and ensure reporting of all alleged violations involving abuse etc. to state licensing/certification agency. The facility would notify the Ombudsman, adult protective services, and law enforcement within 2 hours if the alleged violation involved serious bodily injury, or 24 hours if not resulted in a serious bodily injury. The facility failed to ensure staff identified and responded appropriately to all allegations of abuse, to include resident-to-resident abuse, regarding R16.

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F 0637

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Assess the resident when there is a significant change in condition

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 46960

The facility reported a census of 43 residents with 15 residents included in the sample. Based on observation, interview, and record review, the facility failed to recognize a significant change in a resident's physical condition and perform a comprehensive Minimum Data Set (MDS) assessment within the required 14-day period. This deficient practice had the potential to lead to uncommunicated needs and placed the resident at risk of further deterioration of his physical, mental, and psychosocial well-being. (Resident (R) 30)

Findings included:

- R30's Electronic Health Record (EHR) included diagnoses of diabetes mellitus type 2 (DM2- when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), metabolic encephalopathy (condition in which brain function is disturbed either temporarily or permanently due to different diseases or toxins in the body), dementia (a progressive mental disorder characterized by failing memory, confusion), repeated falls, pain in [the] left hip (joint that comprises the femur [thigh bone] and pelvis), fracture (broken bone) of left femur, fracture of right femur and need for assistance with personal care.

The Annual Minimum Data Set (MDS), dated [DATE], documented a Brief Interview of Mental Status (BIMS) score of seven, which indicated severely impaired cognition. R30 required setup and supervision with all cares with the exception of oral care and bathing, which were dependent on staff for completion, and eating which was performed independently. The assessment documented that R30 had fallen since admission to the facility.

The Medicare 5 Day MDS dated [DATE] documented a BIMS score of four, which indicated severely impaired cognition. R30 required substantial/maximal assistance or dependence on staff for all cares. The assessment documented R30 had a fall within the 30-day look-back period, a fracture related to a fall in the six-month look-back period, major surgery in the 100-day look-back period which required skilled nursing facility (SNF - a facility that provides inpatient skilled nursing care to those who need medical, nursing, or rehabilitative services) and a repair of fractures of the hip.

The Falls Care Area Assessment (CAA) dated 02/15/24 documented R30 was a high risk of falls related to antidepressant (class of medications used to treat mood disorders and relieve symptoms of depression) and history of falls.

The 05/29/24 Care Plan documented that on 03/15/22 R30 was a high risk for falls related to lower leg weakness and confusion and included the following:

On 03/29/22, staff were to educate the resident/family/caregivers about safety reminders and what to do if a fall occurred.

On 03/29/22, staff were to ensure that R30 wore appropriate footwear (shoes or non-slip socks) when ambulating (walking).

On 03/29/22, staff were to follow the facility fall protocol.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/29/22, staff were to provide a safe environment free from spills or clutter with adequate glare-free light, and a working and reachable call light. Staff were to place the bed in the low position at night and place personal items within reach of the resident. On 05/26/24, staff were to be educated related to the placement of the bedside table when the fall mat was in use. The Progress Notes documented the following: On 04/08/24 at 10:58 PM, R30 was readmitted to the facility from the hospital after a surgical repair of a right hip fracture. On 05/06/24 at 03:06 PM, R30 was readmitted to the facility from the hospital after a surgical repair of a left hip fracture. The Progress Notes lacked documentation related to the level of assistance that R30 required with cares. On 06/30/24, review of Tasks in the EHR lacked documentation of assistance provided for cares during the 14-day look-back period. On 06/03/24 at 09:00 AM, Certified Nurse Aide (CNA) J and CNA F stated that R30 required the assistance of two or more staff members for all cares. On 05/30/24 at 09:50 AM, Administrative Nurse E confirmed the most recent comprehensive MDS assessment was dated 02/15/24. Further confirmed that the most recent MDS assessment dated [DATE] was not a comprehensive assessment and that R30 had a documented change in the level of cares he received. Administrative Nurse E confirmed that the MDS assessment dated [DATE] should have been a Significant Change comprehensive assessment. On 06/03/24 at 08:58 AM, Administrative Nurse B stated she expected all treatments and modalities of care provided to the residents to be captured on the appropriate MDS and documented on the care plan. A facility policy was requested regarding the MDS assessments. The facility would utilize the Resident Assessment Instrument (RAI) manual for the MDS development. The facility failed to recognize a significant change in a resident's physical condition and perform a comprehensive MDS assessment within the required 14-day period. This deficient practice had the potential to lead to uncommunicated needs and placed the resident at risk of further deterioration of his physical, mental and psychosocial well-being.

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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 31078

The facility census totaled 43 residents with 15 residents included in the sample. Based on observation, interview, and record review, the facility failed to accurately complete the Minimum Data Set (MDS) for five sampled residents. Resident (R)1, related to hospice and medications on the Care Area Assessment (CAA), R30 related to accidents not addressed on the CAA, R32, related to dialysis and nutrition not addressed on the CAA, and R39, related to medications not addressed on section N on the MDS. These deficient practices had the potential to lead to uncommunicated need for care and services to meet each individual residents' needs.

Findings included:

- R1's electronic medical record (EMR) revealed the following diagnoses that included chronic atrial fibrillation (rapid, irregular heart beat), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), violent behavior, major depressive disorder (major mood disorder which causes persistent feelings pf sadness), intermittent explosive disorder, delusional disorder (untrue persistent belief or perception held by a person although evidence shows it was untrue) personality disorder.

The Admission Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 06, indicating severe cognitive impairment. The resident was dependent on staff for assistance of mobility requiring the use of a wheelchair or walker. The resident received pain medication on schedule, had weight loss and received hospice care (designed for people with an anticipated life expectancy of six months or less). Medications included antipsychotic (class of medications used to treat major mental conditions which cause a break from reality), anticoagulant (blood thinner), insulin, antianxiety (class of medications that calm and relax people), and antidepressant (class of medications used to treat mood disorders).

The quarterly MDS, dated [DATE] revealed no significant changes in status from the previous MDS.

The Care Area Assessment (CAA) dated 02/05/24 revealed the following:

The Cognitive loss/Dementia CAA, documented R1's care plan would reflect his cognitive loss related to dementia and his goal of avoiding complications.

The Psychotropic Drug Use CAA documented R1 was at risk for adverse effects related to high-risk medication use, however the CAA lacked the assessment to accurately reflect the resident's status.

The CAA lacked documentation related to R1 hospice services.

R 1's Care Plan dated 12/31/2023 revealed R1 received medications with black box warnings (BBW is the highest safety-related warning that medications can have assigned by the Food and Drug Administration).

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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	R1 admitted to hospice services on 01/26/2024 for cachexia (a disorder that causes weight loss and muscle loss). A revision to the care plan dated 05/01/24, included the resident was a Do Not Resuscitate (DNR) Observation on 05/28/24 at 10:30 AM revealed the resident in his room visiting with another resident from across the room. On 05/30/24 at 10:45 AM, Licensed Nurse (LN) D reported the resident received hospice. The hospice nurse visited once a week. The resident had behaviors but were usually controlled with medication. On 05/30/24 at 11:00 AM Administrative Nurse E reported she was unaware of what needed to be included in the CAA and that the CAA was to be used to generate the care plan process. She reported did not spend much time with the development of the CAA. On 05/30/24 at 01:00 PM, Administrative Nurse B reviewed the CAAs and verified the CAA should be documented in detail for the causal factors that would create the resident's care plan. She acknowledged the CAAs lacked crucial information regarding the resident's condition to develop the plan of care. A facility policy was requested regarding the CAA and MDS. The facility would utilize the Resident Assessment Instrument (RAI) manual for the CAA process. The facility failed to accurately reflect the resident's status, related to hospice and medications on the CAA analysis which placed the resident at risk for uncommunicated care needs. 46960 -R32's Electronic Health Record (EHR) included diagnoses of diabetes mellitus type 2 (DM2- when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), anemia (a condition without enough healthy red blood cells to carry adequate oxygen to body tissues), stage four chronic kidney disease (CKD - a disease characterized by progressive damage and loss of function in the kidneys) and end-stage renal disease (ESRD-a terminal disease of the kidneys). The Admission Minimum Data Set (MDS), dated [DATE], documented a Brief Interview of Mental Status (BIMS) score of 14 which indicated intact cognition. The resident received insulin daily during the seven-day look-back period and received dialysis. The Care Area Assessment (CAA), dated 04/05/24, lacked documentation related to insulin use or dialysis. The 05/29/24 Care Plan lacked documentation related to insulin use, dialysis, or care of the resident's implanted dialysis catheter. The Physician's Orders documented the following: On 05/11/24 at 08:00 AM, dialysis every Tuesday, Thursday and Saturday, leave the facility at 09:00 AM. (continued on next page)

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F 0641

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

On 04/16/24 at 04:00 PM, prostat (a nutritional supplement shake) 30 milliliters (mL) to be given orally two times a day related to low albumin (amount of protein in the blood) levels and once per day to be given orally after dialysis, on dialysis days.

On 04/03/24 at 06:00 PM, staff to chart the amount of fluid removed from resident while at dialysis, one time per day on Tuesday, Thursday and Saturday following dialysis related to dialysis management.

On 04/03/24 at 06:00 PM, staff to check dialysis catheter (a hollow flexible tube inserted into the body) every shift for monitoring of [dialysis] port.

On 03/29/24 at 05:00 PM, Insulin Lispro solution 100 unit/mL, inject per sliding scale: if [blood sugar is between] 150-199 [milligrams/deciliter {mg/dL}] give one unit, if [blood sugar is between] 200-249 mg/dL give three units, if [blood sugar is between] 250-299 mg/dL give five units, if [blood sugar is between] 300-349 mg/dL give seven units, subcutaneously (SQ) four times per day (QID), before meals (ac) and at bedtime (hs) related to DM2, and if [blood sugar is] greater than 349 mg/dL to call the provider for guidance.

On 03/29/24 at 08:00 PM, Insulin Glargine Solution 100 unit/mL, inject eight units daily at bedtime related to DM2.

The 03/29/24 to 05/30/24 Medication Administration Record (MAR) and Treatment Administration Record (TAR) reviewed, and staff documented administration of medications, blood sugar checks within parameters and monitoring of implanted dialysis catheter every shift.

On 06/03/24 at 08:55 AM Certified Nurse Aide (CNA) J stated that R32 had an implanted dialysis port to the right side of his chest and that CNA staff had been instructed to ensure that it is covered and remained dry during bathing. If bleeding were to occur around the catheter site, CNAs were to inform nursing staff immediately.

On 06/03/24 at 09:03 AM, Licensed Nurse (LN) H stated that R32 had an implanted dialysis port to the right side of his chest and stated that nursing staff assessed the port every shift and if the assessment found anything wrong that staff were to call the physician for further instructions.

On 05/30/24 at 11:00 AM Administrative Nurse E reported she was unaware of what needed to be included in the CAA and that the CAA was to be used to generate the care plan process. She reported did not spend much time with the development of the CAA.

On 05/30/24 at 01:00 PM, Administrative Nurse B verified the CAA should be documented in detail for the causal factors that would create the resident's care plan and acknowledged the CAAs lacked crucial information regarding the resident's condition to develop the plan of care.

A facility policy was requested regarding the CAA and MDS. The facility would utilize the Resident Assessment Instrument (RAI) manual for the CAA process.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility failed to accurately reflect the resident's status, related to dialysis and insulin administration related to DM2 on the CAA analysis. This deficient practice led to uncommunicated care needs which had the potential to negatively impact the physical, mental and psychosocial well-being of R32. - R30's Electronic Health Record (EHR) included diagnoses of diabetes mellitus type 2 (DM2- when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), metabolic encephalopathy (condition in which brain function is disturbed either temporarily or permanently due to different diseases or toxins in the body), dementia (a progressive mental disorder characterized by failing memory, confusion), repeated falls, pain in [the] left hip (joint that comprises the femur [thigh bone] and pelvis), fracture (broken bone) of left femur, fracture of right femur and need for assistance with personal care. The Annual Minimum Data Set (MDS), dated [DATE], documented a Brief Interview of Mental Status (BIMS) score of seven, which indicated severely impaired cognition. R30 required setup and supervision with all cares with the exception of oral care and bathing, which were dependent on staff for completion, and eating which was performed independently. The assessment documented that R30 had fallen since admission to the facility. The Medicare 5 Day MDS dated [DATE], documented a BIMS score of four, which indicated severely impaired cognition. R30 required substantial/maximal assistance or dependence on staff for all cares. The assessment documented R30 had a fall within the 30-day look-back period, a fracture related to a fall in the six-month look-back period, major surgery in the 100-day look-back period which required skilled nursing facility (SNF - a facility that provides inpatient skilled nursing care to those who need medical, nursing, or rehabilitative services) and a repair of fractures of the hip. The Falls Care Area Assessment (CAA) dated 02/15/24 documented R30 was a high risk of falls related to antidepressant (class of medications used to treat mood disorders and relieve symptoms of depression) and history of falls. The CAA lacked documentation related to an actual fall on 02/03/24. The CAA did not accurately reflect the resident's status related to his falls. The 05/29/24 Care Plan documented on 03/15/22, R30 was a high risk for falls related to lower leg weakness and confusion and included the following: On 03/29/22, staff were to educate the resident/family/caregivers about safety reminders and what to do if a fall occurred. On 03/29/22, staff were to ensure that R30 wore appropriate footwear (shoes or non-slip socks) when ambulating (walking). On 03/29/22, staff were to follow the facility fall protocol. On 03/29/22, staff were to provide a safe environment free from spills or clutter with adequate glare-free light, and a working and reachable call light. Staff were to place the bed in the low position at night and place personal items within reach of the resident. On 05/26/24, staff were to be educated related to the placement of the bedside table when the fall mat was in use. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clearwater Nursing & Rehabilitation Center	620 E Wood Street Clearwater, KS 67026

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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	Review of Assessments in the EHR revealed the following: On 10/18/23, R30 assessed as a high risk for falls with a score of 15. On 02/03/24, R30 assessed post (after) fall as low or no risk for falls with a score of six. On 04/04/24, R30 was assessed post fall as high risk for falls with a score of 18. On 04/09/24, R30 was assessed on readmission as high risk for falls with a score of 19. On 04/14/24, R30 was assessed post fall as a high risk for falls with a score of 10. On 04/22/24, R30 was assessed post fall as high risk for falls with a score of 26. On 04/23/24, R30 was assessed as a high risk for falls with a score of 21. On 05/02/24, R30 was assessed post fall as a high risk of falls with a score of 21. On 05/06/24, R30 was assessed on admission as high risk of falls with a score of 21. On 05/26/24, R30 was assessed post fall as a high risk of falls with a score of 30. Review of fall reports 01/01/24 to 05/30/24 revealed the following information: On 02/03/24, R30 fell and sustained a minor injury. The facility determined that the root cause was that R30 had weakness and fatigue from an infection. On 04/04/24, R30 fell and sustained skin tears to the right elbow and a right hip fracture that required hospitalization and surgical repair. On 04/14/24, R30 fell without injury. On 04/21/24, R30 fell without injury. On 04/22/24, R30 fell without injury. On 04/23/24, R30 fell . The facility's fall report lacked documentation of whether or not the resident sustained an injury. On 05/02/24, R30 fell . The immediate intervention implemented by staff was for staff to perform more frequent visual checks after resident is laid down. On 05/26/24, R30 fell . The Progress Notes documented the following: On 02/03/24 at 09:45 AM, R30 was found on the floor with a skin tear to his left forearm. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/04/24 at 02:45 PM, R30 was sent to the hospital by ambulance for a possible right hip fracture, and lacked additional documentation related to the fall or any injuries. On 04/08/24 at 10:58 PM, R30 was being readmitted to the facility from the hospital after surgical stabilization of a right hip fracture. On 04/14/24 at 05:00 PM, R30 was found on the floor in the dining room with no documented injuries. Lacked documentation related to the fall on 04/21/24. On 04/22/24 at 01:25 AM, R30 was found on the floor in the dining room with no injuries. On 04/23/24 at 03:14 AM, R30 was found on the floor by his bed with skin tears to both elbows. On 05/02/24 at 06:32 AM, R30 was found seated on the floor in his room and cried out with pain when staff attempted to assist him off the floor and resident complained of isolated pain to the left leg. On 05/02/24 at 07:04 AM, R30 transferred to the hospital via ambulance for further assessment of the left hip. On 05/06/24 at 03:06 PM, R30 was being readmitted to the facility from the hospital with surgical incisions present on left hip. On 05/26/24 at 12:09 PM, R30 was found on the floor by another (unnamed) resident with skin tears on the right lower leg and left upper arm and the provider ordered an x-ray (an imaging study that takes pictures of bones and soft tissues) of the left hip. On 05/26/24 at 12:19 PM, facility staff documented the results of the x-ray of a possible nondisplaced fracture, and the physician recommended follow-up appointment with surgeon who repaired the hip following the fall on 05/02/24. On 05/30/24 at 11:00 AM Administrative Nurse E reported she was unaware of what needed to be included in the CAA and that the CAA was to be used to generate the care plan process. She reported did not spend much time with the development of the CAA. On 05/30/24 at 01:00 PM, Administrative Nurse B verified the CAA should be documented in detail for the causal factors that would create the resident's care plan and acknowledged the CAAs lacked crucial information regarding the resident's condition to develop the plan of care. A facility policy was requested regarding the CAA and MDS. The facility would utilize the Resident Assessment Instrument (RAI) manual for the CAA process. The facility failed to accurately reflect the resident's status, related to fall and accident hazards on the CAA analysis. This deficient practice led to uncommunicated care needs which negatively impacted the physical, mental and psychosocial well-being of R30. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	50659 - Resident (R)39's Electronic Health Record (EHR) revealed diagnoses that included metabolic encephalopathy (broad term for any brain disease that alters brain function or structure), post-traumatic stress disorder (PTSD a mental health condition that develops following a traumatic event characterized by intrusive thoughts about the incident, recurrent distress/anxiety, flashback and avoidance of similar situations) and dementia adjustment disorder (progressive mental disorder characterized by failing memory, confusion). The Admission Minimum Data Set (MDS) dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 10, which indicated moderately impaired cognition. The resident had no signs or symptoms of delirium or depression. R39's behaviors put others at significant risk of physical injury. The resident wandered one to three days of the lookback period and put the resident at significant risk of getting to a potentially dangerous place. Wandered significantly and intruded on the privacy or activities of others. R39's antidepressant medications were not captured. The Quarterly MDS dated [DATE], documented a BIMS score of 08, which indicated moderately impaired cognition. R39 reported feeling lonely or isolated from those around him rarely. R39 had non-Alzheimer's dementia, depression, and post-traumatic stress disorder. R39 received scheduled antidepressant (class of medications used to treat mood disorders) and antianxiety (class of medications that calm and relax people) medications. Review of the 11/20/23 Care Area Assessments (CAA) lacked any indication the resident had physician ordered antidepressant medications. The care plan, dated 05/29/24, lacked guidance to address the resident's antidepressant medications. The care plan further failed to address the resident's adjustment difficulties and/or history of trauma. The care plan lacked any description of the resident's indications of distress and/or interventions intended to assist the resident to reach and maintain his highest level of mental and psychosocial wellbeing. The Physician's Order dated 05/29/24, documented: Citalopram Hydrobromide (Celexa) (an antidepressant), 1 tablet, by mouth, one time a day, related to PTSD, ordered on 11/15/2023. Mirtazapine (antidepressant), 1 tablet, by mouth, one time a day, related to PTSD, ordered on 11/15/2023. Target Behavior for Celexa use, monitor for tearfulness or crying every day and night shift for behavior monitoring. Note number of episodes of target behavior and redirection code: 0=did not occur; 1=easily altered; 2=difficult to redirect ordered on 11/16/23. Target Behavior for Mirtazapine, use monitor for tearfulness, crying out, withdrawn, or repetitive statements every day and night shift for behavior monitoring. Note number of episodes of target behavior and redirection code: 0=did not occur; 1=easily altered; 2=difficult to redirect ordered on 11/16/2023. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Behaviors - monitor for the following: up to/including itching, picking at skin, restlessness (agitation), hitting, increase in complaints, biting, kicking, spitting, cussing, racial slurs, elopement, stealing, delusions, hallucinations, psychosis, aggression, refusing care. Document: 'n' if monitored and none of the above observed. 'Y' if monitored and any of the above was observed, select chart code 'other/ see nurses notes' and progress note findings every day and night shift for psychotropic use make progress note of any behaviors ordered 12/12/23. Please follow up with Physician Extender V to related to depression ordered on 12/28/23. Buspirone (antianxiety medication), 5 milligrams, 1 tablet, by mouth, two times a day, related to depression, ordered on 02/08/24. Review of Progress Notes dated, 11/15/23 through 05/28/24 documented the following: On 11/15/2023 at 10:30 PM, R39 was very confused with his new surroundings. R39 was exit seeking and pushed on the hall doors until they opened. Staff monitored and redirected R39. On 11/16/2023 at 04:53 PM, R3 had shown exit seeking behaviors. R39 continued to wander throughout the facility and pushed on several exit doors. Redirected as needed. Staff placed a wander guard (bracelet that sets off an alarm when residents wearing one attempt to exit the building without an escort) on his right wrist. On 12/01/2023 at 01:21 PM, R39 was seen in house Physician Extender V on 11/30/23 and no new orders received. On 01/09/2024 at 01:28 PM, R39 seen in house by Consultant Staff T and reported R39's PTSD was a real problem. On 05/30/24 at 10:10 AM, Administrative Nurse E stated R39 did not have his antidepressant medications on the 11/20/23 MDS in section N addressed. Stated that she was not the nurse that completed the MDS. Administrative Nurse E agreed that the medications should have been answered yes on the MDS. On 05/30/24, Administrative Nurse E stated that the RAI manual is used as their policy. The facility failed to accurately complete the MDS for R39 related to antidepressant medications. This practice had the potential to lead to negative psychosocial effects related to safety and uncommunicated needs.

