STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175459	A. Building B. Wing	09/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wheatridge Park Care Center	1501 S Holly Dr Liberal, KS 67901

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 - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50659 The facility reported a census of 40 residents. The sample included 12 residents. Based on interview and record review, the facility failed to provide Resident (R)10 care in a dignified manner during colostomy care. R10 was left lying in his bed for 40 minutes with his door open, undressed waist up and no colostomy (surgical creation of an artificial opening on the stomach wall to excrete feces from the body) bag covered his stoma. This deficient practice placed the resident at risk for decreased psychosocial well-being. Findings included: - Resident (R)10 's Electronic Health Record (EHR) revealed diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion) and need for assistance with personal care. The Annual Minimum Data Set (MDS) dated [DATE], documented a Brief Interview for Mental Status (BIMS) of 15, indicating intact cognition. The resident had a total mood severity score of 00, indicating no depression and no behaviors. R10 required total assistance with activities of daily living (ADLs), which included toileting, dressing, and transfers. R10 was frequently incontinent of bladder and bowel. The Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) dated 12/05/23, documented R10 required variable assistance with ADL function and mobility related to rheumatoid arthritis (chronic inflammatory disease that affected joints and other organ systems). Staff would continue with care plan and a goal to maintain current function. The Quarterly MDS dated [DATE], documented a BIMS of eight, indicating moderately impaired cognition. R10 required total assistance with ADL's, which included toileting, dressing, and transfers. Frequently incontinent of bladder. Not rated for bowels as R10 had a colostomy. The 09/10/24 Care Plan documented R10 had a colostomy related to a fistula (abnormal passage from an internal organ to the body surface or between two internal organs). Staff were instructed to provide ostomy care each shift and as needed. Staff were to encourage R10 to discuss any concerns, fears, issues related to ostomy use or care as indicated, dated 03/18/24. The Physician's Order dated 03/19/24, colostomy care every shift and as needed. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/15/24, a Progress Note at 12:17 PM, two unidentified Certified Nurse Aides notified Licensed Nurse (LN) W that R10's ostomy bag required changing. R10 was angry that he had to wait to get his ostomy changed, yelled, and cursed at staff. Family member called and spoke with LN W, family member concerned R10 had to wait 40 minutes to receive ostomy care. LN W explained to family member that she went as soon as she was able to. On 09/10/24 at 11:37 AM, R10 stated that staff members left him lying in his bed undressed from waist up with no ostomy bag covering his stoma for 40 minutes sometime in June. R10 stated that his door to his room was left open and the curtains were closed. R10 stated he called his family member as he was angry. He stated that the next day he spoke to the Administrative Staff A and was satisfied with the outcome of the nurse being discharged . On 09/11/24 a Grievance dated 06/16/24, revealed LN W was removed from the schedule as R10 had to wait 40 minutes for a new colostomy bag. R10 was satisfied with the outcome and the grievance form was signed by Administrative Staff A on 06/17/24. On 09/11/24 at 01:25 PM, Administrative Staff A confirmed that LN W was no longer employed at the facility after R10 had to wait for a long period of time for care that was required. Administrative Staff A revealed that R10 was satisfied with the outcome. The facility's policy Dignity dated February 2021 documented: Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. Staff to promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures. Promptly responding to a resident's request for toileting assistance. The facility failed to provide Resident (R)10 care in a dignified manner during colostomy care. R10 was left lying in his bed for 40 minutes with his door open, undressed waist up and no colostomy bag covered his stoma. This deficient practice placed the resident at risk for decreased psychosocial well-being.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to manage his or her financial affairs. 50659 The facility reported a census of 40 residents. The sample included 12 residents. Based on interview and record review, the facility failed to ensure Resident (R)7 received his monthly benefits when he requested the funds. Findings included: - On 09/10/24 at 07:45 AM, R7 stated he requested his monthly benefits of 62.00 dollars on 09/06/24 in the morning prior to him leaving the facility for his dialysis (procedure where impurities or wastes were removed from the blood) appointment. R7 stated when he returned to facility in the afternoon, there was no check waiting for him and Administrative Staff I was gone for the day. On 09/12/24 at 09:25 AM, Certified Medication Aide (CMA) V reported she was not aware of any money for residents to have available when the business office was closed. On 09/12/24 at 09:26 AM, Licensed Nurse (LN) U reported he was unaware of any money being available for residents that requested money from staff if the business office was closed. LN U stated he would not know the policy on how residents could receive money at night or on the weekends. On 09/12/24 at 09:30 AM, Social Service Designee (SSD) K reported she was unaware if residents had access to their personal funds on weekends, evening, or night shift when the business office was closed. SSD K reported that residents were encouraged to request their funds from Administrative Staff I or Administrative Staff A on Fridays. Additionally, SSD K stated that Administrative Staff I or Administrative Staff A would have to come to the facility on off hours to ensure a resident received the money requested. On 09/12/24 at 10:42 AM, Administrative Staff I reported that the facility is R7's payee and R7 requested his monthly benefit of 62.00 dollars on 09/06/24 prior to R7 being transported to dialysis. Administrative Staff I confirmed R7 had not received his monthly benefits as of 09/12/24, as R7 did not come back down to the business office to request the money. Administrative Staff I reported she should have delivered the requested funds to R7 the day he requested the funds. Administrative Staff I reported that there was 100.00 dollars in a locked box in the medication room for the residents with personal funds handled by facility for residents to request if the business office was closed. On 09/12/24 at 10:45 AM, Administrative Staff A confirmed the above concern was an issue. The facility's policy Management of Residents' Personal Funds dated March 2021 documented our facility manages personal funs of residents who request to do so. Should the facility be appointed the resident's payee, and directly receive monthly benefits to which the resident is entitled, such funds are managed in accordance with established policies and federal/state requirements. (continued on next page)

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility failed to ensure R7 received his monthly benefit in a timely manner. This deficient practice had the potential to have a negative effect on the overall physical and psychosocial well-being of the resident in the facility.