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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 identified a census of 43 residents which included 15 residents sampled and reviewed for care plan development. Based on interview, observations and record review, the facility failed to develop a comprehensive person-centered care plan for seven residents, Resident (R)32's care plan lacked interventions related to hemodialysis (a procedure where impurities or wastes were removed from the blood) and insulin use related to diabetes mellitus (DM - when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), R1's care plan lacked interventions related to hospice or end-of-life care, R39's care plan lacked interventions related to PTSD (posttraumatic stress disorder - a mental disorder characterized by an acute emotional response to a traumatic event or situation involving severe environmental stress), R22's care plan lacked interventions related to aggressive behaviors which involved resident-to-resident abuse, R26, R30, and R3's care plans lacked interventions related to care and treatment of pressure ulcer/injury. This deficient practice had the potential to lead to uncommunicated needs which could lead to negative impacts on the resident's physical, mental and psychosocial well-being.

Findings included:

-R32's Electronic Health Record (EHR) included diagnoses of diabetes mellitus type 2 (DM2- when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), anemia (a condition without enough healthy red blood cells to carry adequate oxygen to body tissues), stage four chronic kidney disease (CKD - a disease characterized by progressive damage and loss of function in the kidneys) and end-stage renal disease (ESRD-a terminal disease of the kidneys).

The Admission Minimum Data Set (MDS), dated [DATE], documented a Brief Interview of Mental Status (BIMS) score of 14 which indicated intact cognition. The resident received insulin daily during the seven-day look-back period and received dialysis.

The Care Area Assessment (CAA), dated 04/05/24, lacked documentation related to insulin use or dialysis.

The 05/29/24 Care Plan lacked documentation related to insulin use, dialysis, or care of the resident's implanted dialysis catheter.

The Physician's Orders documented the following:

On 05/11/24 at 08:00 AM, Dialysis every Tuesday, Thursday and Saturday leave the facility at 09:00 AM.

On 04/16/24 at 04:00 PM, prostat (a nutritional supplement shake) 30 milliliters (mL) to be given orally two times a day related to low albumin (amount of protein in the blood) levels and once per day to be given orally after dialysis, on dialysis days.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/03/24 at 06:00 PM, staff to chart the amount of fluid removed from resident while at dialysis, one time per day on Tuesday, Thursday and Saturday following dialysis related to dialysis management. On 04/03/24 at 06:00 PM, staff to check dialysis catheter (a hollow flexible tube inserted into the body) every shift for monitoring of [dialysis] port. On 03/29/24 at 05:00 PM, Insulin Lispro solution 100 unit/mL, inject per sliding scale: if [blood sugar is between] 150-199 [milligrams/deciliter {mg/dL}] give one unit, if [blood sugar is between] 200-249 mg/dL give three units, if [blood sugar is between] 250-299 mg/dL give five units, if [blood sugar is between] 300-349 mg/dL give seven units, subcutaneously (SQ) four times per day (QID), before meals (ac) and at bedtime (hs) related to DM2, and if [blood sugar is] greater than 349 mg/dL to call the provider for guidance. On 03/29/24 at 08:00 PM, Insulin Glargine Solution 100 unit/mL, inject eight units daily at bedtime related to DM2. The 03/29/24 to 05/30/24 Medication Administration Record (MAR) and Treatment Administration Record (TAR) reviewed and staff documented administration of medications, blood sugar checks within parameters and monitoring of implanted dialysis catheter every shift. On 06/03/24 at 08:55 AM Certified Nurse Aide (CNA) J stated that R32 had an implanted dialysis port to the right side of his chest and that CNA staff had been instructed to ensure that it is covered and remained dry during bathing. If bleeding were to occur around the catheter site, CNAs were to inform nursing staff immediately. On 06/03/24 at 09:03 AM, Licensed Nurse (LN) H stated that R32 had an implanted dialysis port to the right side of his chest and stated that nursing staff assessed the port every shift and if the assessment found anything wrong that staff were to call the physician for further instructions. On 06/03/24 at 08:50 AM Administrative Nurse E confirmed R32's care plan lacked instructions related to dialysis or insulin administration and that these items needed to be added. On 06/03/24 at 08:58 AM, Administrative Nurse B stated that her expectation was that all treatments and modalities of care provided to the residents should be documented on the care plan. Stated was unable to give an explanation as to why the care plan was missing information. The facility's Care Planning - Interdisciplinary Team (IDT - a team of facility staff consisting of members of various departments including but not limited to; dietary, nursing, maintenance, therapy, etc.) policy dated 10/2021 documented that the facility's IDT team was responsible for the development of an individualized comprehensive care plan for each resident within seven days of the completion of the MDS. The facility failed to develop a comprehensive person-centered care plan for R32 related to hemodialysis or insulin use related to DM2. These deficient practices had the potential to lead to uncommunicated needs that would negatively affect the physical, mental and psychosocial well-being of R32. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- R26's Electronic Health Record (EHR) included diagnoses of diabetes mellitus type 2 (DM2- when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), unsteadiness on feet, need for assistance with personal cares and hemiplegia (paralysis of one side of the body). The Admission Minimum Data Set (MDS), dated [DATE], documented a Brief Interview of Mental Status (BIMS) score of 15 which indicated intact cognition. The assessment documented that R26 had an unstageable pressure ulcer/injury present on admission with pressure relieving devices on his bed and on his chair/wheelchair. The Care Area Assessment (CAA), dated 09/02/23, documented that R26 was admitted to the facility with a wound on his bottom and was referred to wound team for evaluation and treatment. The Quarterly MDS, dated [DATE] documented a BIMS of 14, which indicated intact cognition. The assessment documented that R26 did not have a pressure ulcer/injury and was not assessed for risk of pressure ulcer/injury and did not have devices on his bed or chair/wheelchair. The 05/29/24 Care Plan lacked documentation related to pressure ulcer/injury prevention or interventions for wound healing. The Physician's Orders documented the following: On 05/08/24 at 01:00 PM, nursing to cleanse the right buttock wound with hypochlorous acid, apply collagen powder, 1 gram (gm) to the base of the wound and cover with a bordered foam dressing every Tuesday, Thursday and Saturday and as needed (PRN) for wound healing. The 03/01/24 to 05/29/24 Medication Administration Record (MAR) and Treatment Administration Record (TAR) reviewed, and staff documented administration of medications, and cleaning of wounds as ordered. On 05/30/24 at 09:20 AM, Certified Nurse Aide (CNA) M stated R26 should be turned, and his brief checked every two hours. R26 will refuse to get out of his bed except for maybe one meal per day. R26 was not always compliant with allowing staff to turn him. On 06/03/24 at 08:50 AM, Licensed Nurse (LN) H stated R26 had declined to allow surveyor to observe dressing change to his buttock so she had already performed the task. On 06/03/24 at 08:50 AM Administrative Nurse E confirmed R26's care plan lacked instructions related pressure ulcer/injury prevention and wound care and these items needed to be added. On 06/03/24 at 08:58 AM, Administrative Nurse B stated that her expectation was that all treatments and modalities of care provided to the residents should be documented on the care plan. Administrative Nurse B was unable to give an explanation as to why the care plan was missing information. (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 Care Planning - Interdisciplinary Team (IDT - a team of facility staff consisting of members of various departments including but not limited to; dietary, nursing, maintenance, therapy, etc.) policy dated 10/2021 documented that the facility's IDT team was responsible for the development of an individualized comprehensive care plan for each resident within seven days of the completion of the MDS. The facility failed to develop a comprehensive person-centered care plan for R26 related to pressure ulcer/injury prevention and wound care. These deficient practices had the potential to lead to uncommunicated needs that would negatively affect the physical, mental, and psychosocial well-being of R26. 31078 - R1's electronic medical record (EMR) revealed the following diagnoses that included chronic atrial fibrillation (rapid, irregular heart beat), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), violent behavior, major depressive disorder (major mood disorder which causes persistent feelings pf sadness), intermittent explosive disorder, delusional disorder (untrue persistent belief or perception held by a person although evidence shows it was untrue) personality disorder. The Admission Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 06, indicating severe cognitive impairment. The resident was dependent on staff for assistance of mobility requiring the use of a wheelchair or walker. The resident received pain medication on schedule, had weight loss and received hospice care (designed for people with an anticipated life expectancy of six months or less). Medications included antipsychotic (class of medications used to treat major mental conditions which cause a break from reality), anticoagulant (blood thinner), insulin, antianxiety (class of medications that calm and relax people), and antidepressant (class of medications used to treat mood disorders). The quarterly MDS, dated [DATE] revealed no significant changes in status from the previous MDS. The Care Area Assessment (CAA) dated 02/05/24 revealed the following: The Cognitive loss/Dementia CAA, documented R1's care plan would reflect his cognitive loss related to dementia and his goal of avoiding complications. The Psychotropic Drug Use CAA documented R1 was at risk for adverse effects related to high-risk medication use, however the CAA lacked the assessment to accurately reflect the resident's status. The CAA lacked documentation related to R1 hospice services. R 1's Care Plan dated 12/31/2023 revealed R1 received medications with black box warnings (BBW is the highest safety-related warning that medications can have assigned by the Food and Drug Administration). R1 admitted to hospice services on 01/26/2024 for cachexia (a disorder that causes weight loss and muscle loss). A revision to the care plan dated 05/01/24, included the resident was a Do Not Resuscitate (DNR) (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 05/28/24 at 10:30 AM revealed the resident in his room visiting with another resident from across the room. On 05/30/24 at 10:45 AM, Licensed Nurse (LN) D reported the resident received hospice. The hospice nurse visited once a week. The resident had behaviors but were usually controlled with medication. On 05/30/24 at 09:50 AM, Administrative Nurse E stated that the nurses on the clinical floor had the ability to make additions to the care plan. If they were not able to develop a care plan intervention after a change or addition was needed, they should notify administration who would then create a care plan intervention. On 06/03/24 at 08:58 AM, Administrative Nurse B stated that her expectation was that all treatments and modalities of care provided to the residents should be documented on the care plan. Stated was unable to give an explanation as to why the care plan was missing information. The facility's Care Planning - Interdisciplinary Team (IDT - a team of facility staff consisting of members of various departments including but not limited to; dietary, nursing, maintenance, therapy, etc.) policy dated 10/2021 documented that the facility's IDT team was responsible for the development of an individualized comprehensive care plan for each resident within seven days of the completion of the MDS. The facility failed to develop a comprehensive person-centered care plan for R1 when the care plan lacked interventions related to hospice or end-of-life care. This deficient practice had the potential to lead to uncommunicated needs which would negatively affect the physical, mental, and psychosocial well-being of R1. 50659 - Resident (R) 3's Electronic Health Record (EHR) revealed diagnoses that included a pressure ulcer of right heel stage three (full thickness pressure injury extending through the skin into the tissue below), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made, or the body cannot respond to the insulin) and muscle weakness. The Admission Minimum Data Set (MDS) dated [DATE], documented a Brief Interview for Mental Status (BIMS) of 15, indicating intact cognition. R3 required maximal assistance with activities of daily living (ADL's lower dressing). Total dependence for transfers and toileting. Partial to moderate assistance with wheelchair mobility, bed mobility, personal hygiene, bathing, and upper body dressing. R3 was incontinent of bowel and bladder. The Quarterly MDS dated [DATE], documented a BIMS of 15. No changes in ADL's. The Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) dated 01/02/24, documented the resident required assistance with functional abilities related to acquired loss of the lower limb. The Urinary Incontinence CAA dated 01/02/24, documented R3 had an actual problem of incontinence related to an overactive bladder and urge incontinence. (continued on next page)

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Pressure Ulcer CAA dated 01/02/24, documented the resident had a potential problem of developing pressure ulcer/injury related to incontinence and required maximal assist for transfers. R3's care plan would reflect her risk of pressure ulcer/injury as well as her goal of minimizing risks and avoiding complications. The review of the Care Plan reviewed on 05/29/24, lacked documentation and interventions of a pressure ulcer on R3's right heel stage three. The Physician's Order dated 05/29/24, documented the following: Prevalon boots (have a cushioned bottom that floats the heel off the surface of the mattress, helping to reduce pressure), ensure the heel is free of the surface of the bed by use of Prevalon boots, with pillows under the knees to prevent hyperextension. Apply every day and every night for wound care, ordered on 01/23/24. Right heel Felt pad, cut-to-fit peri wound (skin surrounding the wound) to offload pressure from the wound. Felt pad when ambulating with Physical therapy every 24 hours as needed for ambulating with physical therapy, ordered on 05/10/24. Right lateral heel to be cleansed with normal saline, apply hydrofera blue (a type of moist wound dressing which provides wound protection and addresses bacteria and yeast) to the wound bed, cut to fit, apply border foam, medipore tape every day shift every other day, for wound care. Assess pulse, if unable to palpate use doppler (ultrasonography used to evaluate the direction and pattern of blood flow) and every 24 hours as needed if soiled or dislodged, ordered on 05/21/24. Review of the Progress Notes from 12/26/23 to 05/28/24 documented the following: On 01/23/2024 at 10:30 AM, noted right lateral heel had a deep tissue pressure ulcer (DTI- purple or maroon localized area of discolored intact skin or blood?filled blister due to damage of underlying soft tissue from pressure and/or shear), non-blanchable (skin that does not turn white when pressed, indicating poor blood flow or damage), deep red, maroon or purple discoloration. On 2/2/2024 at 10:09 AM, R3's right lateral heel had a DTI non-blanchable, deep red, maroon or purple discoloration. The wound margin undefined. The wound bed has 76-100 percent (%) epithelialization (the process of becoming covered with or converted to epithelium). The wound had improved. On 04/19/24 at 01:20 PM, documentation revealed the right lateral (away from the mid-line) heel pressure ulcer stage three, with full thickness skin loss. On 5/22/2024 at 12:03 PM, the right lateral heel pressure ulcer stage three, improved. On 05/28/24 at 10:02 AM, R3 stated that she received a pressure ulcer on her right heel after being admitted to the facility. R3 stated it appeared a couple of weeks. R3 stated she was provided with a heel boot to wear in bed, a trapeze on the bed, had appointments at a wound clinic and the facility by a wound nurse provided treatments. (continued on next page)

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Clearwater Nursing & Rehabilitation Center	620 E Wood Street Clearwater, KS 67026

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/30/24 at 10:10 AM, Administrative Nurse E stated R3 did not have a care plan for stage three pressure ulcer or any skin interventions on the care plan. Stated that the Director of Nursing completed the weekly skin rounds and assumed that she would add that to the care plan. Administrative Nurse E stated R3's care plan was incomplete as the ADL section did not have staff instructions on how to provide ADL and agreed care plan intervention section had the word specify in that area of care plan. Administrative Nurse E stated that she and other staff members received education by Consultant Staff S in April and May of 2024. Administrative Nurse E stated Consultant Staff S was not happy how the care plans looked and that everyone needed to complete their parts of the care plan. Administrative Nurse E agreed R3 had a care plan meeting she attended on 03/20/24 and did not notice the care plan was not completed. On 05/30/24 at 01:00 PM, Administrative Nurse B reported there needed to be more detail on care plans that were lacking crucial information regarding the resident condition and the plan to care to care for the resident. She expected the care plans to be accurate and updated as needed. The facility's policy for Care Planning - Interdisciplinary Team, dated October 2021 documented: Our facility's care planning/interdisciplinary team is responsible for development of an individualized comprehensive care plan for each resident. The facility failed to develop a comprehensive, individualized care plan for R3's pressure ulcer, which placed R3 at risk to receive inadequate care and services related to her pressure ulcer. - Resident (R)39's Electronic Health Record (EHR) revealed diagnoses that included metabolic encephalopathy (broad term for any brain disease that alters brain function or structure), post-traumatic stress disorder (PTSD a mental health condition that develops following a traumatic event characterized by intrusive thoughts about the incident, recurrent distress/anxiety, flashback and avoidance of similar situations) and dementia adjustment disorder (progressive mental disorder characterized by failing memory, confusion). The Admission Minimum Data Set (MDS) dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 10, which indicated moderately impaired cognition. The resident had no signs or symptoms of delirium or depression. R39's behaviors put others at significant risk of physical injury. The resident wandered one to three days of the lookback period and put the resident at significant risk of getting to a potentially dangerous place. Wandered significantly and intruded on the privacy or activities of others. R39's preferences were Not assessed. The Quarterly MDS dated [DATE], documented a BIMS score of 08, which indicated moderately impaired cognition. R39 reported feeling lonely or isolated from those around him rarely. R39 had non-Alzheimer's dementia, depression, and post-traumatic stress disorder. R39 received scheduled antidepressant (class of medications used to treat mood disorders) and antianxiety (class of medications that calm and relax people) medications. Review of the 11/20/23 Care Area Assessments (CAA) lacked any indication the resident had a diagnosis of PTSD and/or any indication staff would proceed to care plan interventions related to the resident's PTSD diagnosis. (continued on next page)

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F 0656

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

The care plan, dated 05/29/24, lacked guidance to address the resident's PTSD. The care plan further failed to address the resident's adjustment difficulties and/or history of trauma. The care plan lacked any description of the resident's indications of distress and/or interventions intended to assist the resident to reach and maintain his highest level of mental and psychosocial wellbeing.

The Physician's Order dated 05/29/24, documented:

Citalopram Hydrobromide (Celexa) (an antidepressant), 1 tablet, by mouth, one time a day, related to PTSD, ordered on 11/15/2023.

Mirtazapine (antidepressant), 1 tablet, by mouth, one time a day, related to PTSD, ordered on 11/15/2023.

Target Behavior for Celexa use, monitor for tearfulness or crying every day and night shift for behavior monitoring. Note number of episodes of target behavior and redirection code: 0=did not occur; 1=easily altered; 2=difficult to redirect ordered on 11/16/23.

Target Behavior for Mirtazapine, use monitor for tearfulness, crying out, withdrawn, or repetitive statements every day and night shift for behavior monitoring. Note number of episodes of target behavior and redirection code: 0=did not occur; 1=easily altered; 2=difficult to redirect ordered on 11/16/2023.

Behaviors - monitor for the following: up to/including itching, picking at skin, restlessness (agitation), hitting, increase in complaints, biting, kicking, spitting, cussing, racial slurs, elopement, stealing, delusions, hallucinations, psychosis, aggression, refusing care. Document: 'n' if monitored and none of the above observed. 'Y' if monitored and any of the above was observed, select chart code 'other/ see nurses notes' and progress note findings every day and night shift for psychotropic use make progress note of any behaviors ordered 12/12/23.

Please follow up with Physician Extender V to related to depression ordered on 12/28/23.

Buspirone (antianxiety medication), 5 milligrams, 1 tablet, by mouth, two times a day, related to depression, ordered on 02/08/24.

Review of the 11/15/23 Trauma Assessment revealed the resident had military related trauma. The assessment instructed the reader not to walk up behind the patient if he did not know you were there and to use a walking approach.

Review of Progress Notes dated, 11/15/23 through 05/28/24 documented the following:

On 11/15/2023 at 10:30 PM, R39 was very confused with his new surroundings. R39 was exit seeking and pushed on the hall doors until they opened. Staff monitored and redirected R39.

On 11/16/2023 at 04:53 PM, R3 had shown exit seeking behaviors. R39 continued to wander throughout the facility and pushed on several exit doors. Redirected as needed. Staff placed a wander guard (bracelet that sets off an alarm when residents wearing one attempt to exit the building without an escort) on his right wrist.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/01/2023 at 01:21 PM, R39 was seen in house Physician Extender V on 11/30/23 and no new orders received. On 01/09/2024 at 01:28 PM, R39 seen in house by Consultant Staff T and reported R39's PTSD was a real problem. On 01/08/24 Social Services Notes uploaded in EHR revealed the Consultant Staff T visited the resident. During the visit the resident stated he was just here and that his life was very dull and without any meaning. The note further stated the resident's PTSD was a real problem and that medication may be the only way to help ease the resident's mental stress. On 05/30/24 at 12:30 PM, Social Services Designee (SSD) U stated could not find the intervention for not walking behind the resident and walking approach on the care plan for the staff to know how to approach the resident. SSD U reviewed the care plan on her computer and stated that her care plan could not bring up the entire care plan as it was being slow. SSD U was shown the care plan on another computer and asked her if she saw it on that care plan. SSD U stated she will go speak to Administrative Nurse E about why the care plan is not showing on her computer. Stated she would print off a copy and deliver it. At 02:00 PM, SSD U brought a copy of what was added to Point of Care Tasks on 05/30/24. Approach face to face to prevent further agitation or any triggers. SSD U stated that is now on the tasks for staff. On 05/30/24 at 12:55 PM, Licensed Nurse (LN) D stated that she was not aware to not approach R39 from the back. LN D stated that she was not sure that he had PTSD as a diagnosis. LN D reported if it gets busy in the dining room, staff redirect R39 out of the dining room. On 05/30/24 at 01:00 PM, Certified Nurse Aide (CNA) C stated was not aware that R39 had PTSD and did not know how to approach the resident. CNA C reviewed computer screen on point click care agreed the EHR lacked any direction on how to approach R39. On 05/30/24 at 01:00 PM, Administrative Nurse B reported there needed to be more detail on care plans, because the care plans lacked crucial information regarding the resident's condition and the plan to care to care for the resident. She expected the care plans to be accurate and updated as needed. On 05/30/24 at 01:55 PM, CNA F stated the nurses tell staff in verbal report if there is a change in the care plan, and there was a care plan book on the desk with changes. CNA C was unable to locate the book. CNA C pulled a copy of what he took from the book yesterday a dated 05/24/24. The forms showed a list of all the residents and what type of cares that needed provided. CNA C called it a cheat sheet and stated still needed to look up tasks on point of care to make sure the cheat sheets were correct. CNA C stated he was not aware R39 had PTSD and was not aware how to approach the resident and stated that was not on his cheat sheet. The facility's policy for Care Planning - Interdisciplinary Team, dated October 2021 documented the facility's care planning/interdisciplinary team is responsible for development of an individualized comprehensive care plan for each resident. The facility failed to develop a comprehensive, individualized care plan for R39's PTSD, which placed R39 at risk to receive inadequate care and services related to his PTSD. (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 Electronic Health Record (EHR) revealed diagnoses included vascular dementia (a progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain), major depressive disorder (major mood disorder which causes persistent feelings pf sadness) and senile degeneration of brain. The Significant Change Minimum Data Set (MDS) dated [DATE], documented R22 had severely impaired cognition. R22 required total assistance with activities of daily living (ADL) cares such as oral care, toileting, footwear and personal hygiene; required maximal assistance with dressing, eating, and bathing; and was independent with ambulation. R16 was always incontinent of bladder and bowel. The Quarterly MDS dated [DATE], documented R22 had severely impaired cognition. R22 had physical behavioral symptoms directed toward others. R22 was independent with ambulation. The Cognitive Loss/Dementia CAA dated 02/16/24, documented R22 had an actual problem of cognition loss related to dementia. The Behavioral CAA dated 02/16/24, documented R22 had an actual problem with behavioral symptoms related to wandering. The 05/28/24 Care Plan dated 05/26/23, revised on 12/29/23, documented R22 had impaired cognitive function, dementia, or impaired thought processes. Staff instructed to provide a homelike environment and noted R22 liked to carry a baby doll to bring comfort. The care plan lacked interventions for staff related to resident-to-resident altercations. The Physician's Order dated 05/28/24, included the following orders: Divalproex (medication used to treat bipolar disorder [major mental illness that caused people to have episodes of severe high and low moods]) use and staff were to monitor for tearfulness or crying, aggression, agitation as well as adverse effects every day and night. The staff were to note the number of episodes of target behavior and a redirection code: 0=did not occur; 1=easily altered; 2=difficult to redirect, ordered 12/24/22. Trazodone HCl (antidepressant medication), 50 milligrams (mg), give 1 tablet by mouth at bedtime, related to unspecified dementia, ordered 06/22/23. Divalproex Sodium Delayed Release Sprinkle, 125 mg, give 250 mg by mouth, three times a day, related to major depressive disorder, ordered 03/08/24. Ativan (antianxiety medication) use, and staff were to monitor the resident for anxiety and anger every day and night shift for behavior monitoring. The staff were to note the number of episodes of target behavior and a redirection code: 0=did not occur; 1=easily altered; 2=difficult to redirect, ordered 04/04/24. Ativan, 0.5 milligram (mg), give 0.5 mg by mouth, every four hours as needed, for anxiety/restlessness related to terminal diagnosis, end of life for six months, ordered 04/25/24. Review of the Progress Notes from 12/01/24 to 05/28/24 documented the following resident-to-resident concerns: (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 03/04/24 behavior note at 07:00 PM revealed the dayshift nurse reported R22 sat at the nurse's station and got up to go to his room and his roommate told him to stop and when R22 and the nurse aide walked by him, R22 grabbed his roommate's shoulder and pulled him back toward him. The residents were separated. On 05/12/24 at 04:45 PM, R22 punched R17 in the jaw. [R17 had impaired cognition per the 03/14/24 MDS.] On 05/20/24 at 03:38 PM, R22 raised his closed fist to R2 and made contact with their face. On 05/28/24 at 12:11 PM, R22's family member reported the resident had a resident-to-resident altercation on 05/20/24, and the family member stated the facility did not notify the family they placed R22 on one-on-one. [R2 had impaired cognition per the 02/23/24 MDS.] On 05/28/24 at 11:40 AM, R22 ambulated in hallway with family member. R22 held a baby doll in his arms and had smiled. On 05/29/24 at 01:11 PM, R22 in dining seated in chair with a glass of lemonade in front him. Certified Nurse Aide (CNA) F stood behind R22's chair. On 05/28/24 at 02:57 PM, Certified Nurse Aide (CNA) C stated R22 is aggressive and would hit other residents and staff. CNA C stated she redirected R22 away from others if R22 was in a bad mood. CNA C stated R22 would have a mad expression on his face. On 05/30/24 at 10:10 AM, Administrative Nurse E stated R22 did not have a care plan for his resident-to-resident altercations. Administrative Nurse E stated that she and other staff members received education by Consultant Staff S in April and May of 2024. Administrative Nurse E stated Consultant Staff S was not happy how the care plans looked and that everyone needed to complete their parts of the care plan. Administrative Nurse E agreed R3 had a care plan meeting she attended on 03/20/24 and did not notice the care plan was not completed. On 05/30/24 at 01:00 PM, Administrative Nurse B reported there needed to be more detail on care plans that were lacking crucial information regarding the resident condition and the plan to care to care for the resident. She expect [TRUNCATED]

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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 43. The sample included 15 residents. Based on observation, record review, and interviews, the facility failed to revise the fall care plan with interventions for three residents. Resident (R)16, R24 and R30. This deficient practice placed all three residents at risk for impaired ability to achieve and/or maintain their highest practicable level of physical and emotional wellbeing due to uncommunicated care needs. Findings included: - R16's Electronic Health Record (EHR) revealed diagnoses of intermittent explosive disorder, bipolar disorder (major mental illness that caused people to have episodes of severe high and low moods), dementia (progressive mental disorder characterized by failing memory, confusion), and sexual dysfunction. The Significant Change Minimum Data Set (MDS) dated [DATE], documented staff completed an interview to determine the resident's cognition, which indicated he had moderately impaired cognition. No behaviors were noted on the assessment. R16 required extensive assistance with activities of daily living (ADLs - such as bed mobility, toileting, and hygiene) and required limited assist of one with transfers and ambulation. The Quarterly MDS dated [DATE], documented the resident had a BIMS of seven, which indicated moderately impaired cognition. The resident had no behaviors. R16 required maximal to total dependence with ADLs and required set-up assistance for eating. The Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) dated 06/27/23, documented the resident had an increased need for assistance with ADLs. The Cognitive Loss/Dementia CAA dated 06/27/23, documented the resident had a BIMS score of less than 13. The Falls CAA dated 06/27/23, documented Resident takes antianxiety and antidepressant medications on a routine basis. This can pose a risk of adverse side effects. The 05/29/24 Care Plan R16 at risk for falls related to history of falls, and muscle weakness, had interventions dated 02/22/22, staff instructed to: Ensure resident always had appropriate footwear. Resident required prompt response to all requests. The 05/29/24 Care Plan R16 continued to have falls from bed and continued to get up on his own related to cognition, had an intervention dated 07/17/23, staff instructed toilet the resident every two hours. The 05/29/24 Care Plan lacked interventions for falls that occurred on 12/23/23, 01/07/24 and 05/13/24. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Physician Orders reviewed on 05/29/24 lacked any orders regarded to falls. The Progress Notes reviewed from 12/01/23 through 05/29/24 documented: On 12/23/2023 at 06:18 PM, nurse heard a loud crash and discovered R16 on the floor. R16 stated he slipped out of wheelchair. On 01/07/24 at 08:37 PM, staff notified by R16's roommate that R16 fell from wheelchair. R16 found on the floor on left side by sink in room. On 05/13/24 at 10:55 PM, R16 found on floor in room on his back near the bathroom door. Staff educated to assist resident to bed after dinner. The Fall Risk Assessment completed on 12/23/23, identified R16 as a high risk of falls. The Fall Risk Assessment completed on 01/07/24, identified R16 as a high risk of falls. The Fall Risk Assessment completed on 05/14/24, identified R16 as a high risk of falls. On 05/30/24 at 08:28 AM, Licensed Nurse (LN) D stated that she does not update the care plan after an incident occurred. Stated the Assistant Director of Nursing or the Director of Nursing update the care plan interventions. On 05/30/24 at 09:50 AM, Administrative Nurse E stated that after the crisis of a fall was over, the LN on duty would complete the fall packet which included a root cause analysis and would develop an immediate intervention to put in place for the remainder of the shift or until the stand-up meeting on the following business day. Administrative Nurse E further stated that the nurses on the clinical floor had the ability to make additions to the care plan. If they were not able to develop a care plan intervention after a fall, they should write a note on the fall packet submitted to Administrative Nurse E and administration would implement a permanent care plan intervention. On 5/30/24 at 10:10 AM, Administrative Nurse E stated that the falls on 12/23/23, 01/07/24 & 05/13/24 lacked interventions on the care plans for each fall. Administrative Nurse E produced the care plan on EHR and referred to the interventions from 2022. Administrative Nurse E stated that she has not been able to clean up the care plans stated, R16 had outdated interventions. On 06/03/24 at 08:58 AM, Administrative Nurse B stated she expected all care provided to the residents to be documented on the care plan. Administrative Nurse B stated she was unable to give an explanation as to why the care plan was missing information. The facility's Falls and Fall Risk, Managing policy, dated 10/2021, documented staff would identify interventions related to the resident's specific risks and cause based on previous evaluations and current data, to prevent the resident from falling and try to minimize complications from falling. Staff would monitor and document each response to interventions intended to reduce falling and re-evaluate as needed. The facility failed to implement care plan interventions for this resident who had repeated falls. This deficient practice placed this resident at risk for preventable falls and injuries. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	46960 - R30's Electronic Health Record (EHR) included diagnoses of diabetes mellitus type 2 (DM2- when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), metabolic encephalopathy (condition in which brain function is disturbed either temporarily or permanently due to different diseases or toxins in the body), dementia (a progressive mental disorder characterized by failing memory, confusion), repeated falls, pain in [the] left hip (joint that comprises the femur [thigh bone] and pelvis), fracture (broken bone) of left femur, fracture of right femur and need for assistance with personal care. The Annual Minimum Data Set (MDS), dated [DATE], documented a Brief Interview of Mental Status (BIMS) score of seven, which indicated severely impaired cognition. R30 required setup and supervision with all cares with the exception of oral care and bathing, which were dependent on staff for completion, and eating which was performed independently. The assessment documented that R30 had fallen since admission to the facility. The Medicare 5 Day MDS dated [DATE], documented a BIMS score of four, which indicated severely impaired cognition. R30 required substantial/maximal assistance or dependence on staff for all cares. The assessment documented R30 had a fall within the 30-day look-back period, a fracture related to a fall in the six-month look-back period, major surgery in the 100-day look-back period which required skilled nursing facility (SNF - a facility that provides inpatient skilled nursing care to those who need medical, nursing, or rehabilitative services) and a repair of fractures of the hip. The Falls Care Area Assessment (CAA) dated 02/15/24 documented R30 was a high risk of falls related to antidepressant (class of medications used to treat mood disorders and relieve symptoms of depression) and history of falls. The CAA lacked documentation related to an actual fall on 02/03/24. The CAA did not accurately reflect the resident's status related to his falls. The 05/29/24 Care Plan documented on 03/15/22, R30 was a high risk for falls related to lower leg weakness and confusion and included the following: On 03/29/22, staff were to educate the resident/family/caregivers about safety reminders and what to do if a fall occurred. On 03/29/22, staff were to ensure that R30 wore appropriate footwear (shoes or non-slip socks) when ambulating (walking). On 03/29/22, staff were to follow the facility fall protocol. On 03/29/22, staff were to provide a safe environment free from spills or clutter with adequate glare-free light, and a working and reachable call light. Staff were to place the bed in the low position at night and place personal items within reach of the resident. On 05/26/24, staff were to be educated related to the placement of the bedside table when the fall mat was in use. The care plan lacked revisions and updated interventions for the falls on 02/03/24, 04/04/24, 04/14/24, 04/21/24, 04/22/24, 04/23/24 or 05/02/24. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Assessments in the EHR revealed the following: On 10/18/23, R30 assessed as a high risk for falls with a score of 15. On 02/03/24, R30 assessed post (after) fall as low or no risk for falls with a score of six. On 04/04/24, R30 was assessed post fall as high risk for falls with a score of 18. On 04/09/24, R30 was assessed on readmission as high risk for falls with a score of 19. On 04/14/24, R30 was assessed post fall as a high risk for falls with a score of 10. On 04/22/24, R30 was assessed post fall as high risk for falls with a score of 26. On 04/23/24, R30 was assessed as a high risk for falls with a score of 21. On 05/02/24, R30 was assessed post fall as a high risk of falls with a score of 21. Review of fall reports 01/01/24 to 05/30/24 revealed the following information: On 02/03/24, R30 fell and sustained a minor injury. The facility determined that the root cause was that R30 had weakness and fatigue from an infection. On 04/04/24, R30 fell and sustained skin tears to the right elbow and a right hip fracture that required hospitalization and surgical repair. On 04/14/24, R30 fell without injury. On 04/21/24, R30 fell without injury. On 04/22/24, R30 fell without injury. On 04/23/24, R30 fell . The facility's fall report lacked documentation of whether or not the resident sustained an injury. On 05/02/24, R30 fell . The immediate intervention implemented by staff was for staff to perform more frequent visual checks after resident is laid down. The Progress Notes documented the following: On 02/03/24 at 09:45 AM, R30 was found on the floor with a skin tear to his left forearm. On 04/04/24 at 02:45 PM, R30 was sent to the hospital by ambulance for a possible right hip fracture, and lacked additional documentation related to the fall or any injuries. On 04/08/24 at 10:58 PM, R30 was being readmitted to the facility from the hospital after surgical stabilization of a right hip fracture. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Clearwater Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 620 E Wood Street Clearwater, KS 67026	