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50659 The facility reported a census of 40 residents, with 12 residents sampled, including review for advanced directives (a written document which indicated the medical decisions for health care professionals when the person could not make their own decisions). Based on interview and record review, the facility failed to ensure four residents had accurately completed advanced directives. Resident (R)2 had a Do Not Resuscitate (DNR- or no code, a legal document or order that means the person does not desire cardiopulmonary resuscitation [CPR is an emergency lifesaving procedure performed when the heart stops beating] in the event of cardiac arrest), only signed by a physician. R8 had two DNR's; one signed by the guardian only and the other one signed only by the physician. R10's DNR was not signed by a witness and R 20's DNR was only signed by a physician. Findings included: - Resident (R)2 's Electronic Health Record (EHR) revealed diagnoses of diabetes mellitus type two (DM2-when the body cannot use glucose, not enough insulin made, or the body cannot respond to the insulin) and reduced mobility. The Significant Change Minimum Data Set (MDS) dated [DATE], documented a Brief Interview for Mental Status (BIMS) of 99, indicating intact severely impaired cognition. The resident had a total mood severity score of two, indicating no depression and no behaviors. R2 required total assistance with activities of daily living (ADLs), which included bed mobility, toileting, dressing, and bathing. R2 was always incontinent of bladder. R2 had a stage two pressure ulcer (partial-thickness skin loss into but no deeper than the dermis including intact or ruptured blisters) on admission. There was a pressure relieving device on the bed and the chair. The Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) did not trigger on the [DATE] MDS. The Quarterly MDS dated [DATE], documented a BIMS of 99. The [DATE] Care Plan documented staff were not to perform cardiopulmonary resuscitation (CPR-emergency lifesaving procedure performed when the heart stops beating), dated [DATE]. The Physician's Order dated [DATE], documented a Do Not Resuscitate order. The review of the scanned DNR lacked a signature from the resident or durable power of attorney (DPOA-legal document that named a person to make healthcare decisions when the resident was no longer able to). The DNR was only signed by a physician, dated [DATE]. On [DATE] at 04:45 PM, Social Service Designee (SSD) K confirmed that R2's DNR lacked the resident or DPOA signatures. SSD K revealed that a DNR required a resident or DPOA signature and then signed by the physician. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 04:40 PM, Administrative Nurse B confirmed the advanced directives forms should be completed as per policy and contain all the required signatures. On [DATE] at 10:49 AM, Administrative Staff A confirmed there was an issue with advanced directives not being signed as required. The facility's Advanced Directives policy dated [DATE] documented the resident has the right to formulate an advanced directive, including the right to accept or refuse medical or surgical treatment. Advanced directives are honored in accordance with state law and facility policy. Upon admission, the resident will be provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advanced directive if they choose to do so. DPOA for healthcare is a document delegating authority to a legal representative to make health care decisions in case the individual delegating the authority subsequently becomes incapacitated. The facility failed to ensure R2 had an accurately completed advanced directive. This deficient practice had the potential to lead to uncommunicated needs specifically to end-of-life care. - Resident (R)10 's Electronic Health Record (EHR) revealed diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion) and need for assistance with personal care. The Annual Minimum Data Set (MDS) dated [DATE], documented a Brief Interview for Mental Status (BIMS) of 15, indicating intact cognition. The resident had a total mood severity score of 00, indicating no depression and no behaviors. R10 required total assistance with activities of daily living (ADLs), which included toileting, dressing, and transfers. R10 was frequently incontinent of bladder and bowel. The Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) dated [DATE], documented R10 required variable assistance with ADL function and mobility related to rheumatoid arthritis (chronic inflammatory disease that affected joints and other organ systems). Staff would continue with care plan and a goal to maintain current function. The Quarterly MDS dated [DATE], documented a BIMS of eight, indicating moderately impaired cognition. R10 required total assistance with ADL's, which included toileting, dressing, and transfers. Frequently incontinent of bladder. Not rated for bowels as R10 had a colostomy (surgical creation of an artificial opening on the stomach wall to excrete feces from the body). The [DATE] Care Plan documented staff were not to perform cardiopulmonary resuscitation (CPR-emergency lifesaving procedure performed when the heart stops beating), dated [DATE]. The Physician's Order dated [DATE], documented a Do Not Resuscitate order. The review of the scanned DNR lacked a witness signature on the [DATE] DNR form. On [DATE] at 04:45 PM, Social Service Designee (SSD) K confirmed that R10's DNR lacked the witness signature. SSD K revealed that a DNR required a witness signature. On [DATE] at 04:40 PM, Administrative Nurse B confirmed the advanced directives forms should be completed as per policy and contain all the required signatures. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 10:49 AM, Administrative Staff A confirmed there was an issue with advanced directives not being signed as required. The facility's Advanced Directives policy dated [DATE] documented the resident has the right to formulate an advanced directive, including the right to accept or refuse medical or surgical treatment. Advanced directives are honored in accordance with state law and facility policy. Upon admission, the resident will be provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advanced directive if they choose to do so. DPOA for healthcare is a document delegating authority to a legal representative to make health care decisions in case the individual delegating the authority subsequently becomes incapacitated. The facility failed to ensure R10 had an accurately completed advanced directive. This deficient practice had the potential to lead to uncommunicated needs specifically to end-of-life care. - Resident (R)20 's Electronic Health Record (EHR) revealed diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion) and osteoporosis (abnormal loss of bone density and deterioration of bone tissue with an increased fracture risk). The Annual Minimum Data Set (MDS) dated [DATE], documented a Brief Interview for Mental Status (BIMS) of 99, indicating intact severely impaired cognition. The resident had a total