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/14/24 at 05:00 PM, R30 was found on the floor in the dining room with no documented injuries. Lacked documentation related to the fall on 04/21/24. On 04/22/24 at 01:25 AM, R30 was found on the floor in the dining room with no injuries. On 04/23/24 at 03:14 AM, R30 was found on the floor by his bed with skin tears to both elbows. On 05/02/24 at 06:32 AM, R30 was found seated on the floor in his room and cried out with pain when staff attempted to assist him off the floor and resident complained of isolated pain to the left leg. On 05/02/24 at 07:04 AM, R30 transferred to the hospital via ambulance for further assessment of the left hip. On 05/06/24 at 03:06 PM, R30 was being readmitted to the facility from the hospital with surgical incisions present on left hip. On 05/26/24 at 12:09 PM, R30 was found on the floor by another (unnamed) resident with skin tears on the right lower leg and left upper arm and the provider ordered an x-ray (an imaging study that takes pictures of bones and soft tissues) of the left hip. On 05/26/24 at 12:19 PM, facility staff documented the results of the x-ray of a possible nondisplaced fracture, and the physician recommended follow-up appointment with surgeon who repaired the hip following the fall on 05/02/24. On 06/03/24 at 08:50 AM Administrative Nurse E stated R30's care plan lacked revisions to the care plans. On 06/03/24 at 08:58 AM, Administrative Nurse B stated that her expectation was that all treatments and modalities of care provided to the residents should be documented on the care plan. Stated was unable to give an explanation as to why the care plan was missing information. The facility's Care Planning - Interdisciplinary Team (IDT - a team of facility staff consisting of members of various departments including but not limited to; dietary, nursing, maintenance, therapy, etc.) policy dated 10/2021 documented that the facility's IDT team was responsible for the development of an individualized comprehensive care plan for each resident within seven days of the completion of the MDS. The facility failed to revise R30's comprehensive person-centered care plan to include fall and accident hazards. This deficient practice had the potential to lead to uncommunicated needs that would negatively affect the physical, mental and psychosocial well-being of R30. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Review of R24's Electronic Health Record (EHR) revealed the following diagnoses: senile degeneration of brain, muscle weakness (generalized), other abnormalities of gait and mobility, need for assistance with personal care, cognitive communication deficit, other symptoms and signs involving cognitive functions and awareness, essential (primary), right shoulder, pain in right shoulder, and impulse disorder. Review of the 01/23/24 Significant Change Minimum Data Set (MDS) revealed the resident had a Brief Interview for Mental Status (BIMS) score of three, which indicated significantly impaired cognition. The resident had inattention behavior present, which fluctuated. The resident rejected care and wandered one to three days of the lookback period. The resident's wandering put the resident at risk of getting into a potentially dangerous place and intruded on the privacy or activities of others. The resident had no falls since the last assessment. Review of the Falls Care Area assessment dated [DATE] revealed R24's care plan would reflect his high risk for falls and his goal of minimizing risks. Review of the 04/19/24 Quarterly MDS revealed the resident had a BIMS score of two, which indicated severe cognitive impairment. The resident had rejection of cares, which occurred one to three days of the lookback period. The resident had wandering behaviors, which occurred four to six days of the lookback period. The resident had a fall since entry or the prior assessment. The resident had two or more non-injury falls since admission or prior assessment. Review of the Care Plan started 04/02/24 with a completion date of 04/30/24 revealed the following interventions: On 08/18/20 - Staff were to monitor the resident's vital signs per protocol and take the resident's blood pressure lying/sitting/standing one time within the first 24 hours after the fall. On 08/20/20 - Staff were to know the resident required supervision of one staff for toilet use. On 08/20/20 - Staff were to encourage the resident to participate to the fullest extent possible with each interaction. On 08/20/20 Staff were to encourage the resident to use the call light to call for assistance. On 08/20/20 - Staff would monitor/document/report as needed any changes, any potential for improvement, reasons for self-care deficit, expected course, declines in function. On 06/14/23 - For no apparent acute injury staff were to determine and address causative factors of the fall. On 06/14/23 - Staff were to monitor/document/report as needed for 72 hours to the resident's physician signs/symptoms, which included: bruises, change in mental status, new onset confusion, sleepiness, inability to maintain posture, and agitation. Review of the Fall Risk Assessments in the EHR from 01/02/24 to 05/27/24 revealed the resident had 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	Review of the Interdisciplinary Team Post Fall assessment dated [DATE] at 09:00 PM revealed the resident appeared to be trying to sit at a table in the dining hall on a rolling chair that was located near the resident. Staff would ensure the rolling chairs were removed from the dining hall once the feeders were done eating. Review of the 03/27/24 Fall Report Charting revealed the resident was found on his back, on the floor in dining hall near a rolling chair. It appeared the resident tried to sit at the table on a rolling chair. The resident had no injuries noted at the time of the fall. Review of the resident's Care Plan lacked any interventions that corresponded to the 03/26/24 fall. Review of the Interdisciplinary Team Post Fall assessment dated [DATE] at 08:15 PM revealed the resident was already on fall charting, confused, and hard to re-direct at times. Review of the Nurse's Note dated 03/28/24 at 08:15 PM revealed the resident had a fall. The resident was in a wheelchair and an assessment completed with no injury noticed. The resident could not tell what happened but complained when asked specifically about pain, that his back hurts. Staff were to take the resident to the bathroom and lay him down after dinner. The note lacked any further description of the fall. Review of the resident's Care Plan lacked any interventions that corresponded to the 03/28/24 fall. Review of the Interdisciplinary Team Post Fall assessment dated [DATE] revealed an incomplete assessment. Review of the Nurse's Note dated 04/12/24 at 02:34 PM revealed the nurse writer and the Social Service Designee (SSD) walked down the hallway and saw the resident laying on the floor next to his bed and covered in urine. Review of the resident's Care Plan lacked any interventions that corresponded to the 04/12/24 fall. Review of the Interdisciplinary Team Post Fall assessment dated [DATE] at 11:00 AM revealed the resident removed gripped socks. Review of the Nurse's Note dated 04/15/24 at 11:08 AM revealed staff found the resident in front of the door to his room with his back against his roommate's bed. The resident's legs were in front of him and straight. Staff were to provide more frequent checks to the resident when resting in his room between meals. Review of the resident's Care Plan lacked any interventions that corresponded to the 04/15/24 fall. Review of the Interdisciplinary Team Post Fall assessment dated [DATE] at 05:00 PM revealed the resident stood up and held hands with another resident who was in a wheelchair. The resident lost his balance and fell to the ground. Review of the Nurse's Note dated 04/25/24 at 10:24 AM revealed the resident remained on fall follow up for a witnessed fall. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the undated Certified Nurse Aide (CNA) Fall Investigation revealed staff last saw the resident in the dining room. The resident was having a hard time walking in the morning and during the day. The form asked the CNA what could be done to prevent further falls for the resident and they replied, Do like a balance test. When asked why the resident fell the CNA stated, he was holding hands with another resident and loss his balance The CNA further stated maybe staff could educate the resident and keep him where staff could supervise him all of the time. The resident had on Grip socks at the time of the fall. Review of the resident's Care Plan lacked any interventions that corresponded to the 04/24/24 fall. Review of the Interdisciplinary Team Post Fall assessment dated [DATE] at 04:15 PM revealed the resident had no footwear present and the resident ambulated unassisted. Review of the Nurse's Note dated 05/14/24 at 04:48 PM revealed the resident was on floor in his room, laying behind the door and on his right side. The resident was without clothing at time of fall and found in front of the closet with his clothing on the floor. Staff were educated on frequent rounding when the resident was unattended and resting in his room. Review of the resident's Care Plan revealed an intervention dated 05/14/24 which revealed staff were educated on frequent rounding when the resident was unattended and resting in his room related to impulsive behaviors. Review of the Interdisciplinary Team Post Fall assessment dated [DATE] at 03:45 PM revealed the resident sat near the nurses' station in his wheelchair when he lost his balance and rolled out of the wheelchair as he leaned forward to reach for something. The assessment noted the resident hit his head on the front left side and the resident braced himself with his left arm and shoulder. The resident's EHR lacked any Nurse's Notes regarding the fall dated 05/22/24. Review of the resident's Care Plan lacked any interventions that corresponded to the 05/22/24 fall. Review of the Interdisciplinary Team Post Fall assessment dated [DATE] at 09:57 PM revealed the resident was not wearing appropriate footwear at the time of the fall. The resident was found sitting on the floor and staff were instructed to check on the resident every two hours. Review of the Nurse's Note dated 05/23/24 at 02:11 AM revealed the resident was found on the floor on his bottom with his upper body touching his recliner. Staff were instructed to check on the resident every two hours. Review of the resident's Care Plan lacked any interventions that corresponded to the 05/22/24 fall. On 05/30/24 at 11:14 AM, Licensed Nurse (LN) D stated the LN would fill out the facility fall packet and initiate an immediate intervention for the rest of the shift after a fall and communicate that to the staff on duty. The fall packet was then placed in the folder for Administrative Nurse E for her to review and then make a permanent intervention in the care plan to prevent future falls. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/30/24 at 09:50 AM, Administrative Nurse E stated that after the crisis of a fall was over, the LN on duty would complete the fall packet, which included causal analysis for the fall and they would develop an immediate intervention to put in place for the remainder of the shift or until the stand-up meeting on the following business day. Administrative Nurse E further stated that the nurses on the clinical floor had the ability to make additions to the care plan and if they were not able to develop a care plan intervention after the fall that they should write a note on the fall packet submitted to Administrative Nurse E and administration would implement a permanent care plan intervention. On 06/03/24 at 08:58 AM, Administrative Nurse B stated that her expectation was that all treatments and modalities of care provided to the residents should be documented on the care plan. Stated was unable to give an explanation as to why the care plan was missing information. The facility's Falls and Fall Risk, Managing policy, dated 10/2021 documented that the staff would identify interventions related to the resident's specific risks and caused based on previous evaluations and current data, to prevent the resident from falling and try to minimize complications from falling. Further documented that staff would monitor and document each response to interventions intended to reduce falling and re-evaluate as needed. The facility failed revise R24's care plan with interventions to prevent further falls when he had multiple falls in two months.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31078 The facility reported a census of 43 residents with 15 residents included in the sample. Based on observation, interview, and record review, the facility failed to provide appropriate and timely Activities of Daily Living (ADLs) for one resident regarding untrimmed facial hair for one Resident (R)17. Findings included: - R17's Electronic Medical Record (EMR) revealed diagnoses that included acute and subacute infective endocarditis (inflammation of the muscles of the heart), and dysphagia (swallowing difficulty) following cerebral infarction (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). The Admission Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 08, indicating moderately impaired cognitive impairment. The resident required assistance of one staff with daily cares. The Activities of Daily Living (ADL Functional/ Rehabilitation Care Area Assessment (CAA) dated 06/21/23 revealed R17 had decreased function of ADL's. Assist the resident as needed with ADLs to prevent complications. The Care Plan dated 05/27/23, lacked guidance related to how often R17's preference for removal of facial beard growth. Staff were to bathe/shower the resident bathing/showering two times weekly and as necessary. Review of the shower sheets and the electronic medical records for April and May 2024 lacked documentation for facial shaves. Observation on 05/28/24 at 11:23 AM revealed the resident sat on the side of his bed. R17 was unshaven and had a growth of facial hair stubbles. The resident reported staff had not shaved him for quite some time. He reported staff would sometimes shave him but was not able to remember the last time staff shaved him. Observation on 05/29/24 at 11:56 AM revealed the resident remained unshaved and continued to have facial growth. Observation on 06/03/24 at 09:45 AM revealed the resident continued to be unshaved. R17 reported staff have not shaved him for a long time and he preferred to be shaved because his whiskers bothered him. On 05/28/24 at 11:00 AM, Certified Nursing Assistant (CNA) C reported the resident was to have showers on the night shift. Staff should shave the resident each time he received a shower. On 05/30/24 at 09:40 AM, CNA G reported staff should shave have him twice a week, when staff were to provide him with a shower. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/30/24 at 01:00 PM, Administrative Nurse B reported the resident should be shaved as needed between bathing. She expected the residents be offered shaving when doing morning cares. On 06/03/24 at 09:30 AM, CNA F reported the resident was bathed twice a week and staff should shave him with each bath. On 06/03/24 at 09:30 AM Licensed Nurse (LN) H reported the residents are shaved twice weekly and in between as needed. She was not aware the resident had not been shaved. The facility's policy for Quality of Care revised October 2010, revealed Person- Centered Care and the facility prioritizes individual preferences, choices, and unique needs, promoting a person-centered approach in care planning and care delivery. The facility failed to provide this dependent resident with removal of his facial hair.

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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** 31078 The facility totaled 43 residents, with 15 included in the sample, and one resident reviewed for Hospice care. Based on observation, interview, and record review the facility failed to provide treatment and care in accordance with professional standards with the failure to coordinate resident care with hospice services. Findings included: - R1's electronic medical record (EMR) revealed the following diagnoses that included chronic atrial fibrillation (rapid, irregular heart beat), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and intermittent explosive disorder, delusional disorder (untrue persistent belief or perception held by a person although evidence shows it was untrue) hypertension (elevated blood pressure), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), and hypothyroidism (condition characterized by decreased activity of the thyroid gland). The Admission Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 06, indicating severe cognitive impairment. The resident was dependent on staff for assistance of mobility requiring the use of a wheelchair or walker. The resident received pain medication on schedule, had weight loss and received hospice care (designed for people with an anticipated life expectancy of six months or less). Medications included antipsychotic (class of medications used to treat major mental conditions which cause a break from reality), anticoagulant (blood thinner), insulin, antianxiety (class of medications that calm and relax people), and antidepressant (class of medications used to treat mood disorders). The Quartery MDS, dated [DATE] revealed no significant changes in status from the previous MDS. The Care Area Assessment (CAA) dated 02/05/24 revealed the following: The Cognitive loss/Dementia CAA, documented R1's care plan would reflect his cognitive loss related to dementia and his goal of avoiding complications. The CAA lacked documentation related to R1 hospice services. R1 admitted to hospice services on 01/26/2024 for cachexia (a disorder that causes weight loss and muscle loss). A revision to the care plan dated 05/01/24, included the resident was a Do Not Resuscitate (DNR). The care plan lacked guidance for staff related to hospice. Observation on 05/28/24 at 10:30 AM revealed the resident in his room visiting with another resident from across the room. The resident had no behaviors and exhibited no signs of anxiety or distress. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/28/24 at 01:00 PM, Certified Nurse Aide (CNA) C reported the resident received Hospice services and the home health aide usually came twice a week and would give him a shower on one of those days but did not know what hospice staff did for the resident. On 05/30/24 at 10:45 AM, Licensed Nurse (LN) D reported the resident received hospice services. The hospice nurse came about once a week unless the resident required more visits. On 05/30/24 at 11:00 AM, Administrative Nurse E reported she was unaware of what needed to be included in the care plan and did not know that the CAA was to be used to generate the care plan. She was unaware of the need to coordinate the care between the nursing and hospice care. She thought they both did their own care for the resident. On 05/30/24 at 01:00 PM, Administrative Nurse B reviewed the care plans and verified the care plans lacked crucial information regarding the resident condition and the plan to care for the resident. She expected the care plans to be accurate and updated as needed. The facility did not provide a policy regarding Hospice care, as requested on 05/28/24. The facility failed to provide treatment and care in accordance with professional standards with the failure to ensure the coordinated resident care with hospice services.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37026 The facility census totaled 43 with 15 in the sample and two residents reviewed for pressure injuries. Based on observation, interview, and record review the facility failed to place interventions to prevent pressure injuries (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction) for Resident (R) 30, and R3 who developed preventable, facility acquired, stage 3 (full thickness pressure injury extending through the skin into the tissue below) pressure injuries at the facility, and for R26, related to stage 3 pressure injury. The facility further failed to place interventions on the resident's care plans to prevent worsening of the wounds. Findings included: - Review of R30's Electronic Health Record (EHR) revealed the resident had the following diagnoses: displaced intertrochanteric fracture of left femur (broken left hip), type 2 diabetes mellitus without complications (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), displaced intertrochanteric fracture of right femur (broken right hip), pain in left hip, and weakness. Review of the Annual Minimum Data Set Assessment (MDS) dated [DATE] revealed the resident had a Brief Interview for Mental Status (BIMS) Score of 07, which indicated moderately impaired cognition. The resident required set up or clean up assistance with toileting, personal hygiene, and lower body dressing. The resident was independent with rolling/turning in bed, lying to sitting, and sitting to standing. The resident was always had bladder incontinence and was frequently had bowel incontinence. The resident had no pressure injuries at the time of the assessment. The resident did not have a pressure reducing device for his chair, pressure reducing device for his bed, and was not on a turning/repositioning program. Review of the Pressure Ulcer/Injury Care Area assessment dated [DATE] revealed the resident had a risk for developing pressure injuries related to bowel and bladder incontinence. The resident's care plan would address his incontinence with a goal of avoiding complications. Review of the 5-Day MDS assessment dated [DATE] revealed the resident had a BIMS of 04, which indicated severely impaired cognition. The resident had functional limitation in range of motion on both sides. The resident was dependent on staff for toileting hygiene and lower body dressing. The resident required partial/moderate assistance to roll left and right, to go from sitting to lying, and lying to sitting. The resident required a formal assessment for pressure injury risk and a clinical assessment. The resident had a risk of developing pressure injuries and had no unhealed pressure injuries at the time of the assessment. The resident had surgical wounds and skin tears. He required a pressure reducing device for his chair and bed but was not on a turning/repositioning program. Review of the 04/09/24 and 05/06/24 Braden Scale for Predicting Pressure Ulcer Risk assessments revealed the resident had a risk for pressure ulcer development. Review of the R30's Care Plan revealed the following interventions: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	04/11/24 - Staff were to know the resident had an activity of daily living self-care performance deficit related to dementia. 04/11/24 - Staff were to know the resident had bladder incontinence related to cognitive dysfunction. 04/12/22 - Staff were to know the resident could reposition himself independently in bed. The resident's care plan lacked an update to indicate he required partial/moderate assistance to roll in bed per the 05/10/24 MDS assessment. The resident's care plan lacked any intervention intended to prevent the development of pressure injuries, even though the resident was identified as at risk on 04/09/24 and 05/06/24 and after surgical repair of both left and right femur fractures. Review of Skin Only Evaluations lacked evidence staff performed a full body assessment of the resident's skin. The assessments identified actual wounds, but no other information or description of what areas were reviewed/assessed. Review of the 05/17/24 Skin Only Note lacked any specific assessment of the resident's buttocks. Review of the 05/19/24 at 02:36 PM Skin Only Note revealed the resident had a skin issue to the right buttock, which measured 2.0 centimeters (cm) length (l) by 0.5 cm width (w) by 0.1 cm depth. The resident further had a skin issue to the left buttock, which measured 3.0 cm l by 0.5 cm w by 0.1 cm d. The note lacked any further description of the wound and or notification of the resident's physician. The resident's care plan lacked any interventions related to pressure injuries when the resident developed actual pressure injuries to the left and right buttocks on 05/19/24. Review of the 05/22/24 at 02:31 PM Skin Only Note revealed the resident had a wound to the left buttock, which was identified as a stage 3, full thickness, pressure injury, which measured 1.1 cm l by 0.6 cm w by 0. 1 cm depth. The wound had a moderate amount of drainage noted. The note identified wounds to the resident's right lower extremity and right forearm were resolved but lacked any further documentation of the wound to the resident's right buttock identified on 05/19/24. The resident's care plan lacked any interventions related to pressure injuries when the resident developed actual pressure injuries to the left and right buttocks on 05/19/24. Review of the resident's Physician's Orders revealed an order, which was active on 05/23/24 (one day after the wound to the resident's buttock was identified) for staff to cleanse the resident's left buttock with wound cleanser, apply calcium alginate (highly absorbent dressing) to the wound base (cut to fit inside wound edges), and cover with bordered foam dressing. Review of the resident's Physician's Orders lacked any orders for the resident's right buttock wound. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Clearwater Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 620 E Wood Street Clearwater, KS 67026	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the 05/31/24 at 03:14 PM Skin Only Evaluation revealed the resident had a wound to the left buttock, which was identified with 85 percent slough (dead tissue, usually cream or yellow in color) and 15 percent epithelial (new skin growing in a superficial wound) tissue. The note identified the wound as a stage 3, full thickness, pressure injury, which measured 0.9 cm l by 0.9 cm w. The wound had moderate drainage present. The note lacked any further documentation of the wound to the resident's right buttock identified on 05/19/24. Review of the 05/31/24 Skin Only Evaluation at 11:31 PM lacked any documentation regarding the resident's wound to his buttocks. The resident's care plan lacked any interventions related to pressure injuries when the resident developed actual pressure injuries to the left and right buttocks on 05/19/24. Review of the Skin Observation Task documentation revealed staff marked none of the above present from 05/06/24 to 06/03/24 when asked if the resident had scratches, red areas, discoloration, skin tears, open areas, if the resident refused assessment, and if the resident was not available all but one time on 06/01/24 when the resident was identified with a skin tear. The documentation noted no skin conditions present even though the resident had two documented pressure injuries and multiple skin conditions related to recent falls. Observations on 06/03/24 revealed the following: At 07:35 AM the resident was in bed laying on his back with no pressure reducing measures in place to prevent worsening of his stage 3 pressure injury to the buttocks. At 07:50AM the resident remained in bed and on his buttocks. At 08:05 AM the resident remained on his back and on his buttocks. At 08:20 AM the resident was repositioned in bed and laying on his left side. Observation of Licensed Nurse (LN) H on 06/03/24 at 09:03 AM as she performed wound care revealed she cleansed the wound, placed calcium alginate on wound bed, secured the open area with bordered gauze dressing, and estimated the measurement the wound. At the time of the observation the wound was estimated to measure 3 cm by 0.1 cm by 0.0 cm. The resident's bed lacked an air mattress at the time of the observation. During an interview with Administrative Nurse E on 05/30/24 at 09:50 AM she confirmed the resident's pressure injury and associated interventions were not on the resident's care plan but should have been. During an interview on 05/30/24 at 01:00 PM with Administrative Nurse B she acknowledged the resident's care plan lacked crucial information regarding the resident condition and/or a plan to care to care for the resident. She expected the resident's care plan to be accurate to the resident's needs and updated as needed. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The facility's Pressure Injuries Overview policy, dated 03/2020, documented the purpose of the procedure was to provide information regarding definitions and clinical features of pressure injuries but lacked guidance related to the actual care of pressure related injuries. The facility failed to place interventions to prevent pressure injuries for R30, who developed a preventable, facility acquired, stage 3 pressure injury. The facility further failed to place interventions on the resident's care plan to prevent worsening of the wound. 50659 - Resident (R) 3's Electronic Health Record (EHR) revealed diagnoses that included a pressure ulcer of the right heel stage three (full thickness pressure injury extending through the skin into the tissue below), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made, or the body cannot respond to the insulin) and muscle weakness. The Admission Minimum Data Set (MDS) dated [DATE], documented a Brief Interview for Mental Status (BIMS) of 15, indicating intact cognition. R3 required maximal assistance with activities of daily living (ADL's lower dressing). R3 required total dependence for transfers and toileting. Partial to moderate assistance with wheelchair mobility, bed mobility, personal hygiene, bathing, and upper body dressing. R3 was incontinent of bowel and bladder. R3 was at risk for potential problems of developing pressure ulcer/injuries. The Quarterly MDS dated [DATE], documented a BIMS of 15. No changes in ADL's. The Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) dated 01/02/24, documented the resident required assistance with functional abilities related to acquired loss of the lower limb. The Pressure Ulcer CAA dated 01/02/24, documented the resident had a potential problem of developing pressure ulcer/injury related to incontinence and required maximal assist for transfers. R3's care plan would reflect her risk of pressure ulcer/injury as well as her goal of minimizing risks and avoiding complications. The review of the Care Plan reviewed on 05/29/24, lacked documentation and interventions related to pressure ulcer prevention and/or identifiecation of a facility acquired pressure ulcer on R3's right heel stage three. The Physician's Order dated 05/29/24, documented the following: Prevalon boots (have a cushioned bottom that floats the heel off the surface of the mattress, helping to reduce pressure), ensure the heel is free of the surface of the bed by use of Prevalon boots, with pillows under the knees to prevent hyperextension. Apply every day and every night for wound care, ordered on 01/23/24. Right heel Felt pad, cut-to-fit peri wound (skin surrounding the wound) to offload pressure from the wound. Felt pad when ambulating with Physical therapy every 24 hours as needed for ambulating with physical therapy, ordered on 05/10/24. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Right lateral heel to be cleansed with normal saline, apply hydrofera blue (a type of moist wound dressing which provides wound protection and addresses bacteria and yeast) to the wound bed, cut to fit, apply border foam, medipore tape every day shift every other day, for wound care. Assess pulse, if unable to palpate use doppler (ultrasonography used to evaluate the direction and pattern of blood flow) and every 24 hours as needed if soiled or dislodged, ordered on 05/21/24. Review of the Progress Notes from 12/26/23 to 05/28/24 documented the following: On 01/23/2024 at 10:30 AM, noted the right lateral (away from the mid-line) heel had a deep tissue pressure ulcer (DTI- purple or maroon localized area of discolored intact skin or blood?filled blister due to damage of underlying soft tissue from pressure and/or shear), non-blanchable (skin that does not turn white when pressed, indicating poor blood flow or damage), deep red, maroon or purple discoloration. On 02/02/2024 at 10:09 AM, R3's right lateral heel had a DTI non-blanchable, deep red, maroon or purple discoloration. The wound margin undefined. The wound bed has 76-100 percent (%) epithelialization (the process of becoming covered with or converted to epithelium). The wound had improved. On 04/19/24 at 01:20 PM, documentation revealed the right lateral heel pressure ulcer stage three, with full thickness skin loss. On 05/22/2024 at 12:03 PM, the right lateral heel pressure ulcer stage three, improved. On 05/28/24 at 10:02 AM, R3 stated that she acquired a pressure ulcer on her right heel after being admitted to the facility. R3 stated it appeared a couple of weeks after being admitted . R3 stated she was provided with a heel boot to wear in bed, a trapeze on the bed and an air mattress after she acquired the wound. She stated she had appointments at a wound clinic and at the facility by a wound nurse, they provided treatments for her left leg surgical site that she had when she admitted . On 05/30/24 at 10:10 AM, Administrative Nurse E stated R3 did not have a care plan for stage three pressure ulcer or any skin interventions on the care plan. Stated that the Director of Nursing completed the weekly skin rounds and assumed that she would add that to the care plan. Administrative Nurse E stated R3's care plan was incomplete as the ADL section did not have staff instructions on how to provide ADL and agreed care plan intervention section had the word specify in that area of care plan. Administrative Nurse E stated that she and other staff members received education by Consultant Staff S in April and May of 2024. Administrative Nurse E stated Consultant Staff S was not happy how the care plans looked and that everyone needed to complete their parts of the care plan. Administrative Nurse E agreed R3 had a care plan meeting she attended on 03/20/24 and did not notice the care plan was not completed. On 05/30/24 at 01:00 PM, Administrative Nurse B reported there needed to be more detail on care plans that were lacking crucial information regarding the resident condition and the plan to care for the resident. She expected the care plans to be accurate and updated as needed. The facility's Pressure Injuries Overview policy, dated 03/2020, documented the purpose of the procedure was to provide information regarding definitions and clinical features of pressure injuries but lacked guidance related to the actual care of pressure related injuries. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The facility failed to place interventions to prevent pressure injuries for R3, who developed a preventable, facility acquired, stage 3 pressure injury. The facility further failed to place interventions on the resident's care plan to prevent worsening of the wound. 46960 - R26's Electronic Health Record (EHR) included diagnoses of diabetes mellitus type 2 (DM2- when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), unsteadiness on feet, need for assistance with personal cares and hemiplegia (paralysis of one side of the body). The Admission Minimum Data Set (MDS), dated [DATE], documented a Brief Interview of Mental Status (BIMS) score of 15 which indicated intact cognition. The assessment documented that R26 had an unstageable pressure ulcer/injury present on admission with pressure relieving devices on his bed and on his chair/wheelchair. The Care Area Assessment (CAA), dated 09/02/23, documented that R26 admitted to the facility with a wound on his bottom and was referred to wound team for evaluation and treatment. The Quarterly MDS, dated [DATE] documented a BIMS of 14, which indicated intact cognition. The assessment documented that R26 did not have a pressure ulcer/injury and was not assessed for risk of pressure ulcer/injury and did not have devices on his bed or chair/wheelchair. The 05/29/24 Care Plan lacked documentation related to pressure ulcer/injury prevention or interventions for wound healing, even though the resident was identified at risk for development of pressure ulcers. The 05/09/24 Braden Scale (tool used to predict pressure ulcer risk), revealed a score of 17, and R26 was at risk for development of pressure ulcers). The Physician's Orders documented the following: On 05/08/24 at 01:00 PM, nursing to cleanse the right buttock wound with hypochlorous acid, apply collagen powder, 1 gram (gm) to the base of the wound and cover with a bordered foam dressing every Tuesday, Thursday and Saturday and as needed (PRN) for wound healing. The 03/01/24 to 05/29/24 Medication Administration Record (MAR) and Treatment Administration Record (TAR) reviewed, and staff documented administration of medications, and cleaning of wounds as ordered. Review of the skin assessment, on 04/23/24, documented no skin issues. Review of the progress notes on 04/23/24 revealed the skin warm and dry, no current issues noted. Redness to bottom, barrier cream applied. The resident's care plan lacked any update regarding the resident's rednes to his bottom or any interventions to prevent further breakdown of the resident's skin. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 05/09/24, the Skin Assessment documentation revealed the resident's left buttock had 75 percent (%) granulation (new tissue formed during wound healing) and 25% slough (dead tissue, usually cream or yellow in color). The right buttock had 60% granulation, 20% sough, and 20% epithelial tissue (new skin growing in a superficial wound). The resident's care plan lacked any update regarding the injury to the resident's buttocks or any interventions to prevent further breakdown of the resident's skin. The 05/09/24 Progress Note documented the resident had a left buttock pressure ulcer/injury stage III, with full thickness skin loss and measured 5.6 by 2 by 0.1.(the documentation lacked whether the wound measured in centimeter) The right buttock was stage III, with full thickness skin loss and measured 4.7 by 1.9 by 0.1 (lacked type of measurement) and the right buttock had 60% granulation, 20% slough and 20% epithelial. The resident's care plan lacked any update regarding the injury to the resident's buttocks or any interventions to prevent further breakdown of the resident's skin. On 05/30/24 at 09:20 AM, Certified Nurse Aide (CNA) M stated R26 should be turned, and his brief checked every two hours. R26 would refuse to get out of his bed except for maybe one meal per day. R26 was not always compliant with allowing staff to turn him. Staff should report to the charge nurse if something odd is on someone's skin during cares or bathing. On 06/03/24 at 08:50 AM, Licensed Nurse (LN) H stated R26 had declined to allow surveyor to observe dressing change to his buttock, so she had already performed the task. On 06/03/24 at 08:50 AM Administrative Nurse E confirmed R26's care plan lacked instructions related pressure ulcer/injury prevention and wound care and these items needed to be added. On 06/03/24 at 08:58 AM, Administrative Nurse B stated that her expectation was that all treatments and modalities of care provided to the residents should be documented on the care plan. Administrative Nurse B was unable to give an explanation as to why the care plan was missing information. The facility's Pressure Injuries Overview policy, dated 03/2020, documented the purpose of the procedure was to provide information regarding definitions and clinical features of pressure injuries but lacked guidance related to the actual care of pressure related injuries. The facility failed to place interventions related to pressure injuries for R26 related to his stage 3 pressure injuries. The facility further failed to place interventions on the resident's care plan to prevent possible worsening of the wounds.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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** 31078 The facility reported a census of 43 residents, with 15 included in the sample. Based on observation, interview, and record review, the facility failed to ensure an environment as free from accident hazards as possible when the hot water in four resident rooms and a beauty shop measured at hazardous levels ranging between 138 and 157 degrees Fahrenheit (F). This failure affected six residents (Resident (R) 3, R15, R19, R22, R29, and R30) two of which were cognitively impaired and independently mobile, and any resident who received services in the beauty shop rinse sink. This failure placed the residents in immediate jeopardy to their health and safety and at risk for burns and injury related to hot water exposure. Furthermore, the facility failed to thoroughly document and place effective interventions for each of R24's 12 documented falls since 03/26/24 (approximately 2 months). The facility also failed to conduct thorough fall investigations and provide adequate supervision and effective fall interventions to prevent falls for cognitively impaired R30, who fell multiple times with not fall prevention interventions implemented. Two of the falls experienced by R30 resulted in major injury (one fall resulted in a broken right hip and within a month he fell and broke his left hip) which required emergency medical treatment and surgical repair. Findings included: - During the annual onsite survey on 05/28/24, several residents mentioned hot water concerns. Resident (R) 3 reported the water in their room was hot and the resident reported they told the aides about it several weeks ago. Another resident stated the hot water got really hot and they had to adjust it to keep from being burned. R19 reported they used the hot water in the bathroom about every other day and it got hot, and they had to turn it down. The surveyor observed concerns regarding hot water temperatures in the sinks in several resident rooms, which affected resident rooms at the end of the 200 hallway. The surveyor found the following hot water at hazardous temperatures: At 10:18 AM the water temperature at the sink in room [ROOM NUMBER] measured 157 degrees F. At 10:20 AM the water temperature at the sink in room [ROOM NUMBER] measured 144 degrees F. At 10:24 AM the water temperature at the sink in room [ROOM NUMBER] measured 152 degrees F. At 10:39 AM the water temperature at the sink in room [ROOM NUMBER] measured 140 degrees F. At 11:00 AM the beauty shop had a temp of 138 degrees F in the wash out sink. Maintenance Staff Q checked the hot water temperatures at the same time, using his thermometer, and verified the temperatures matched the temperatures taken by the State Surveyor. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The likelihood for a serious adverse outcome exists, due to the hazardous water temperatures affecting the Beauty shop and four resident rooms. Two of the four residents residing in the resident rooms were cognitively impaired and independently mobile. A third-degree burn (penetrate the entire thickness of the skin and permanently destroys tissue) can occur after skin exposure to hazardous hot water temperatures of 155 degrees F in 1 second, 148 degrees F in 2 seconds, 140 degrees F in 5 seconds, and 133 degrees F in 15 seconds. This placed the elderly residents, who have decreased thermal skin barriers, at increased risk for severe burns and injury. During an interview on 05/28/24 at 12:05 PM Maintenance Staff Q reported the facility installed a new water heater on 03/27/24. The gauge on the tank was set for 120 degrees F and no higher. He stated he checked the water temps in some of the resident rooms one week and the other the following week. He recorded the temps in TELS (maintenance program) and would print those. Maintenance Staff Q said he did not know of the elevated water temperatures and had not run across any hot water temperatures above 120 degrees F. On 05/28/24 at 02:15 PM Maintenance Staff Q provided water temperature logs and explained he checked the water temperature on three different rooms, on each hall, and then averaged those for the hall temperature on the water logs. During an interview on 05/28/24 at 02:20 PM Maintenance Supervisor R reported it would take him until next week to go to Wichita to buy a temperature gauge and install it on the tank. Until that time, he would have Maintenance Staff Q check the water temperature of the four rooms and beauty shop. Maintenance Supervisor R reported the temperatures were within normal, now that they turned the tank down and drained it to start it over. The temperatures were now below 120 degrees F in all four rooms and the beauty shop. On 05/28/24 at 12:24 PM Maintenance Supervisor R reported there was a small hot water tank on the end of 200 hall in an employee restroom. He stated when he went to check the tank, something had been pushed up against the tank and turned the setting up, which caused the hot water at the end of that (200) hall and the beauty shop. He said he was not aware Maintenance Staff Q did not know of the water tank and had not been monitoring it. Maintenance Supervisor R stated it had been at least three months since the hot water tank had been checked. On 05/28/24 at 12:30 PM Administrative staff A reported she felt like the facility had a system in place to monitor the water temps and was unsure how the water heater on the 200-hall got turned up so high to heat the water as hot as it was. Review of the facility policy named Environment-Water Temperatures dated October 2021 revealed Management staff and Environmental Services will provide safe and comfortable water temperatures for resident use at a variation from 98 degrees Fahrenheit to a maximum of 120 degrees Fahrenheit. Environmental Service Staff will monitor water temperatures for proper temperatures by testing and documenting water temps on a weekly basis. Areas tested should include sinks closest to the water heating systems and furthest away. On 05/28/24 at 04:25 PM the surveyor provided the IJ Template to Administrative Staff A and Administrative Nurse B and notified the facility failure to ensure safe hot water temperatures for four resident rooms, affecting and a beauty shop, placed the residents in immediate jeopardy and at risk for severe burn and injury. (continued on next page)

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F 0689

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Some

The facility submitted an acceptable plan for removal of the immediacy on 05/28/24 at 06:18 PM, which included the following:

1. Staff in-serviced on facility Physical Environment - Water Temps Policy and Procedure (P&P), completed by 05/28/24. Staff would not be allowed to work until signatures were received.

2. The facility drained the hot water tank at the end of the 200 hall on 05/28/24.

3. The facility checked the temperature of all rooms after the tank was drained and all were below 120 degrees on 05/28/24.

4. The facility ordered a new temperature gauge for the hot water tank on 05/28/24.

5. The facility will check the water temperatures daily for 30 days for rooms 209, 210, 211, 212, and then resume weekly temperature checks per policy.

6. We will have a QAPI meeting 05/29/24 to review.

The surveyor verified the facility implemented the corrective actions, while onsite 05/29/24 at 08:00 AM. The deficient practice remained at an E scope and severity, after removal of the immediacy.

46960

- R30's Electronic Health Record (EHR) included diagnoses of diabetes mellitus type 2 (DM2- when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), metabolic encephalopathy (condition in which brain function is disturbed either temporarily or permanently due to different diseases or toxins in the body), dementia (a progressive mental disorder characterized by failing memory, confusion), repeated falls and need for assistance with personal care.

The Annual Minimum Data Set (MDS), dated [DATE], documented a Brief Interview of Mental Status (BIMS) score of seven, which indicated severely impaired cognition. R30 required setup and supervision with all cares with the exception of oral care and bathing, which were dependent on staff for completion, and eating which was performed independently. The assessment documented that R30 had fallen since admission to the facility.

The Medicare 5 Day MDS dated [DATE] documented a BIMS score of four, which indicated severely impaired cognition. R30 required substantial/maximal assistance or dependence on staff for all cares. The assessment documented R30 had a fall within the 30-day look-back period, a fracture related to a fall in the six-month look-back period, major surgery in the 100-day look-back period which required skilled nursing facility (SNF - a facility that provides inpatient skilled nursing care to those who need medical, nursing, or rehabilitative services) and a repair of fractures of the hip.

The Falls Care Area Assessment (CAA) dated 02/15/24 documented R30 was a high risk of falls related to antidepressant (class of medications used to treat mood disorders and relieve symptoms of depression) and history of falls.

The 05/29/24 Care Plan documented that on 03/15/22 R30 was a high risk for falls related to lower leg weakness and confusion and included the following interventions:

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 03/29/22, staff were to educate the resident/family/caregivers about safety reminders and what to do if a fall occurred. On 03/29/22, staff were to ensure R30 wore appropriate footwear (shoes or non-slip socks) when ambulating (walking). On 03/29/22, staff were to follow the facility fall protocol and provide a safe environment free from spills or clutter with adequate glare-free light, and a working and reachable call light. Staff were to place the bed in the low position at night and place personal items within reach of the resident. On 05/26/24, staff were to be educated related to the placement of the bedside table when the fall mat was in use. Review of the Fall Risk Assessments in the EHR revealed the facility identified R30 as a high risk for falls on 10/18/23. Review of the Interdisciplinary Team (IDT) Fall assessment dated [DATE] at 09:45 AM revealed the resident had a fall during the day. Assistive devices were not being used appropriately at the time of the fall and the resident had a skin tear. The assessment lacked any other description of the fall. The Progress Notes documented on 02/03/24 at 09:45 AM, R30 was found on the floor with a skin tear to his left forearm. Review of the Fall Report revealed on 02/03/24, R30 fell and sustained a minor injury. The facility determined that the root cause was that R30 had weakness and fatigue from an infection. The fall report lacked an immediate intervention by staff on duty to mitigate the risk of falls or a care planned intervention to prevent future falls. The Fall Risk Assessment staff completed for R30 after his 02/03/24 fall, identified R30 as a low risk for falls. Review of the Interdisciplinary Team (IDT) Fall assessment dated [DATE] at 02:30 PM revealed the resident had a fall during the day. The resident had on grip socks at the time of the fall. The resident had a skin tear to the right elbow and possible hip fracture. The resident walked into the dining room from physical therapy, lost his balance, and fell on to his back, hitting his head on the parallel bars. The resident reported his pain was at an 8 on a scale of 10 to the right hip. The facility called an ambulance to transport the resident to the hospital for further assessment. The Progress Notes dated 04/04/24 at 02:45 PM, revealed R30 was sent to the hospital by ambulance for a possible right hip fracture, and lacked additional documentation related to the fall or any injuries. Review of the Fall Report revealed on 04/04/24, R30 fell and sustained skin tears to the right elbow and a right hip fracture that required hospitalization and surgical repair. The facility's fall report lacked identification of the causal factor of the fall, immediate interventions implemented by the staff on duty or care plan interventions to prevent future falls. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175454	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clearwater Nursing & Rehabilitation Center	620 E Wood Street Clearwater, KS 67026