mood severity score of 00, indicating no depression and no behaviors. R20 required total assistance with activities of daily living (ADLs), which included bed mobility, toileting, dressing, and bathing. R20 was always incontinent of bladder. The Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA), dated [DATE] lacked analysis of findings documented. The Quarterly MDS dated [DATE], documented a BIMS of 99. The [DATE] Care Plan documented staff were not to perform cardiopulmonary resuscitation (CPR-emergency lifesaving procedure performed when the heart stops beating), dated [DATE]. The Physician's Order dated [DATE], documented a Do Not Resuscitate order. The review of the scanned DNR lacked a signature from the resident or durable power of attorney (DPOA-legal document that named a person to make healthcare decisions when the resident was no longer able to) and lacked a witness signature. The DNR was only signed by a physician, dated [DATE]. On [DATE] at 04:45 PM, Social Service Designee (SSD) K confirmed that R20's DNR lacked the resident or DPOA signatures and witness signature. SSD K revealed that a DNR required a resident or DPOA signature, then a witness signature and then signed by the physician. On [DATE] at 04:40 PM, Administrative Nurse B confirmed the advanced directives forms should be completed as per policy and contain all the required signatures. On [DATE] at 10:49 AM, Administrative Staff A confirmed there was an issue with advanced directives not being signed as required. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's Advanced Directives policy dated [DATE] documented the resident has the right to formulate an advanced directive, including the right to accept or refuse medical or surgical treatment. Advanced directives are honored in accordance with state law and facility policy. Upon admission, the resident will be provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advanced directive if they choose to do so. DPOA for healthcare is a document delegating authority to a legal representative to make health care decisions in case the individual delegating the authority subsequently becomes incapacitated. The facility failed to ensure R20 had an accurately completed advanced directive. This deficient practice had the potential to lead to uncommunicated needs specifically to end-of-life care. 46960 - Review of the Electronic Health Record (EHR) for Resident (R)8 included the diagnoses of osteoporosis (abnormal loss of bone density and deterioration of bone tissue with an increased fracture risk), history of falling, repeated falls, generalized muscle weakness, lack of coordination and dementia (a progressive mental disorder characterized by failing memory, confusion). The Significant Change Minimum Data Set (MDS) dated [DATE], documented R8 was unable to complete the Brief Interview for Mental Status (BIMS) assessment and staff assessed R8 to have severely impaired cognition. The assessment documented R8 required substantial or maximal assistance from staff for cares. R8 was dependent on staff to perform oral hygiene. R8 required supervision and setup for eating. R8 was frequently incontinent of bladder and always incontinent of bowel. The Cognitive Loss / Dementia Care Area Assessment (CAA) dated [DATE], documented R8 as deceased . The Quarterly MDS dated [DATE], documented R8 was unable to complete the BIMS assessment and staff assessed R8 to have severely impaired cognition. The assessment documented R8 was dependent on staff for toileting, bathing and all forms of hygiene and required substantial or maximal assistance for all other cares except eating which was required supervision/setup. R8 was frequently incontinent of bowel and always incontinent of bladder. The [DATE] Care Plan documented the following: 1. On [DATE], two interventions documented staff were not to perform cardiopulmonary resuscitation (CPR-emergency lifesaving procedure performed when the heart stops beating). 2. On [DATE], staff were to honor the resident's wishes. 3. On [DATE], staff were to notify the physician and family of the resident's passing. 4. On [DATE], staff were to provide comfort to the resident's family during a time of loss. The Physician's Order dated [DATE], documented a Do Not Resuscitate order. The review of the EHR scanned documents revealed the following: (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. A DNR order, dated [DATE], lacked a signature from the resident or durable power of attorney (DPOA-legal document that named a person to make healthcare decisions when the resident was no longer able to). Additionally, the document lacked a witness signature. The DNR was signed by R8's guardian/conservator, dated [DATE], and a physician, dated [DATE]. 2. A DNR order, dated [DATE], lacked a signature from the resident or DPOA or witness. The DNR was only signed by a physician dated [DATE]. On [DATE] at 08:22 AM, Social Service Designee (SSD) K that residents DNR should have a resident or DPOA signature and a witness, and a physician signature. SSD K confirmed that some residents DNR orders were missing signatures. SSD K also confirmed that guardians/conservators cannot sign a resident's DNR order without a court order. On [DATE] at 04:40 PM, Administrative Nurse B confirmed the advanced directives forms should be completed as per policy and contain all the required signatures and cannot be signed by a resident's guardian/conservator. On [DATE] at 10:49 AM, Administrative Staff A confirmed there was an issue with advanced directives not being signed as required. The facility's Advanced Directives policy dated [DATE] documented the resident has the right to formulate an advanced directive, including the right to accept or refuse medical or surgical treatment. Advanced directives are honored in accordance with state law and facility policy. Upon admission, the resident will be provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advanced directive if they choose to do so. DPOA for healthcare is a document delegating authority to a legal representative to make health care decisions in case the individual delegating the authority subsequently becomes incapacitated. The facility failed to ensure R8 had an accurately completed advanced directive. This deficient practice had the potential to lead to uncommunicated needs specifically to end-of-life care.