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The Fall Risk Assessment completed for R30 after his 04/04/24 fall, identified R30 as a high risk for falls. The Progress Notes dated 04/08/24 at 10:58 PM, revealed R30 readmitted to the facility from the hospital after surgical stabilization of a right hip fracture. The 04/09/24 readmission Fall Risk Assessment identified R30 as high risk for falls. Review of the Interdisciplinary Team (IDT) Fall assessment dated [DATE] at 05:00 PM revealed the resident had a fall during the day. The resident was found on the floor in the dining room. The assessment lacked any other description of the fall. The Progress Notes dated 04/14/24 at 05:00 PM, revealed R30 was found on the floor in the dining room with no documented injuries. Review of Fall Report revealed on 04/14/24, R30 fell without injury. The facility determined that the causal factor of the fall was old age and confusion with cancer diagnosis [Review of R30's EHR revealed no cancer diagnoses]. The fall report documented the immediate intervention implemented by staff on duty was visual checks every two hours, however the care plan lacked a permanent intervention to prevent future falls. The Fall Risk Assessment completed for R30 after his 04/14/24 fall, identified R30 as a high risk for falls. Review of the Interdisciplinary Team (IDT) Fall assessment dated [DATE] at 07:50 PM revealed the resident had a fall in the evening. Staff observed the resident laying on the floor next to his wheelchair in the dining room and the resident could not say exactly what happened to cause the fall. The Progress Notes dated 04/22/24 at 01:25 AM, revealed R30 was found on the floor in the dining room with no injuries. Review of Fall Report revealed on 04/21/24, R30 fell without injury. The facility's fall report lacked identification of the causal factor of the fall, immediate intervention implemented by staff on duty, or permanent care plan intervention to prevent future falls. Review of the Interdisciplinary Team (IDT) Fall assessment dated [DATE] at 04:00 PM revealed the resident had a fall during the day. The resident had a hip fracture, received narcotic pain medications, and wore grip socks. The resident was chronically confused. He was found on the floor in his room, lying in his back, and parallel to his bed. Review of Fall Report revealed on 04/22/24 R30 fell without injury. The facility's fall report lacked identification of the causal factor of the fall, immediate intervention implemented by staff on duty, or permanent care plan intervention to prevent future falls. The Fall Risk Assessment completed on 04/22/24 identified R30 as a high risk for falls. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the Interdisciplinary Team (IDT) Fall assessment dated [DATE] at 01:00 AM revealed the resident had a fall during the night. The resident had skin tears to bilateral elbows. The skin tears were cleansed, and staff applied bordered gauze and a Band-Aid. The Progress Notes dated 04/23/24 at 03:14 AM, revealed R30 was found on the floor by his bed with skin tears to both elbows. Review of Fall Report revealed on 04/23/24 R30 fell . The facility's fall report lacked documentation of whether or not the resident sustained an injury. Additionally, the fall report lacked a completed RCA, or permanent care plan intervention to prevent future falls. The fall report documented an immediate intervention from staff on duty to obtain a urinalysis (UA - laboratory analysis of the urine) order from the provider. The Fall Risk Assessment completed on 04/23/24 identified R30 as a high risk for falls. Review of the Interdisciplinary Team (IDT) Fall assessment dated [DATE] at 06:20 AM revealed the resident had a fall during the day. The resident had pain to his left leg and staff placed a call to emergency management services. The assessment lacked any other description of the fall. The Progress Notes dated 05/02/24 at 06:32 AM, revealed R30 was found seated on the floor in his room and cried out with pain when staff attempted to assist him off the floor. The resident complained of isolated pain to his left leg. Review of Fall Report revealed on 05/02/24 R30 fell . The facility's fall report lacked documentation of any injuries, identification of causal factor, or an identified care plan intervention to prevent future falls. The immediate intervention implemented by staff was for staff to perform more frequent visual checks after resident was laid down. The Progress Notes dated 05/02/24 at 07:04 AM, revealed R30 transferred to the hospital via ambulance for further assessment of the left hip. The Fall Risk Assessment completed on 05/02/24 identified R30 as a high risk for falls. The Progress Notes dated 05/06/24 at 03:06 PM, revealed R30 readmitted to the facility from the hospital with surgical incisions present on his left hip. The Fall Risk Assessment completed on 05/06/24 identified R30 as a high risk for falls. Review of the Interdisciplinary Team (IDT) Fall assessment dated [DATE] at 10:30 AM revealed the resident got out of bed on his own without using assistive devices. The resident had pain his left hip and skin tears to the right and left upper extremities. R30's provider ordered an x-ray of his left hip. The resident was found on the floor on his left hip after attempting to sit up on the side of the bed to eat his breakfast. The resident's fall mat was not in place next to the side of the bed because the bedside table was in the way. Staff were educated to keep the fall matt at the side of the bed at all times and attempt to have resident get out of bed to eat meals to attempt to prevent falls from occurring. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The Progress Notes dated 05/26/24 at 12:09 PM, revealed R30 was found on the floor by another (unnamed) resident with skin tears on the right lower leg and left upper arm and the provider ordered an x-ray (an imaging study that takes pictures of bones and soft tissues) of the left hip. The Progress Notes dated 05/26/24 at 12:19 PM, revealed facility staff documented the results of the x-ray of a possible nondisplaced fracture, and the physician recommended follow-up appointment with surgeon who repaired the hip following the fall on 05/02/24. Review of the Fall Report revealed on 05/26/24 R30 fell . The facility's fall report lacked documentation of any injuries, or any immediate interventions implemented by staff on duty. The facility determined the causal factor of the fall was the mattress (fall mat) was moved away from the bed and the lack of help getting the resident up at breakfast. The Fall Risk Assessment completed on 05/26/24, identified R30 as a high risk of falls. Observation of R30 on 05/29/24 at 01:32 PM revealed the resident sat in a high back wheelchair in the common area across from the nurse's station. The resident had ace wraps noted to both lower legs/feet, with toes exposed. The resident sat quietly and with shoulders hunched forward a bit and an unshaven face. R30 did not display signs of pain or attempts to get out of his wheelchair. He sat in his wheelchair and watched people walking by the area. On 05/30/24 at 09:20 AM, Certified Nurse Aide (CNA) M stated in the event of a resident fall, one CNA should stay with the resident and make them as comfortable as possible without moving them, while another CNA or staff member alerted the nurse. Once the nurse completed their assessment, the CNAs would obtain the resident's vital signs and follow the nurse instructions. On 05/30/24 at 11:14 AM, Licensed Nurse (LN) D stated if a resident were to fall, a CNA would stay with the resident and alert other staff to notify the nurse. Then the nurse would go assess the resident and render aid as needed, then the staff collectively would assist the resident off of the floor safely if possible. After the fall crisis was over, the LN were to notify the physician, Administrative Staff A, Administrative Nurse B, and the resident's responsible party. The LN would then fill out the fall packet which included a root cause analysis (RCA) and initiate an immediate intervention for the rest of the shift and communicate that to the staff on duty. The fall packet was then placed in the folder for Administrative Nurse E for her to review and create a permanent intervention in the care plan to prevent future falls. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 05/30/24 at 09:50 AM, Administrative Nurse E stated that after the crisis of a fall was over, the LN on duty would complete the fall packet which included a root cause analysis and would develop an immediate intervention to put in place for the remainder of the shift or until the stand-up meeting on the following business day. Administrative Nurse E further stated that the nurses on the clinical floor had the ability to make additions to the care plan. If they were not able to develop a care plan intervention after a fall, they should write a note on the fall packet submitted to Administrative Nurse E and administration would implement a permanent care plan intervention. Administrative Nurse E stated when reviewing fall reports, if a fall with major injury was discovered, she would alert Administrative Nurse B that a report needed to be filed with the State Agency (SA). Further stated for R30's fall on 04/04/24, Administrative Nurse N was notified of the need to file a report with the SA due to fracture of the right hip that required hospitalization and surgical repair. Additionally stated that for R30's fall on 05/02/24, Administrative Nurse B was notified of the need to file a report with the SA due to a fracture of the left hip that required hospitalization and surgical repair. On 06/03/24 at 08:58 AM, Administrative Nurse B stated she expected all treatments and modalities of care provided to the residents to be documented on the care plan. Administrative Nurse B stated she was unable to give an explanation as to why the care plan was missing information. The facility's Falls and Fall Risk, Managing policy, dated 10/2021, documented staff would identify interventions related to the resident's specific risks and cause based on previous evaluations and current data, to prevent the resident from falling and try to minimize complications from falling. Staff would monitor and document each response to interventions intended to reduce falling and re-evaluate as needed. The facility's Accidents and Incidents - Investigating and Reporting policy, dated 10/2021 documented that all accidents or incidents shall be investigated and reported to administration and that accident reports would be reviewed by the safety committee or QAPI (quality assurance process improvement - a process through which facilities improve the quality of care and services delivered to residents) for trends related to accident or safety hazards in the facility and would analyze individual resident vulnerabilities. The facility failed to provide a policy about quality of life related to accident/safety hazards as requested on 06/03/24. The facility failed to provide the necessary care and services to attain or maintain the highest practicable physical mental and psychosocial well-being for a cognitively impaired resident who was identified with a high risk for falls, R30. The facility failed to implement interventions after multiple falls experienced by R30. On 04/04/24 R30 fell which resulted in a fractured right hip (which required hospitalization and surgical repair), fell again on 04/14/24, 04/21/24, 04/22/24, 04/23/24, on 05/02/24 (resulted in a fractured left hip which also required hospitalization and surgical repair), and on 05/25/24. These cumulative failures of care plan revision and accidents regarding the numerous falls for R30, resulted in deficient practice for quality of life, and had a negative psychosocial outcome, related to the risk for further falls, further injury, pain, decreased range of motion, and delayed healing of surgical repairs. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The facility failed to ensure appropriate and effective fall prevention interventions and thorough fall investigations for cognitively impaired R30, who was identified with a high risk for falls and had a fall history, to prevent repeated falls with major injury. The facility failed to implement fall prevention interventions after multiple falls experienced by R30. On 04/04/24, R30 fell which resulted in a fractured (broken bone) right hip and required hospitalization and surgical repair. R30 fell four additional times in April (04/14/24, 04/21/24, 04/22/24, and 04/23/24), resulting in skin tears and placing the resident at risk for further injury and delayed healing to the right hip healing fracture. Less than a month after R30's fall with a right hip fracture, R30 fell again on 05/02/24, which resulted in a fractured left hip which also required hospitalization and surgical repair. R30 fell again on 05/26/24, for the seventh time in two months. - Review of R24's Electronic Health Record (EHR) revealed the following diagnoses: senile degeneration of brain, muscle weakness (generalized), other abnormalities of gait and mobility, need for assistance with personal care, cognitive communication deficit, other symptoms and signs involving cognitive functions and awareness, essential (primary), right shoulder, pain in right shoulder, and impulse disorder. Review of the 01/23/24 Significant Change Minimum Data Set (MDS) revealed the resident had a Brief Interview for Mental Status (BIMS) score of three, which indicated significantly impaired cognition. The resident had inattention behavior present, which fluctuated. The resident rejected care and wandered one to three days of the lookback period. The resident's wandering put the resident at risk of getting into a potentially dangerous place and intruded on the privacy or activities of others. The resident had no falls since the last assessment. Review of the Falls Care Area assessment dated [DATE] revealed R24's care plan would reflect his high risk for falls and his goal of minimizing risks. Review of the 04/19/24 Quarterly MDS revealed the resident had a BIMS score of two, which indicated severe cognitive impairment. The resident had rejection of cares, which occurred one to three days of the lookback period. The resident had wandering behaviors, which occurred four to six days of the lookback period. The resident had a fall since entry or the prior assessment. The resident had two or more non-injury falls since admission or prior assessment. Review of the Care Plan started 04/02/24 with a completion date of 04/30/24 revealed the following interventions: On 08/18/20 the staff were to monitor the resident's vital signs per protocol and take the resident's blood pressure lying/sitting/standing one time within the first 24 hours after the fall. On 08/20/20 the staff were to know the resident required supervision of one staff for toilet use. On 08/20/20 the staff were to encourage the resident to participate to the fullest extent possible with each interaction. On 08/20/20 the staff were to encourage the resident to use the call light to call for assistance. On 08/20/20 the staff would monitor/document/report as needed any changes, any potential for improvement, reasons for self-care deficit, expected course, declines in function. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 06/14/23, for no apparent acute injury, the staff were to determine and address causative factors of the fall. On 06/14/23, the staff were to monitor/document/report as needed for 72 hours to the resident's physician any signs/symptoms, which included: bruises, change in mental status, new onset confusion, sleepiness, inability to maintain posture, and agitation. Review of the Fall Risk Assessments in the EHR from 01/02/24 to 05/27/24 revealed the resident had a high risk for falls. Review of the Interdisciplinary Team Post Fall assessment dated [DATE] at 09:00 PM revealed the resident appeared to be trying to sit at a table in the dining hall on a rolling chair that was located near the resident. Staff would ensure the rolling chairs were removed from the dining hall once the feeders were done eating. Review of the 03/27/24 Fall Report Charting revealed the resident was found on his back, on the floor in dining hall near a rolling chair. It appeared the resident tried to sit at the table on a rolling chair. The resident had no injuries noted at the time of the fall. Review of the resident's Care Plan lacked any interventions that corresponded to the 03/26/24 fall. Review of the Interdisciplinary Team Post Fall assessment dated [DATE] at 08:15 PM revealed the resident was already on fall charting, confused, and hard to re-direct at times. Review of the Nurse's Note dated 03/28/24 at 08:15 PM revealed the resident had a fall. The resident was in a wheelchair and an assessment completed with no injury noticed. The resident could not tell what happened but complained when asked specifically about pain, that his back hurts. Staff were to take the resident to the bathroom and lay him down after dinner. The note lacked any further description of the fall. Review of the resident's Care Plan lacked any interventions that corresponded to the 03/28/24 fall. Review of the Interdisciplinary Team Post Fall assessment dated [DATE] at 06:00 PM revealed the resident removed their socks and slippers. The resident was found on floor of their room during evening medication pass by a Certified Medication Aide (CMA). The resident laid on his back with his pants and brief removed. The resident was assisted into wheelchair and staff placed a new brief and pants on the resident. Review of the Nurse's Note dated 04/01/24 at 06:00 PM revealed the resident was found lying on the floor on his back during the evening medication pass by the CMA. The resident removed his brief and pants and voided on the floor. The floor was free of clutter, besides the blanket that the resident kept wrapped around him. Review of the resident's Care Plan revealed an intervention dated 04/02/24 for staff to toilet R24 every two hours. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the Interdisciplinary Team Post Fall assessment dated [DATE] revealed an incomplete assessment. Review of the Nurse's Note dated 04/12/24 at 02:34 PM revealed the nurse writer and the Social Service Designee (SSD) walked down the hallway and saw the resident laying on the floor next to his bed and covered in urine. Review of the resident's Care Plan lacked any interventions that corresponded to the 04/12/24 fall. Review of the Interdisciplinary Team Post Fall assessment dated [DATE] at 11:00 AM revealed the resident removed gripped socks. Review of the Nurse's Note dated 04/15/24 at 11:08 AM revealed staff found the resident in front of the door to his room with his back against his roommate's bed. The resident's legs were in front of him and straight. Staff were to provide more frequent checks to the resident when resting in his room between meals. Review of the resident's Care Plan lacked any interventions that corresponded to the 04/15/24 fall. Review of the Interdisciplinary Team Post Fall assessment dated [DATE] at 05:00 PM revealed the resident stood up and held hands with another resident who was in a wheelchair. The resident lost his balance and fell to the ground. Review of the Nurse's Note dated 04/25/24 at 10:24 AM revealed the resident remained on fall follow up for a witnessed fall. Review of the undated Certified Nurse Aide (CNA) Fall Investigation revealed staff last saw the resident in the dining room. The resident was having a hard time walking in the morning and during the day. The form asked the CNA what could be done to prevent further falls for the resident and they replied, Do like a balance test. When asked why the resident fell the CNA stated, he was holding hands with another resident and loss his balance The CNA further stated maybe staff could educate the resi [TRUNCATED]

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35717 The facility identified a census of 43 residents, which included 15 residents sampled, and one resident reviewed for Dialysis. Based on interview, observation, and record review, the facility failed to develop a comprehensive person-centered care plan for Resident (R)32's related to hemodialysis (a procedure where impurities or wastes were removed from the blood) the resident received three times a week. This deficient practice had the potential to lead to uncommunicated needs regarding dialysis care which could lead to negative impacts on the resident's physical, mental and psychosocial well-being. Findings included: - R32's Electronic Health Record (EHR) included diagnoses of diabetes mellitus type 2 (DM2- when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), anemia (a condition without enough healthy red blood cells to carry adequate oxygen to body tissues), stage four chronic kidney disease (CKD - a disease characterized by progressive damage and loss of function in the kidneys) and end-stage renal disease (ESRD-a terminal disease of the kidneys). The Admission Minimum Data Set (MDS), dated [DATE], documented a Brief Interview of Mental Status (BIMS) score of 14 which indicated intact cognition. The resident received insulin daily during the seven-day look-back period and received dialysis. The Care Area Assessment (CAA), dated 04/05/24, lacked documentation related to insulin use or dialysis. The 05/29/24 Care Plan lacked instructions and/or interventions for staff related to R32's three times a week dialysis or care of the resident's implanted dialysis catheter. The Physician's Orders documented the following: On 05/11/24 at 08:00 AM, Dialysis every Tuesday, Thursday, and Saturday R32 would leave the facility at 09:00 AM. On 04/16/24 at 04:00 PM, prostat (a nutritional supplement shake) 30 milliliters (mL) to be given orally two times a day related to low albumin (amount of protein in the blood) levels and once per day to be given orally after dialysis, on dialysis days. On 04/03/24 at 06:00 PM, staff to chart the amount of fluid removed from resident while at dialysis, one time per day on Tuesday, Thursday and Saturday following dialysis related to dialysis management. On 04/03/24 at 06:00 PM, staff to check dialysis catheter (a hollow flexible tube inserted into the body) every shift for monitoring of [dialysis] port. The 03/29/24 to 05/30/24 Medication Administration Record (MAR) and Treatment Administration Record (TAR) reviewed and staff documented monitoring of implanted dialysis catheter every shift. (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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the 03/29/24 through 05/30/24 Dialysis Communication sheets, used to communicate care between the Dialysis Center and the facility regarding each Dialysis treatment for R32, revealed the facility staff did not fill out the bottom section of the form post dialysis for R32 on numerous occasions. Observation on 05/29/24 at 01:37 PM revealed R32 sat in his room on his bed with his shoulders shrugged forward, head hanging forward a bit, sitting on the side of his bed. He was unshaven, and wore a shirt looked stretched out at the neck, as the opening hung loosely over his upper chest exposing his upper chest area. During an interview with cognitively intact R32 on 05/29/24 at 01:37 PM, R32 stated the transportation company was unreliable and not timely on getting him to his Dialysis appointments. R32 stated that due to the lateness of transporation, R32 has had his Dialysis time shortened, stating he did not get the full Dialysis treatment on several occasions. R32 stated the staff do not check on his dialysis port (R32 pointed to the dialysis port on his right upper chest) when he gets back from dialysis or every shift. R32 further stated there was a Dialysis book that had Dialysis sheets but stated when he got back from Dialyis the facility did not always look at the sheet and sometimes he was in his room with the book in the back of his Wheelchair bag (motioned to the wheelchair). He stated he goes back to his room and leaves the book in his bag, since they did not get it when he got back from Dialysis. R32 further stated the staff do not obtain his vitals everytime he gets back from Dialysis. R32 did say the night shift nurse would check on the Dialysis port every once in a while. On 06/03/24 at 08:55 AM Certified Nurse Aide (CNA) J stated that R32 had an implanted dialysis port to the right side of his chest and that CNA staff had been instructed to ensure that it is covered and remained dry during bathing. If bleeding were to occur around the catheter site, CNAs were to inform nursing staff immediately. On 06/03/24 at 09:03 AM, Licensed Nurse (LN) H stated that R32 had an implanted dialysis port to the right side of his chest and stated that nursing staff assessed the port every shift and if the assessment found anything wrong that staff were to call the physician for further instructions. On 06/03/24 at 08:50 AM Administrative Nurse E confirmed R32's care plan lacked instructions related to dialysis or insulin administration and that these items needed to be added. On 06/03/24 at 08:58 AM, Administrative Nurse B stated that her expectation was that all treatments and modalities of care provided to the residents should be documented on the care plan. Stated was unable to give an explanation as to why the care plan was missing information. The facility's Care Planning - Interdisciplinary Team (IDT - a team of facility staff consisting of members of various departments including but not limited to; dietary, nursing, maintenance, therapy, etc.) policy dated 10/2021 documented that the facility's IDT team was responsible for the development of an individualized comprehensive care plan for each resident within seven days of the completion of the MDS. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Clearwater Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 620 E Wood Street Clearwater, KS 67026	

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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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility failed to ensure a developed a comprehensive person-centered care plan, to ensure the coordination of care for R32 related to his three times a week hemodialysis he recieved outside of the facility at a local Dialysis Center. These deficient practices had the potential to lead to uncommunicated needs that would negatively affect the physical, mental and psychosocial well-being of R32.