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50659 The facility reported a census of 40 residents. The sample included 12 residents. Based on interview and record review, the facility failed to ensure the correct and complete Beneficiary Protection Notification forms were issued to one of three residents reviewed, Resident (R)146. Findings included: - On 09/11/24 review of the Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage Form CMS-20052 (SNFABN) and the Notification of Medicare Non-Coverage Form 10123(NOMNC- the form used to notify Medicare A participants of their rights to appeal and the last covered date of service) both forms lacked Resident (R)146's signature before her discharge home on 03/08/24. Option three checked to reflect I don't want the care listed above. I understand that I'm not responsible for paying, and I can't appeal to see if Medicare would pay. The box was marked off with an X. A handwritten comment on both forms Resident discharged from facility before signature was received. The forms were only signed by the Social Service Designee (SSD) K on 03/08/24. On 09/11/24 review of Physical Therapy Discharge Summary revealed R146 was discharged on physical therapy on 03/07/24, as R146 met maximal potential. On 09/11/24 review of Occupational Therapy Discharge Summary revealed R146 was discharged from occupational therapy on 03/07/24, as R146 met maximal potential. On 03/06/24 at 01:24 PM, a Progress Note revealed the facility received discharge orders from R146's physician, to be discharged on current treatment plan. On 03/07/24 at 08:49 AM, a Progress Note revealed R146 to be discharged home on current treatment plan on 03/08/24. On 03/08/24 at 09:01 AM, a Progress Note revealed R146 discharged from the facility. On 09/11/24 at 03:38 PM, Administrative Staff I reported R146 requested the discharge and R146's husband came to the facility on [DATE] and R146 wanted to go home. Administrative Staff I had made no comment when questioned about discharge orders requested on 03/04/24 and received on 03/06/24. On 09/11/24 at 04:40 PM, Social Service Designee (SSD) K revealed R146 had a planned discharged . SSD K confirmed she received the SNFABN and NOMNC forms on 03/08/24 from Administrative Staff I to have R146 sign. SSD K confirmed she wrote the comment on the form that resident discharged from the facility before R146's signature obtained. Additionally, SSD K reported that Administrative Staff I normally would complete the required forms. On 09/12/24 at 10:49 AM, Administrative Staff A confirmed the above concern was an issue. On 09/12/24 at 02:45 PM, Physical Therapy Staff Y revealed R146 was a planned discharge to home and she gave Administrative Staff I the NOMNC a few days prior to her discharge. (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's policy Medicare Advance Beneficiary and Medicare Non-Coverage Notices dated September 2022, documented residents are informed in advance when changes will occur to their bills. The resident is informed that they may choose to continue receiving skilled services that may not be paid by Medicare and assume financial responsibility. A NOMNC is issued to the resident at least two calendar days before benefits end. The facility failed to ensure the correct and complete Beneficiary Protection Notification forms were issued to R146, as required.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46960 The facility identified a census of 40 residents which included 12 residents sampled, that included five residents reviewed for notification of discharge to residents' representative and the Office of the State Long-Term Care Ombudsman. The facility failed to provide written notification to the representatives of Resident (R) 8, R26, R2, R10 and R21. Additionally, the facility also failed to notify the Office of the Long-Term Care Ombudsman (LTCO-a public official who works to resolve resident issues in nursing facilities). These deficient practices placed the residents at risk for impaired rights and uninformed care choices and had the potential to lead to uncommunicated needs related to continuity of care across the healthcare spectrum. Findings included: - Review of the Electronic Health Record (EHR) for Resident (R) 8 revealed a hospitalization from [DATE] to 05/06/24. Review of the EHR Progress Notes lacked documentation that R8's representative was notified of the hospitalization by the facility. Review of the EHR scanned documents lacked documentation that the facility notified the LTCO regarding the hospitalization of R8. On 09/12/24 at 09:40 AM, Social Services Designee (SSD) K stated she did not know of the requirement to contact the LTCO when a resident was transferred or discharged . On 09/12/24 at 10:49 AM, Administrative Staff A stated that he was unsure about the bed hold policy and would need to look at the policy. Administrative Staff A reported that the LTCO should be notified once a month regarding transfers or discharges to a hospital. The facility lacked a policy related to notifications of residents' representatives or LTCO upon transfer or discharge. The facility failed to provide written notification to the representatives of R8 or the LTCO when this resident required hospitalization . This deficient practice placed R8 at risk for impaired rights and uninformed care choices and had the potential to lead to uncommunicated needs related to continuity of care across the healthcare spectrum. - Review of the Electronic Health Record (EHR) for Resident (R) 26 revealed a hospitalization from [DATE] to 08/06/24. Review of the EHR Progress Notes lacked documentation that R26's representative was notified of the hospitalization by the facility. Review of the EHR scanned documents lacked documentation that the facility notified the LTCO regarding the hospitalization of R26. (continued on next page)

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	175459	A. Building B. Wing	09/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wheatridge Park Care Center	1501 S Holly Dr Liberal, KS 67901

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 09/12/24 at 09:40 AM, Social Services Designee (SSD) K stated she did not know of the requirement to contact the LTCO when a resident was transferred or discharged . On 09/12/24 at 10:49 AM, Administrative Staff A stated that he was unsure about the bed hold policy and would need to look at the policy. Administrative Staff A reported that the LTCO should be notified once a month regarding transfers or discharges to a hospital. The facility lacked a policy related to notifications of residents' representatives or LTCO upon transfer or discharge. The facility failed to provide written notification to the representatives of R26 or the LTCO when this resident required hospitalization . This deficient practice placed R26 at risk for impaired rights and uninformed care choices and had the potential to lead to uncommunicated needs related to continuity of care across the healthcare spectrum. 50659 - Resident (R) 2's Electronic Health Record (EHR) revealed diagnoses of diabetes mellitus type two (DM2-when the body cannot use glucose, not enough insulin made, or the body cannot respond to the insulin) and reduced mobility. The Significant Change Minimum Data Set (MDS) dated [DATE], documented a Brief Interview for Mental Status (BIMS) of 99, indicating severely impaired cognition. The resident had a total mood severity score of two, indicating no depression and R2 had no behaviors. R2 required total assistance with activities of daily living (ADLs), which included bed mobility, toileting, dressing, and bathing. R2 was always incontinent of bladder. R2 had a stage two pressure ulcer (partial-thickness skin loss into but no deeper than the dermis including intact or ruptured blisters) on admission. The Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) did not trigger on the 10/25/23 MDS. The Pressure Ulcer CAA dated 11/02/23, documented an actual skin breakdown and R2 was at risk for further skin breakdown due to incontinence. Treatment and preventative measures were in place and the facility consulted a wound care physician. The facility would proceed with care planning to ensure that interventions were in place to heal an existing wound and prevent new skin breakdown. The Quarterly MDS dated [DATE], documented a BIMS of 99. R2 required total assistance of staff with ADLs. R2 had two stage three pressure ulcers (full thickness pressure injury extending through the skin into the tissue below), which were facility acquired and had pressure relieving devices on the bed and the chair. Review of the Progress Notes from 01/01/24 to 09/10/24 documented the following: On 04/16/24, a Progress Note at 11:08 AM, wound care clinic staff had R2 admitted to a hospital for a worsened foot ulcer and noted the left heel wound required debridement (medical removal of dead, damaged, or infected tissue to improve the healing potential for the remaining healthy tissue). Family notified. (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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/18/24, a Progress Note at 01:44 PM, R2 readmitted back to the facility. Review of the EHR scanned documents lacked documentation that the facility notified the Office of the Long-Term Care Ombudsman (LTCO-a public official who works to resolve resident issues in nursing facilities) regarding the hospitalization of R2. On 09/12/24 at 09:40 AM, Social Services Designee (SSD) K stated she did not know of the requirement to contact the LTCO when a resident was transferred or discharged . On 09/12/24 at 10:49 AM, Administrative Staff A stated that he was unsure about the bed hold policy and would need to look at the policy. Administrative Staff A reported that the LTCO should be notified once a month regarding transfers or discharges to a hospital. The facility lacked a policy related to notifications of residents' representatives or LTCO upon transfer or discharge. The facility failed to provide written notification to the LTCO when R2 required hospitalization . This deficient practice placed R2 at risk for impaired rights and uninformed care choices and had the potential to lead to uncommunicated needs related to continuity of care across the healthcare spectrum. - Resident (R)10 's Electronic Health Record (EHR) revealed diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion) and need for assistance with personal care. The Annual Minimum Data Set (MDS) dated [DATE], documented a Brief Interview for Mental Status (BIMS) of 15, indicating intact cognition. The resident had a total mood severity score of 00, indicating no depression and no behaviors. R10 required total assistance with activities of daily living (ADLs), which included toileting, dressing, and transfers. R10 was frequently incontinent of bladder and bowel. The Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) dated 12/05/23, documented R10 required variable assistance with ADL function and mobility related to rheumatoid arthritis (chronic inflammatory disease that affected joints and other organ systems). Staff would continue with care plan and a goal to maintain current function. The Quarterly MDS dated [DATE], documented a BIMS of eight, indicating moderately impaired cognition. R10 required total assistance with ADL's, which included toileting, dressing, and transfers. Frequently incontinent of bladder. Not rated for bowels as R10 had a colostomy (surgical creation of an artificial opening on the stomach wall to excrete feces from the body). On 09/10/24 11:37 AM, R10 reported he had been in the hospital in March 2024 for his stomach pain and had to have a colostomy completed. Review of the EHR scanned documents lacked documentation that the facility notified the Office of the Long-Term Care Ombudsman (LTCO-a public official who works to resolve resident issues in nursing facilities) regarding the hospitalization of R10. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 09/12/24 at 09:40 AM, Social Services Designee (SSD) K stated she did not know of the requirement to contact the LTCO when a resident was transferred or discharged . On 09/12/24 at 10:49 AM, Administrative Staff A stated that he was unsure about the bed hold policy and would need to look at the policy. Administrative Staff A reported that the LTCO should be notified once a month regarding transfers or discharges to a hospital. The facility lacked a policy related to notifications of residents' representatives or LTCO upon transfer or discharge. The facility failed to provide written notification to the LTCO when this R10 required hospitalization . This deficient practice placed R10 at risk for impaired rights and uninformed care choices and had the potential to lead to uncommunicated needs related to continuity of care across the healthcare spectrum. - Resident (R)21 's Electronic Health Record (EHR) revealed diagnoses of chronic obstructive pulmonary disease (COPD- progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing) and sleep apnea (disorder of sleep characterized by periods without respirations). The 05/20/24 Admission Minimum Data Set (MDS), documented a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The resident had a total mood severity score of 00, indicating no depression and no behaviors. R21 required total assistance with activities of daily living (ADLs), with toileting hygiene. Maximal assistance dressing and transfers. The 05/27/24 Care Area Assessment (CAA) lacked analysis of findings documented. The 08/05/24 Quarterly MDS, documented a BIMS score of 15, indicating intact cognition. R21 required total assistance with most ADLs. R21 required oxygen. Review of the EHR for Resident (R)21 revealed a hospitalization from [DATE] to 06/27/24, a hospitalization from [DATE] to 07/08/24 and a hospitalization from [DATE] to 07/31/24. Review of the EHR scanned documents lacked documentation that the facility notified the Office of the Long-Term Care Ombudsman (LTCO-a public official who works to resolve resident issues in nursing facilities) regarding the hospitalization of R21. On 09/12/24 at 09:40 AM, Social Services Designee (SSD) K stated she did not know of the requirement to contact the LTCO when a resident was transferred or discharged . On 09/12/24 at 10:49 AM, Administrative Staff A stated that he was unsure about the bed hold policy and would need to look at the policy. Administrative Staff A reported that the LTCO should be notified once a month regarding transfers or discharges to a hospital. The facility lacked a policy related to notifications of residents' representatives or LTCO upon transfer or discharge. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility failed to provide written notification to the LTCO when this R21 required hospitalization . This deficient practice placed R21 at risk for impaired rights and uninformed care choices and had the potential to lead to uncommunicated needs related to continuity of care across the healthcare spectrum.