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F 0725

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Many

Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.

35717

The facility reported a census of 43 residents. Based on interview and record review the facility failed to ensure adequate staffing to meet the needs of the residents of the facility. In 2023 the facility lacked 8-hour Registered Nurse (RN) coverage for 29 days, as reported by the facility. In 2023 the facility lacked 24-hour Licensed Nurse (LN) coverage for 127 days, about 35% of the year. This deficient practice affected all residents in the facility. (See the citations found on current recertification survey to include 4 IJ, harm, and subsequent Substandard Quality of Care.)

Finding included:

- During the annual survey, which began on 05/28/24, several residents reported issues involving lack of staff (Res ID and time of interview withheld for anonymity):

1. Staff do not respond to call lights promptly and said regularly they are not answered for over 45 minutes.

2. Staff do not answer call lights for 20-30 minutes on any shift and stated weekend staffing was slower.

3. Staff can be slow to respond and said they waited for 45 minutes for staff assistance with toileting.

Review of the 2023 facility reported PBJ data revealed the following infraction dates representing dates the facility reported lack of required 8-hour Registered Nurse coverage in the facility:

January: 3 days (16, 23, 29).

February: 5 days (1, 5, 9, 25, 26).

March: 3 days (4, 18, 25).

April 2023: 6 days (2, 8, 15, 16, 29, 30).

May 2023: 5 days (6, 7, 13, 14, 27).

July 2023: 1 days (2).

August 2023: 2 days (20, 27).

November 2023: 4 days (16, 17, 23, 24).

Of the 2023 8-hour RN infraction dates revealed: 2 on Monday, 1 on Wednesday, 12 on Saturday, and 13 on Sunday.

(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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility reported PBJ data revealed the following infraction dates representing dates the facility reported the lack of required 24-hour Licensed Nurse coverage in the facility: January 2023: 17 days (1, 7, 9-10, 12, 16, 19-20, 22-30). February 2023: 18 days (1-2, 4-9, 12, 14, 21-28). March 2023: 17 days (1-9, 11-13, 16, 21, 23, 25-26). April 2023: 15 days (3, 9-11, 13-16, 19-23, 25, 29). May 2023: 7 days (6-7, 9, 20, 22-23, 27). June 2023: 6 days (3, 15, 17-19, 24) July 2023: 1 day (30). August 2023: 11 days (6-7, 13-16, 19-20, 26-28). September 2023: 10 days (2-3, 8, 10-11, 16, 23-24, 29-30). October 2023: 6 days (12, 14-15, 18, 21-22). November 2023: 2 days (26, 29). December 2023: 17 days (1-6, 9-10, 14-15, 17-18, 19, 21, 23, 30-31). Of the 2023 24-hour LN infraction dates: 18 on Monday, 15 on Tuesday, 11 on Wednesday, 16 on Thursday, 10 on Friday, 28 on Saturday, and 29 on Sunday. Lack of staffing directly affects resident care as evidenced by the number of citations found on the current recertificaiton survey to include 4 Immediate Jeopardy (IJ), harm, and subsequent substandard quality of care. See all associated tags in current recertification survey (IKSC11), including repeated deficient practice from prior recertification survey. Observation on the recertification survey from 05/28/24-05/30/24 and 6/03/24 revealed numerous (5 or more) instances of residents hollering out from their room for assistance from staff. Almost constant sounds of call lights in the hallways, however no visual indication of room activated when looking down each hallway. The survey team observed several instances of residents asking the surveyors for assistance and stating they were waiting on staff for help, but they had not come. The surveyors went to find staff and had to catch the staff between rooms. During the survey several direct care staff (names, dates, and times removed for anonymity) reported low staffing concerns. (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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 06/03/24 at 11:00 AM, Administrative Nurse B reported the actual working schedules reflected call-ins, staff changes, etc. Administrative Nurse B reported the working schedules were updated and reported to the state. Administrative Nurse B reported during the current quarter of 2024 (the surveyor did not have access to this report at that time) the facility only had one day in May in which they did not have 8 hour RN coverage. The facility failed to provide sufficient staffing to meet the needs of the residents to include 8-hour RN coverage and 24-hour LN coverage. This failure had the potential to negatively affect all residents in the facility and placed them at risk for decreased quality of life, treatment, and care.

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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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 35717 The facility reported a census of 43 residents. Based on observations, interviews, and record review the facility failed to ensure 8-hour Registered Nurse coverage each day, as required, in order to meet the needs of the residents. This failure had the potential to negatively affect all residents in the facility and placed them at risk for decreased quality of life, treatment, and care. Finding included: - During the annual survey, which began on 05/28/24, several residents reported issues involving lack of staff. Review of the 2023 facility reported PBJ data revealed the following infraction dates representing dates the facility reported lack of required 8-hour Registered Nurse coverage in the facility: January: 3 days (16, 23, 29). February: 5 days (1, 5, 9, 25, 26). March: 3 days (4, 18, 25). April 2023: 6 days (2, 8, 15, 16, 29, 30). May 2023: 5 days (6, 7, 13, 14, 27). July 2023: 1 days (2). August 2023: 2 days (20, 27). November 2023: 4 days (16, 17, 23, 24). Of the 2023 8-hour RN infraction dates revealed: 2 on Monday, 1 on Wednesday, 12 on Saturday, and 13 on Sunday. Lack of staffing directly affects resident care as evidenced by the number of citations found on the current recertificaiton survey to include 5 Immediate Jeopardy (IJ), harm, and subsequent substandard quality of care. See all associated tags in current recertification survey (IKSC11), including repeated deficient practice from prior recertification survey and complaint survey. Observation on the recertification survey from 05/28/24-05/30/24 and 6/03/24 revealed numerous (5 or more) instances of residents hollering out from their room for assistance from staff. Almost constant sounds of call lights in the hallways, however no visual indication of room activated when looking down each hallway. The survey team observed several instances of residents asking the surveyors for assistance and stating they were waiting on staff for help, but they had not come. The surveyors went to find staff and had to catch the staff between rooms. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clearwater Nursing & Rehabilitation Center	620 E Wood Street Clearwater, KS 67026

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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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During the survey several direct care staff (names, dates, and times removed for anonymity) reported low staffing concerns. During an interview on 06/03/24 at 11:00 AM, Administrative Nurse B reported the actual working schedules reflected call-ins, staff changes, etc. Administrative Nurse B reported the working schedules were updated and reported to the state. Administrative Nurse B reported during the current quarter of 2024 (the surveyor did not have access to this report at that time) the facility only had one day in May in which they did not have 8 hour RN coverage. The facility failed to ensure 8 hour Registered Nurse coverage each day, as required, in order to meet the needs of the residents. This failure had the potential to negatively affect all residents in the facility and placed them at risk for decreased quality of life, treatment, and care.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50659 The facility reported a census of 43 residents, with 15 residents in the sample, that included one resident reviewed for treatment/services/mental and psychosocial concerns. Based on observation, interview, and record review the facility failed to provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for Resident (R)39, who had a history of personal trauma and a diagnosis of post-traumatic stress disorder. This placed the resident at risk for impaired quality of life due to untreated and ongoing mental health concerns. Findings included: - Resident (R)39's Electronic Health Record (EHR) revealed diagnoses that included metabolic encephalopathy (broad term for any brain disease that alters brain function or structure), post-traumatic stress disorder (PTSD a mental health condition that develops following a traumatic event characterized by intrusive thoughts about the incident, recurrent distress/anxiety, flashback and avoidance of similar situations) and dementia adjustment disorder (progressive mental disorder characterized by failing memory, confusion). The Admission Minimum Data Set (MDS) dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 10, which indicated moderately impaired cognition. The resident had no signs or symptoms of delirium or depression. R39's behaviors put others at significant risk of physical injury. The resident wandered one to three days of the lookback period and put the resident at significant risk of getting to a potentially dangerous place. R 39 wandered significantly and intruded on the privacy or activities of others. R39's preferences were Not assessed. The Quarterly MDS dated [DATE], documented a BIMS score of eight, which indicated moderately impaired cognition. R39 reported feeling lonely or isolated from those around him rarely. R39 had non-Alzheimer's dementia, depression, and post-traumatic stress disorder. R39 received scheduled antidepressant (class of medications used to treat mood disorders) and antianxiety (class of medications that calm and relax people) medications. Review of the 11/20/23 Care Area Assessments (CAA) lacked any indication the resident had a diagnosis of PTSD and/or any indication staff would proceed to care plan interventions related to the resident's PTSD diagnosis. The care plan, dated 05/29/24, lacked guidance to address the resident's PTSD. The care plan further failed to address the resident's adjustment difficulties and/or history of trauma. The care plan lacked any description of the resident's indications of distress and/or interventions intended to assist the resident to reach and maintain his highest level of mental and psychosocial wellbeing. Review of the 11/15/23 Trauma Assessment revealed the resident had military related trauma. The assessment instructed the reader not to walk up behind the patient if he did not know you were there and to use a walking approach. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/09/2024 at 01:28 PM, R39 was seen in house by Consultant Staff T and reported R39's PTSD was a real problem. On 01/08/24 Social Services Notes uploaded in EHR revealed the Consultant Staff T visited the resident. During the visit the resident stated he was just here and that his life was very dull and without any meaning. The note further stated the resident's PTSD was a real problem and that medication may be the only way to help ease the resident's mental stress. During an observation/interview of the resident on 05/28/24 at 09:15 AM, R39 was in his room seated in a chair with lights off and stated he liked it dark. R39 appeared sad and had a frown on his face. R39 made statements that no one cared about him. The resident stated he liked to stay in his room, but then voiced who cares if I like it here. On 05/30/24 at 12:30 PM, Social Services Designee (SSD) U stated could not find an intervention related to not walking behind the resident and the use of a walking approach on the resident's care plan, which would direct the staff to know how to approach the resident. SSD U reviewed the care plan on her computer and stated that her care plan could not bring up the entire care plan as it was being slow. SSD U was shown the care plan on another computer and asked her if she saw it on that care plan. SSD U stated she would go speak to Administrative Nurse E about why the care plan is not showing on her computer. Stated she would print off a copy and deliver it. At 02:00 PM, SSD U brought a copy of what was added to Point of Care Tasks on 05/30/24 (today), which directed staff to approach the resident face to face to prevent further agitation or any triggers. On 05/30/24 at 12:55 PM, Licensed Nurse (LN) D stated she was not aware to not approach R39 from the back. LN D stated that she was not sure if he had PTSD as a diagnosis. LN D reported if it was busy in the dining room, staff redirected R39 out of the dining room. On 05/30/24 at 01:00 PM, Certified Nurse Aide (CNA) C stated she was not aware that R39 had PTSD and did not know how to approach the resident. CNA C reviewed the computer screen on point click care agreed the EHR lacked any direction on how to approach R39. On 05/30/24 at 01:00 PM, Administrative Nurse B reported there needed to be more detail on care plans, because the care plans lacked crucial information regarding the resident's condition and the plan to care to care for the resident. She expected the care plans to be accurate and updated as needed. On 05/30/24 at 01:55 PM, CNA C stated he was not aware R39 had PTSD and was not aware how to approach the resident. The facility's policy for Trauma Informed Care, dated October 2021 documented the policy would guide staff in appropriate and compassionate care specific to individuals who have experienced trauma. Staff are provided with education about trauma and PTSD. Nursing staff are trained on screening tools, assessments and how to identify triggers associated with re-traumatization. The facility failed to provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for R39, who had a history of personal trauma and a diagnosis of post-traumatic stress disorder.

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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 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** 31078 The facility census totaled 43 residents with 15 residents included in the sample, that included five residents reviewed for unnecessary medications. Based on observation, interview, and record review, the facility failed to follow up on pharmacy recommendations in a timely manner for one Resident (R)1, regarding as needed lorazepam (a medication used for severe agitation) to obtain a new prescription every 14 days, to minimize or prevent adverse consequences related to medication therapy. Findings include: - R1's electronic medical record (EMR) revealed the following diagnoses that included chronic atrial fibrillation (rapid, irregular heart beat), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), violent behavior, major depressive disorder (major mood disorder which causes persistent feelings pf sadness), intermittent explosive disorder, delusional disorder (untrue persistent belief or perception held by a person although evidence shows it was untrue) and personality disorder. The Admission Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of six, indicating severe cognitive impairment. R1 received antipsychotic (class of medications used to treat major mental conditions which cause a break from reality), anticoagulant (blood thinner), insulin, antianxiety (class of medications that calm and relax people), and antidepressant (class of medications used to treat mood disorders). The quarterly MDS dated [DATE] revealed no significant changes in status since last MDS dated [DATE]. The physician's order included lorazepam, 1 milligram (mg), every six hours, as needed (PRN), for anxiety, ordered 01/28/24. The order lacked an end date. Review of the Consulting Pharmacist Monthly Medication Review revealed the following: On 02/21/24, the resident receiving lorazepam 1.0 mg PRN with no end date of the 14-day requirement. The EMR lacked a physician response. On 03/23/24, the resident receiving Lorazepam 0.5 mg PRN with no end date of the 14-day requirement. On 04/04/24, the physician responded with end of life, change to six months. Observation on 05/28/24 at 10:30 AM, revealed the resident in his room visiting with another resident from across the room. The resident had no behaviors and exhibited no signs of anxiety or distress. On 05/28/24 at 01:00 PM, Certified Nursing Assistant (CNA) C reported the resident had behaviors. Nothing physical, but he would become vocally abusive if he got upset. (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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/30/24 at 10:45 AM, Licensed Nurse (LN) D reported the resident had behaviors but were usually controlled with medication. He yells out obscenities. On 05/30/24 at 01:00 PM, Administrative Nurse B reported she reviewed the pharmacy reviews when the recommendations would come in. Verified the untimeliness of the physician response. A policy for Pharmacy reviews was requested though no policy received. The facility failed to follow up on pharmacy recommendations in a timely manner for this resident, regarding as needed lorazepam (a medication used for severe agitation) to obtain a new prescription every 14 days, to minimize or prevent adverse consequences related to medication therapy.

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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 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 31078

The facility census totaled 43 residents with 15 residents included in the sample, that included five residents reviewed for unnecessary medications. Based on observation, interview, and record review, the facility failed to ensure two Residents (R) 1, regarding as needed lorazepam (a medication used for severe agitation) and R24, regarding failure to monitor the use of an antipsychotic medication (medication used to treat psychosis).

Findings include:

- R1's Electronic Medical Record (EMR) revealed the following diagnoses that included chronic atrial fibrillation (rapid, irregular heart beat), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), violent behavior, major depressive disorder (major mood disorder which causes persistent feelings pf sadness), intermittent explosive disorder, delusional disorder (untrue persistent belief or perception held by a person although evidence shows it was untrue) and personality disorder.

The Admission Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of six, indicating severe cognitive impairment. R1 received antipsychotic (class of medications used to treat major mental conditions which cause a break from reality), anticoagulant (blood thinner), insulin, antianxiety (class of medications that calm and relax people), and antidepressant (class of medications used to treat mood disorders).

The Quarterly MDS dated [DATE] revealed no significant changes in status since the last MDS dated [DATE].

The resident's Physician's Orders included an order dated 01/26/24 for lorazepam (a medication used for anxiety or severe agitation), 1 milligram (mg), every six hours, as needed (PRN), for anxiety. The order lacked an end date.

Review of the Consulting Pharmacist Monthly Medication Review revealed the following:

On 02/21/24, the resident received lorazepam 1.0 mg, PRN, with no end date to meet the 14-day federal regulatory requirement. The EMR lacked a physician response.

On 03/23/24, the resident received Lorazepam 0.5 mg, PRN, with no end date to meet the 14-day federal regulatory requirement. On 04/04/24, the physician responded with end of life, and changed the end date for the medication to six months.

Observation on 05/28/24 at 10:30 AM, revealed the resident in his room visiting with another resident from across the room. The resident had no behaviors and exhibited no signs of anxiety or distress.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/28/24 at 01:00 PM, Certified Nursing Assistant (CNA) C reported the resident had behaviors. CNA C stated the resident's behaviors were nothing physical, but he would become vocally abusive if he got upset. On 05/30/24 at 10:45 AM, Licensed Nurse (LN) D reported the resident had behaviors but they were usually controlled with medication and stated he yelled out obscenities. The facility lacked a policy for PRN anti-anxiety medication. The facility failed to obtain new orders every 14 days or provide an appropriate rationale for extended as needed use of lorazepam for this resident, as required. This deficient practice had the potential negatively affect the physical, mental and psychosocial well-being of the resident. 46960 - Review of R24's Electronic Health Record (EHR) revealed the resident had the following diagnoses: senile degeneration of brain, delusional disorders, other symptoms and signs involving cognitive functions and awareness, major depressive disorder, dementia in other diseases classified elsewhere with agitation, major depressive disorder, impulse disorder, unspecified sexual dysfunction not due to a substance or known physiological condition, and other problems related to lifestyle. Review of the 01/23/24 Significant Change Minimum Data Set (MDS) revealed the resident had a Brief Interview for Mental Status (BIMS) score of 03, which indicated significantly impaired cognition. The resident required antipsychotic medication. The resident received antipsychotic medications on a routine basis only and the physician documented a gradual dose reduction (GDR) of antipsychotic medications as clinically contraindicated on 11/27/23. Review of the Psychotropic Drug Use Care Area Assessment (CAA) dated 01/23/24 revealed the resident had a risk for potential adverse reactions related to high-risk medication use. R24's care plan would reflect his use of high-risk medication use and his goal of minimizing risks. Review of the 04/19/24 Quarterly MDS revealed the resident had a BIMS score of 2, which indicated severe cognitive impairment. The resident received antipsychotic, antianxiety, and antidepressant medications during the look back period. The resident received antipsychotic medications on a routine basis only. Review of the resident's Care Plan revealed the following interventions: On 12/31/23 - Staff would know the resident used psychotropic medications related to his disease processes. On 12/31/23 - Staff would administer psychotropic medications as ordered by the physician and monitor for side effects and effectiveness every shift. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clearwater Nursing & Rehabilitation Center	620 E Wood Street Clearwater, KS 67026

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/31/21 - Staff would monitor/document/report as needed any adverse reactions of psychotropic medications, which include: unsteady gait, tardive dyskinesia, EPS (shuffling gait, rigid muscles, shaking), frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideations, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, muscle cramps nausea, vomiting, and behavior symptoms not usual to the person. On 05/30/23 and revised on 05/29/24 - Staff were to know the resident took medications with Black Box Warnings. On 05/29/24 - Staff were to administer medications to the resident as ordered and monitor/document for side effects and effectiveness. Review of the resident's Physician's Orders revealed the resident received Seroquel (antipsychotic medication) of varying doses from 06/05/23 to current (05/2024). Review of Abnormal Involuntary Movement Scale (AIMS) assessments revealed the facility completed the assessments on the following dates: 01/19/24, 04/08/23, 04/11/23, and 09/04/23. The resident's record lacked evidence the facility completed AIMS assessments quarterly while the resident continued the use of antipsychotic medications. An interview at 12:49 AM on 06/04/24 with Administrative Staff B revealed AIMS assessments should follow the MDS schedule (quarterly and as needed). The facility failed to ensure staff performed AIMS assessments for R24 quarterly and as needed when he received antipsychotic medications for an extended period of time.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 46960 The facility reported a census of 43 residents. Based on observation, interview, and record review, the facility failed to serve the residents of the facility food, which was palatable, attractive, and served at the appropriate temperature. Findings included: - During an interview with Resident (R) 26 on 05/28/24 at 12:50 PM, the resident stated when staff delivered his meals to his room, the food was always cold. On 05/30/24 at 01:07 PM, the survey team requested a sample meal tray and Dietary Staff O delivered the meal tray. The vegetables on the meal tray were measured by Dietary Staff O and measured 122 degrees Fahrenheit (F), which was below the required serving temperature of 135 degrees F. On 05/30/24 at 01:07 PM, the survey team tasted the meal tray for palatability and determined that the vegetables were not palatable. Dietary Staff O also tasted and confirmed the vegetables were not palatable due to temperature and should be served at the appropriate temperature. The facility lacked a policy for palatable foods. The facility failed to serve the residents of the facility food, which was palatable, attractive, and served at the appropriate temperatures.