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50659 The facility had a census of 40 residents. The sample included 12 residents with five residents reviewed for hospitalization . Based on observation, interview, and record review, the facility failed to provide a bed hold notice to Residents, (R)2, R10, R21 and R26 and/or their representative with a written notice specifying the duration of the bed-hold policy, at the time of the residents' transfers to the hospital. Findings included: - Resident (R) 2's Electronic Health Record (EHR) revealed diagnoses of diabetes mellitus type two (DM2-when the body cannot use glucose, not enough insulin made, or the body cannot respond to the insulin) and reduced mobility. The Significant Change Minimum Data Set (MDS) dated [DATE], documented a Brief Interview for Mental Status (BIMS) of 99, indicating severely impaired cognition. The resident had a total mood severity score of two, indicating no depression and R2 had no behaviors. R2 required total assistance with activities of daily living (ADLs), which included bed mobility, toileting, dressing, and bathing. R2 was always incontinent of bladder. R2 had a stage two pressure ulcer (partial-thickness skin loss into but no deeper than the dermis including intact or ruptured blisters) on admission. The Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) did not trigger on the 10/25/23 MDS. The Pressure Ulcer CAA dated 11/02/23, documented an actual skin breakdown and R2 was at risk for further skin breakdown due to incontinence. Treatment and preventative measures were in place and the facility consulted a wound care physician. The facility would proceed with care planning to ensure that interventions were in place to heal an existing wound and prevent new skin breakdown. The Quarterly MDS dated [DATE], documented a BIMS of 99. R2 required total assistance of staff with ADLs. R2 had two stage three pressure ulcers, which were facility acquired and had pressure relieving devices on the bed and the chair. The 09/10/24 Care Plan lacked any documentation regarding a bed hold. Review of the Progress Notes from 01/01/24 to 09/10/24 documented the following: On 04/16/24, a Progress Note at 11:08 AM, wound care clinic staff had R2 admitted to a hospital for a worsened foot ulcer and noted the left heel wound required debridement (medical removal of dead, damaged, or infected tissue to improve the healing potential for the remaining healthy tissue). On 4/18/24, a Progress Note at 01:44 PM, R2 readmitted back to facility. Review of EHR on 09/10/24 lacked any documentation for a bed hold. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 09/12/24 at 09:30 AM, Social Service Designee (SSD) K reported she did not provide R2 or representative with a written bed-hold policy, because she would have documented that in the progress notes. On 09/12/24 at 09:57 AM, Administrative Nurse B reported charge nurses do not complete a bed hold form when a resident transferred to a hospital. She reported that Administrative Staff I or SSD K would be responsible to complete the bed hold form. On 09/12/24 at 10:42 AM, Administrative Staff I reported she would not complete any bed hold forms for residents or representative when a resident would be transferred to the hospital. On 09/12/24 at 10:49 AM, Administrative Staff A reported he was unsure about the bed hold policy and would need to read the policy. The facility's policy Bed-Holds and Returns dated October 2022, documented residents and or representatives are informed in writing of the facility and staff (if applicable) bed-hold policies. All residents and or representatives are provided written information regarding the facility and state bed-hold policies, which address holding or reserving a resident's bed during periods of absence (hospitalization s). Residents, regardless of payer source, are provided written notice about these policies. At the time of transfer (or, if the transfer was an emergency, within 24 hours). The facility failed to provide a bed-hold notice to R2 and/or their representative specifying the duration of the bed hold policy, at the time of the resident's transfer to the hospital. - Resident (R)10 's Electronic Health Record (EHR) revealed diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion) and need for assistance with personal care. The Annual Minimum Data Set (MDS) dated [DATE], documented a Brief Interview for Mental Status (BIMS) of 15, indicating intact cognition. The resident had a total mood severity score of 00, indicating no depression and no behaviors. R10 required total assistance with activities of daily living (ADLs), which included toileting, dressing, and transfers. R10 was frequently incontinent of bladder and bowel. The Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) dated 12/05/23, documented R10 required variable assistance with ADL function and mobility related to rheumatoid arthritis (chronic inflammatory disease that affected joints and other organ systems). Staff would continue with care plan and a goal to maintain current function. The Quarterly MDS dated [DATE], documented a BIMS of eight, indicating moderately impaired cognition. R10 required total assistance with ADL's, which included toileting, dressing, and transfers. Frequently incontinent of bladder. Not rated for bowels as R10 had a colostomy (surgical creation of an artificial opening on the stomach wall to excrete feces from the body). The 09/10/24 Care Plan lacked any documentation regarding a bed hold. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/01/24, a Progress Note at 04:25 PM, physician updated on R10 abdominal pain, had not voided and was lethargic. Physician had ordered a straight catheter yesterday (a flexible tube inserted through a narrow opening into a body cavity, particularly the bladder, for removing fluid). R10 refused the catheter. The physician ordered an indwelling catheter to be placed, and if unable to place in house, send R10 to the hospital. On 03/01/24, a Progress Note at 04:42 PM, R10 was transferred to the hospital as resident refused the indwelling catheter to be placed. On 03/13/24, a Progress Note at 12:20 AM, R10 remained in hospital, On 03/15/24, a Progress Note at 06:30 PM, R10 readmitted back to facility. On 09/10/24 at 11:37 AM, R10 reported he had been in the hospital in March 2024 for his stomach pain and had to have a colostomy. Review of EHR on 09/10/24 lacked any documentation for a bed hold. On 09/12/24 at 09:30 AM, Social Service Designee (SSD) K reported she did not provide R10 or representative with a written bed-hold policy, because she would have documented that in the progress notes. On 09/12/24 at 09:57 AM, Administrative Nurse B reported charge nurses do not complete a bed hold form when a resident transferred to a hospital. She reported that Administrative Staff I or SSD K would be responsible to complete the bed hold form. On 09/12/24 at 10:42 AM, Administrative Staff I reported she would not complete any bed hold forms for residents or representative when a resident would be transferred to the hospital. On 09/12/24 at 10:49 