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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 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. 46960 The facility reported a census of 43 residents. Based on observation, record review, and interview, the facility failed to prepare and serve food under sanitary conditions, to the residents of the facility appropriately to prevent the potential for food borne illness. This deficient practice had the potential to negatively affect all the residents of the facility. Findings included: - During an initial tour of the kitchen on 05/28/24 at 08:20 AM, with Dietary Staff O, the following areas of concern were noted: 1. The main kitchen refrigerator contained three large, opened containers of sour cream which all lacked an open date. 2. The main kitchen refrigerator contained a small package of spoiled lettuce, wrapped in plastic wrap, with a date of 05/14/24. 3. The main kitchen refrigerator contained two large, opened containers of salad dressings which lacked an open date. 4. The main kitchen refrigerator contained a large container of cheese-pimento salad which lacked an open date. 5. The main kitchen refrigerator contained a small plastic bag with an unknown meat product which lacked an identification label as well as an open date. 6. The main kitchen refrigerator contained a small plastic bag with a half of a spoiled onion which lacked a date. 7. The main kitchen refrigerator contained an uncovered block of butter which was undated. 8. The main kitchen refrigerator contained an uncovered block of cheese slices which was undated. 9. The walk-in freezer contained an uncovered box of uncooked, formed cookies which was lacked an open date. On 05/28/24 at 08:30 AM, Dietary Staff O stated that items that are opened in the refrigerator should be labeled with open date and use/discard by date of seven days for most foods, and 30 days for salad dressing and other multi-use packages. Additionally stated that items in the walk-in refrigerator and walk-in freezer should be covered to prevent exposure to the environment inside the refrigerator or freezer to prevent spoilage. The refrigerator in the kitchen for resident use items should not contain items that belong to staff for staff consumption. The facility failed to provide a policy regarding the dating of foods as requested on 05/28/24. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility failed to provide a policy regarding storage of staff items in resident refrigerators. The facility provided a Refrigerator & Freezer Storage Chart produced by the United States Food & Drug Administration (US FDA - a federal agency that protects the public health by regulating human and veterinary drugs, biological products, medical devices, food, cosmetics, and tobacco), dated 03/2018 that lacked documentation related to the safe storage of items documented above. The facility failed to prepare and serve food under sanitary conditions, to the residents of the facility appropriately to prevent the potential for food borne illness. This deficient practice had the potential to negatively affect all the residents of the facility.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. 34056 The facility reported a census of 43 residents. Based on observation, interview and record review, the facility failed to properly dispose of garbage and refuse by not ensuring the dumpster lid was always closed. Findings included: - On 05/28/24 at 08:20 AM, observation revealed the lid to the dumpster, used for garbage and refuse, contained a cover that sat in the open position on the back of the dumpster. On 05/28/24 at 08:20 AM, Dietary staff O stated she was unaware the dumpsters were part of the kitchen staff's responsibilities to ensure that they remained closed. On 06/06/24 at 01:50 PM, Administrative Nurse B stated that the expectation was for the lid on the dumpster to be in the closed position at all times and stated that she was aware of the regulatory requirement. The facility lacked a policy for ensuring the dumpsters lid was closed at all times. The facility failed to properly dispose of garbage and refuse by not ensuring the dumpster lid was closed at all times.

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F 0835 Level of Harm - Minimal harm or potential for 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 43 residents. Based on observations, record reviews, and interviews the facility failed to put in place an effective administration who ensured the facility was administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident who resided at the facility. This deficient practice placed the residents at risk for decreased quality of care, quality of treatment, and sense of well-being. Findings included: - The facility failed to ensure 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 treat each resident with dignity, respect, and in a manner and environment that promoted the enhancement of resident's quality of life when the facility utilized Styrofoam containers for seven residents in their rooms for their meal trays. The facility failed to ensure the resident's representative for Resident (R) 22, the right to be informed when the resident had an increase in behaviors and the facility required the resident to be placed on staff one-to-one observation due to his behaviors. The facility failed to maintain a clean, comfortable and homelike environment for four Residents (R)7, R26, R35 and R145, who had no means to control the temperature of their rooms. The facility failed to ensure staff identified and responded appropriately to all allegations of abuse, which included resident-to-resident abuse. 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 by federal regulations. The facility failed to investigate all allegations of resident-to-resident abuse, failed to protect residents from further incidents of abuse, and the facility failed to ensure staff provided adequate supervision and effective care planned interventions to prevent resident-to-resident abuse. The facility failed to recognize a significant change in a resident's physical condition and perform a Comprehensive Minimum Data Set (MDS) assessment within the required 14-day period of the resident's change in condition. This deficient practice had the potential to lead to uncommunicated needs and placed the resident at risk for further deterioration of his physical, mental, and psychosocial well-being. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility failed to accurately complete the Minimum Data Set (MDS) for five sampled residents, as required by the federal regulations. The facility failed to develop a comprehensive person-centered care plan for seven of the 15 residents sampled. The facility failed to revise fall care plans with interventions for three residents for three of the 15 residents sampled. The facility failed to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for cognitively impaired Resident (R) 30, who was identified with a high risk for falls and had a fall history, to ensure his quality of life. The facility failed to provide appropriate and timely Activities of Daily Living (ADLs) regarding untrimmed facial hair for one Resident (R) 17. The facility failed to provide treatment and care in accordance with professional standards by the failure to coordinate resident care with hospice services. The facility failed to provide treatment and services necessary to prevent the development of pressure ulcers for three residents. The facility failed to ensure an environment as free from accident hazards as possible when the hot water in four resident rooms and a beauty shop measured at hazardous levels ranging between 138 and 157-degrees Fahrenheit (F). Furthermore, the facility failed to thoroughly document and place effective interventions for each of R24's twelve documented falls since 03/26/24 (approximately 2 months). The facility failed to ensure thorough fall investigations to identify causal factors and implement effective care plan fall prevention interventions to prevent further falls for cognitively impaired R30, who had repeated falls. R30 fell multiple times with two of the falls within a month, both resulting in major injury (broken left him and right hip) which required emergency medical treatment and surgical repair. The facility failed to provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for Resident (R) 39, who had a history of personal trauma and a diagnosis of post-traumatic stress disorder. The facility failed to follow up on pharmacy recommendations in a timely manner for one Resident (R) 1, regarding as needed lorazepam (a medication used for severe agitation) to obtain a new prescription every 14 days, to minimize or prevent adverse consequences related to medication therapy. The facility failed to ensure two Residents (R) 1, regarding as needed lorazepam (a medication used for severe agitation) and R 24, regarding failure to monitor the use of an antipsychotic medication (medication used to treat psychosis). The facility failed to serve the residents of the facility food, which was palatable, attractive, and served at the appropriate temperature. (continued on next page)

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F 0835 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 the residents of the facility appropriately to prevent the potential for food borne illness. The facility failed to properly dispose of garbage and refuse by not ensuring the dumpster lid was always closed. The facility failed to electronically submit to Centers for Medicare and Medicaid Services (CMS) with complete and accurate direct staffing information, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS (i.e. Payroll Base Journal (PBJ), related to licensed nursing staffing information, when the facility failed to accurately report Registered Nurse (RN) coverage on 29 dates between January 1, 2023 and 09/30/23. The facility failed to maintain an effective infection control program with the failure of laundry services to maintain a closed clean linen cart while delivering laundry, and the failure to maintain enhanced barrier precautions (infection control interventions designed to reduce transmission of resistant organisms which employs targeted gown and glove use during high contact cares) (EBP) when providing cares to a resident with a chronic wound. 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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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 31078 The facility reported a census of 43 residents. Based on observation, interview, and record review the facility failed to electronically submit to Centers for Medicare and Medicaid Services (CMS) with complete and accurate direct staffing information, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS (i.e. Payroll Base Journal (PBJ), related to licensed nursing staffing information, when the facility failed to accurately report Registered Nurse (RN) coverage on 29 dates between January 1, 2023 and 09/30/23. Findings Included: - Review of the Payroll Base Journal (PBJ) Staffing Data Report for fiscal year (FY), Quarter 2 2023 (January 1-March 31) revealed a lack of Registered Nurse (RN) coverage for eight hours every 24 hours on the following dates: On 01/16 Monday (MO), On 01/23, MO, On 01/29, Sunday (SU), On 02/01, Wednesday (WE), On 02/05, SU, On 02/09, Thursday (TH), On 02/25, Saturday (SA), On 02/26, SU On 03/04, SA On 03/18, SA On 03/25, SA Review of the PBJ for FY, Quarter 3, 2023 (April 1- June 30), revealed a lack of Registered Nurse (RN) coverage for eight hours every 24 hours on the following dates: On 04/02, SU, On 04/08, SA, On 04/15, SA, (continued on next page)

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 04/16, SU, On 04/29, SA, On 04/30, SU, On 05/06, SA, On 05/07, SU, On 05/13, SA, On 05/14, SU, On 05/27, SA, Review of the PBJ for FY, Quarter 4, 2023 (July 1 - September 30), revealed a lack of Registered Nurse (RN) coverage for eight hours every 24 hours on the following dates: On 07/02, SU, On 08/20, SU, On 08/27, SU, On 09/16, SA, On 09/17, SU, On 09/23, SA, On 09/24, SU, On 06/03/24 at 11:00 AM, Administrative Nurse B stated the facility had an RN on duty on all days except for 05/04/24. The PBJ report was inaccurate. The facility lacked a policy for the accurate completion of the PBJ report. The facility failed to electronically submit to Centers for Medicare and Medicaid Services (CMS) with complete and accurate direct staffing information, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS (i.e., Payroll Base Journal (PBJ), related to licensed nursing staffing information when the facility failed to accurately report 24 hour per day RN coverage on 29 dates between 01/01/23 and 09/30/23.

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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. 35717 The facility reported a census of 43 residents. Based on the observations, interview, and record review obtained on the current survey IKSC11 and its numerous findings of deficient practice including 5 Immediate Jeopardy citations which constituted Substandard Quality of Care, and with several of the deficient practice areas noted as repeat citations from the prior survey, the facility failed to demonstrate an effective Quality Assurance and Performance Improvement (QAPI) program. This failure affected all 43 residents of the facility and placed them at risk for a decreased quality of life, decreased quality of care, and continued resident to resident abuse. (See all citations associated with IKSC11). Findings Included: - During the first day of the onsite recertification survey, 05/28/24, the surveyors discovered 4 Immediate Jeopardy (IJ) concerns which were not identified by the facility. The surveyors issued IJ templates to the facility for hazardous hot water temperatures (See finding at F689), for lack of preventing continued resident-to-resident abuse (See finding at F600), for lack of reporting all allegations of abuse (See finding at F609), and for lack of protecting residents from further abuse and lack of investigating all allegations of abuse (See finding at F610). The IJs further constituted Substandard Quality of Care and changed the recertification survey to an Extended Recertification Survey. Review of the prior annual recertification survey 89NQ11 dated 11/08/22 revealed areas of care were identified as deficient practice to include Comprehensive Assessments (F636), Baseline Care Plan (F655), Activities of Daily Living (ADL) Care Provided for Dependent Residents (F677), Treatment to Prevent Pressure Ulcers (F686), Free of Accident Hazards/Supervision (F689), Drug Regimen Review, Report Irregular, Act On (F756), and Food Procurement (F812). The Current survey also found deficient practice in 5 of the same areas, as evidence the facility had not maintained corrective measures in known areas of concern. Review of complaint surveys since the prior survey on 11/08/22 revealed the facility received a deficiency related to F600 abuse on the W8ZO11 complaint survey dated 06/21/23, regarding the same resident cited in the with continued resident-to-resident physical abuse in which the current survey identified IJ at F600, F609, and F610. The Current survey also found deficient practice in 5 of the same areas, as evidence the facility had not maintained corrective measures in known areas of concern. The current survey IKSC11 found deficient practice with the following failures: The facility failed to treat each resident with dignity, respect, and in a manner and environment that promoted the enhancement of resident's quality of life when the facility utilized Styrofoam containers for seven residents in their rooms for their meal trays. The facility failed to ensure the resident's representative for Resident (R) 22, the right to be informed when the resident had an increase in behaviors and the facility required the resident to be placed on staff one-to-one observation due to his behaviors. (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 maintain a clean, comfortable, and homelike environment for four Residents (R)7, R 26, R35 and R145, who had no means to control the temperature of their rooms. The facility failed to ensure staff identified and responded appropriately to all allegations of abuse, which included resident-to-resident abuse. 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 by federal regulations. The facility failed to investigate all allegations of resident-to-resident abuse, failed to protect residents from further incidents of abuse, and the facility failed to ensure staff provided adequate supervision and effective care planned interventions to prevent resident-to-resident abuse. The facility failed to recognize a significant change in a resident's physical condition and perform a Comprehensive Minimum Data Set (MDS) assessment within the required 14-day period of the resident's change in condition. This deficient practice had the potential to lead to uncommunicated needs and placed the resident at risk for further deterioration of his physical, mental, and psychosocial well-being. The facility failed to accurately complete the Minimum Data Set (MDS) for five sampled residents, as required by the federal regulations. The facility failed to develop a comprehensive person-centered care plan for seven of the 15 residents sampled. The facility failed to revise fall care plans with interventions for three residents for three of the 15 residents sampled. The facility failed to provide appropriate and timely Activities of Daily Living (ADLs) regarding untrimmed facial hair for one Resident(R)17. The facility failed to provide treatment and care in accordance with professional standards by the failure to coordinate resident care with hospice services. The facility failed to provide treatment and services necessary to prevent the development of pressure ulcers for three residents. (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 ensure an environment as free from accident hazards as possible when the hot water in four resident rooms and a beauty shop measured at hazardous levels ranging between 138 and 157-degrees Fahrenheit (F). Furthermore, the facility failed to thoroughly document and place effective interventions for each of R24's twelve documented falls since 03/26/24 (approximately 2 months). The facility failed to ensure thorough fall investigations to identify causal factore and implement care plan fall prevention interventions to prevent falls for cognitively impaired Resident (R) 30, who was identified with a high risk for falls and had a fall history. R30 had numerous falls with no care plan interventions implemented to prevent further falls, which resulted in two falls with major injury (a broken left hip and within a month a broken right hip) which required emergency medical treatment and surgical repair. The facility failed to provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for Resident (R) 39, who had a history of personal trauma and a diagnosis of post-traumatic stress disorder. The facility failed to ensure adequate staffing to meet the needs of the residents of the facility. In 2023 the facility lacked 8-hour Registered Nurse (RN) coverage for 29 days, as reported by the facility. In 2023 the facility lacked 24-hour Licensed Nurse (LN) coverage for 127 days, about 35% of the year. This deficient practice affected all residents in the facility. (See the citations found on current recertification survey to include 5 IJ, harm, and substandard quality of care.) The facility failed to ensure 8-hour Registered Nurse coverage each day, as required, in order to meet the needs of the residents. This failure had the potential to negatively affect all residents in the facility and placed them at risk for decreased quality of life, treatment, and care. The facility failed to follow up on pharmacy recommendations in a timely manner for one Resident(R)1, regarding as needed lorazepam (a medication used for severe agitation) to obtain a new prescription every 14 days, to minimize or prevent adverse consequences related to medication therapy. The facility failed to ensure two Residents (R) 1, regarding as needed lorazepam (a medication used for severe agitation) and R 24, regarding failure to monitor the use of an antipsychotic medication (medication used to treat psychosis). The facility failed to serve the residents of the facility food, which was palatable, attractive, and served at the appropriate temperature. The facility failed to prepare and serve food under sanitary conditions, to the residents of the facility appropriately to prevent the potential for food borne illness. The facility failed to properly dispose of garbage and refuse by not ensuring the dumpster lid was always closed. The facility failed to electronically submit to Centers for Medicare and Medicaid Services (CMS) with complete and accurate direct staffing information, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS (i.e. Payroll Base Journal (PBJ), related to licensed nursing staffing information, when the facility failed to accurately report Registered Nurse (RN) coverage on 29 dates between 01/01/23 and 09/30/23. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175454	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/03/2024
NAME OF PROVIDER OR SUPPLIER: Clearwater Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 620 E Wood Street Clearwater, KS 67026	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility failed to maintain an effective infection control program with the failure of laundry services to maintain a closed clean linen cart while delivering laundry, and the failure to maintain enhanced barrier precautions (infection control interventions designed to reduce transmission of resistant organisms which employs targeted gown and glove use during high contact cares) (EBP) when providing cares to a resident with a chronic wound. 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. The facility failed to have an effective QAPI program to identify the quality issues in the facility and implement and maintain corrective actions to ensure the highest mental, physical, and psychosocial wellbeing of each resident. This deficient practice affected all 43 residents of the facility and placed them at risk for substandard quality of care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175454	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clearwater Nursing & Rehabilitation Center	620 E Wood Street Clearwater, KS 67026

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46960 The facility identified a census of 43 residents. Based on interview, observations, and record review, the facility failed to maintain an effective infection control program when laundry services failed to maintain a closed clean linen cart while delivering laundry, and further failed to maintain enhanced barrier precautions (infection control interventions designed to reduce transmission of resistant organisms which employs targeted gown and glove use during high contact cares) (EBP) when providing cares to a resident with a chronic wound. Findings included: - On 05/30/24 at 08:33 AM, observation revealed Laundry Aide X push a laundry cart down a hallway with the cover down, raised the cover, and delivered the laundry items to a resident's room, exited the room, performed hand hygiene. Laundry Aide X then delivered linens to a second resident's room and left the laundry cart in the hallway with a raised cover. Laundry Aide X stated they were unsure of whether or not linen carts were required to be covered when unattended. On 06/03/24 at 09:03 AM, Licensed Nurse (LN) H provided wound care to Resident (R) 30, performed hand hygiene, collected supplies in a bag. LN H cleaned the wound with wound cleanser, removed gloves, and performed hand hygiene. LN H applied new gloves, placed Calcium Alginate (highly absorbent dressing) on the wound bed and secured the border gauze dressing, removed gloves, and performed hand hygiene. LN H was ssisted by Certified Nurse Aide (CNA) J and CNA F. At the time of the observation, LN H stated staff should have been on enhanced barrier precautions during wound care and should have implemented that intervention. On 06/03/24 at 09:30 AM, Administrative Nurse B stated that EBP should have beed in place for any resident who had a vector of infection into the body, including chronic wounds. On 06/03/24 at 04:00 PM, Maintenance Staff Q stated that all clean linen carts should be transported with the cover closed at all times. The facility's policy Enhanced [NAME] Precautions dated 03/2024, documented: The facility follows recommendations and guidance from the Centers of Disease Control to keep residents safe from Healthcare Acquired Infections (are infections people get while they are receiving health care for another condition) (HAI). EPB are implemented as one intervention the facility uses to reduce transmissions of resistant organisms that employs targeted personal protective equipment used during high contact resident care activities. Wound care and skin opening requiring a dressing. The facility failed to maintain an effective infection control program with the failure of laundry services to maintain a closed clean linen cart while delivering laundry, and the failure to maintain enhanced barrier precautions (EBP) when providing cares to a resident with a chronic wound.