AM, Administrative Staff A reported he was unsure about the bed hold policy and would need to read the policy. The facility's policy Bed-Holds and Returns dated October 2022, documented residents and or representatives are informed in writing of the facility and staff (if applicable) bed-hold policies. All residents and or representatives are provided written information regarding the facility and state bed-hold policies, which address holding or reserving a resident's bed during periods of absence (hospitalization s). Residents, regardless of payer source, are provided written notice about these policies. At the time of transfer (or, if the transfer was an emergency, within 24 hours). The facility failed to provide a bed hold notice to R10 and/or their representative specifying the duration of the bed-hold policy, at the time of the resident's transfer to the hospital. - Resident (R)21 's Electronic Health Record (EHR) revealed diagnoses of chronic obstructive pulmonary disease (COPD- progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing) and sleep apnea (disorder of sleep characterized by periods without respirations). (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 05/20/24 Admission Minimum Data Set (MDS), documented a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The resident had a total mood severity score of 00, indicating no depression and no behaviors. R21 required total assistance with activities of daily living (ADLs), with toileting hygiene and required maximal assistance with dressing and transfers. The 05/27/24 Care Area Assessment (CAA) lacked analysis of findings documented. The 08/05/24 Quarterly MDS, documented a BIMS score of 15, indicating intact cognition. R21 required total assistance with most ADLs. R21 required oxygen. The 09/10/24 Care Plan lacked any documentation regarding a bed hold. Review of the Progress Notes from 01/01/24 to 09/10/24 documented the following: On 06/20/24, a Progress Note at 03:54 PM, R21 transferred to a hospital with altered mental status and functional decline. R21 admitted to hospital for alerted level of consciousness and elevated laboratory results. The responsible party notified. On 06/27/24, a Progress Note at 05:29 PM, R21 readmitted back to the facility. On 07/05/24, a Progress Note at 08:53 AM, R21 transferred to a hospital for altered mental status. The responsible party notified. On 07/05/24, a Progress Note at 12:44 PM, R21 was admitted to the hospital for respiratory failure (results from inadequate gas exchange by the respiratory system). On 07/08/24, a Progress Note at 11:40 PM, R21 readmitted back to facility. On 07/28/24, a Progress Note at 06:33 PM, R21 transferred to a hospital for shortness of breath and altered mental status. The responsible party notified. On 07/28/24, a Progress Note at 08:40 PM, R21 admitted to hospital for chronic kidney disease (a condition that occurs when the kidneys are damaged and can't filter blood properly) and a urinary tract infection (UTI-an infection in any part of the urinary system). On 07/31/24, a Progress Note at 03:20 PM, R21 readmitted back to the facility. Review of EHR on 09/10/24 lacked any documentation for a bed hold. On 09/12/24 at 09:30 AM, Social Service Designee (SSD) K reported she did not provide R21 or representative with a written bed-hold policy, because she would have documented that in the progress notes. On 09/12/24 at 09:57 AM, Administrative Nurse B reported charge nurses do not complete a bed hold form when a resident transferred to a hospital. She reported that Administrative Staff I or SSD K would be responsible to complete the bed hold form. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 09/12/24 at 10:42 AM, Administrative Staff I reported she would not complete any bed hold forms for residents or representative when a resident would be transferred to the hospital. On 09/12/24 at 10:49 AM, Administrative Staff A reported he was unsure about the bed hold policy and would need to read the policy. The facility's policy Bed-Holds and Returns dated October 2022, documented residents and or representatives are informed in writing of the facility and staff (if applicable) bed-hold policies. All residents and or representatives are provided written information regarding the facility and state bed-hold policies, which address holding or reserving a resident's bed during periods of absence (hospitalization s). Residents, regardless of payer source, are provided written notice about these policies. At the time of transfer (or, if the transfer was an emergency, within 24 hours). The facility failed to provide a bed hold notice to R21 and/or their representative specifying the duration of the bed-hold policy, at the time of the resident's transfer to the hospital. 46960 - Resident (R) 26's Electronic Health Record (EHR) revealed diagnoses of altered mental status, infection and inflammatory reaction due to catheter, Wernicke's encephalopathy (an acute neurological condition marked by mental confusion and unsteady gait), sepsis (systemic reaction that develops when the chemicals in the immune system release into the blood stream to fight an infection which cause inflammation throughout the entire body instead. Severe cases of sepsis can lead to the medical emergency, septic shock.) and hypertension (HTN- elevated blood pressure) Review of Discharge Minimum Data Set (MDS) dated [DATE] documented R26 had an unplanned discharge with a return anticipated. Review of Quarterly MDS dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of nine, which indicated moderate cognitive impairment. R26 was independent with all cares. R26 had behaviors of wandering one to three days in the look back period and other behavioral symptoms not directed towards others one to three days during the look back period. The 09/10/24 Care Plan lacked any documentation regarding a bed hold. Review of Progress Notes revealed the following: On 08/04/24 at 02:41 PM, a Progress Note documented R26 had blood from his penis. R26 transferred to the hospital at 01:40 PM. The progress note lacked evidence that the responsible party was notified, or a bed hold given to the resident and/or responsible party. On 08/04/24 at 06:26 PM, a Progress note documented R26 was admitted to the hospital for elevated white blood cell count and fever. The progress note lacked evidence that a responsible party was notified or bed hold given to the resident/responsible party. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a Census Log in the EHR revealed R26 discharged on [DATE] and returned to the facility on [DATE]. Review of EHR on 09/10/24 lacked any documentation for a bed hold. On 09/12/24 at 09:30 AM, Social Service Designee (SSD) K reported she did not provide R26 or representative with a written bed-hold policy, because she would have documented that in the progress notes. On 09/12/24 at 09:57 AM, Administrative Nurse B reported charge nurses do not complete a bed hold form when a resident transferred to a hospital. She reported that Administrative Staff I or SSD K would be responsible to complete the bed hold form. On 09/12/24 at 10:42 AM, Administrative Staff I reported she would not complete any bed hold forms for residents or representative when a resident would be transferred to the hospital. On 09/12/24 at 10:49 AM, Administrative Staff A reported he was unsure about the bed hold policy and would need to read the policy. The facility's policy Bed-Holds and Returns dated October 2022, documented residents and or representatives are informed in writing of the facility and staff (if applicable) bed-hold policies. All residents and or representatives are provided written information regarding the facility and state bed-hold policies, which address holding or reserving a resident's bed during periods of absence (hospitalization s). Residents, regardless of payer source, are provided written notice about these policies. At the time of transfer (or, if the transfer was an emergency, within 24 hours). The facility failed to provide a bed hold notice to R26 and/or their representative specifying the duration of the bed-hold policy, at the time of the resident's transfer to the hospital.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wheatridge Park Care Center	1501 S Holly Dr Liberal, KS 67901

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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50659 The facility reported a census of 40 residents. The sample included 12 residents. Based on record review and interviews, the facility failed to complete Care Area Assessments that addressed the individual underlying causes, contributing factors and risk factors for five residents. Resident (R)7 and R21 had incomplete and repetitive documentation, Additionally R8 all the CAA notes documented R8 was deceased , when R8 was still a resident in facility on [DATE]. R144 had no CAA notes for two triggered categories. Findings included: - Resident (R)7's medical diagnoses included chronic respiratory failure (a long-term condition that occurs when the body's respiratory system is unable to exchange oxygen and carbon dioxide properly) and morbid obesity (excessive body fat). The [DATE] Admission Minimum Data Set (MDS), documented a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. R7 required total assistance with activities of daily living (ADLs), with toileting hygiene, bathing, dressing, personal care, and transfers. R7 required oxygen and dialysis (procedure where impurities or wastes were removed from the blood). The [DATE] Functional Abilities Care Area Assessment, Nutritional, Urinary Incontinence and the Pressure Ulcer CAAs were all documented as the same note for analysis and care plan consideration for R7. admitted for skilled services. Dialysis patient and diagnosis of morbid obesity. Needed assistance with ADL's and transfers related to impaired mobility. R7 was at risk for falls and skin breakdown related to impaired mobility and incontinence. Weights as indicated. The [DATE] Quarterly MDS, documented a BIMS score of 15, indicating intact cognition. R7 required total assistance with ADLs, .R7 required oxygen and dialysis. On [DATE] at 03:20 PM, Administrative Nurse C reported the MDS's are completed off site by Consultant Nurse J. Administrative Nurse C reported the Consultant Nurse J calls the facility every day at the morning meeting and a tele-conference completed with the Interdisciplinary team. On [DATE] at 09:57 AM, Administrative Nurse B revealed she expected the MDS information to be completed correctly. On [DATE] at 03:02 PM, Consultant Nurse J was called on her phone number provided and did not answer the call. Review of facility's policy Resident Assessment Instrument Completion of the RAI dated [DATE] documented: The MDS completion is comprised of many individuals known as the Interdisciplinary Team and that there are many sections that are completed. (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The policy lacked any documentation about the CAAs. The facility failed to accurately complete the CAAs for (R)7 related to functional abilities, urinary incontinence, nutritional status and pressure ulcer/injury. This placed the resident at risk for uncommunicated care needs. - Resident (R)144's medical diagnoses included sleep apnea (disorder of sleep characterized by periods without respirations) and chronic respiratory failure (a condition that results in the inability to effectively exchange carbon dioxide and oxygen). The [DATE] Admission Minimum Data Set (MDS), documented a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. The resident had a total mood severity score of four, indicating no to minimal depression and R144 had no behaviors. R144 required total assistance with activities of daily living (ADLs), with transfers and wheelchair mobility. Maximal assistance with toileting, dressing and bed mobility. Frequently incontinent of bladder. R144 required oxygen. discharge date is more than three months away. The [DATE] Functional Abilities Care Area Assessment, Nutritional, Urinary Incontinence and the Pressure Ulcer CAAs were all documented as the same note for analysis and care plan consideration for R144. He admitted to the facility for skilled services. R144 required assistance with ADL's and transfers related to impaired mobility. R7 was at risk for falls and skin breakdown related to impaired mobility and incontinence. The Psychosocial Well-Being and Activities CAA that triggered lacked any documentation. On [DATE] at 03:20 PM, Administrative Nurse C reported the MDS's are completed off site by Consultant Nurse J. Administrative Nurse C reported the Consultant Nurse J calls the facility every day at the morning meeting and a tele-conference completed with the Interdisciplinary team. On [DATE] at 09:57 AM, Administrative Nurse B revealed she expected the MDS information to be completed correctly. On [DATE] at 03:02 PM, Consultant Nurse J was called on her phone number provided and did not answer the call. Review of facility's policy Resident Assessment Instrument Completion of the RAI dated [DATE], documented: The MDS completion is comprised of many individuals known as the Interdisciplinary Team and that there are many sections that are completed. The policy lacked any documentation about the CAAs. The facility failed to accurately complete the CAAs for (R)144 related to functional abilities, urinary incontinence, nutritional status and pressure ulcer/injury. This placed the resident at risk for uncommunicated care needs. (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Resident (R)21 's Electronic Health Record (EHR) revealed diagnoses of chronic obstructive pulmonary disease (COPD- progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing) and sleep apnea (disorder of sleep characterized by periods without respirations). The [DATE] Admission Minimum Data Set (MDS), documented a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The resident had a total mood severity score of 00, indicating no depression and no behaviors. R21 required total assistance with activities of daily living (ADLs), with toileting hygiene. Maximal assistance dressing and transfers. The [DATE] Functional Abilities Care Area Assessment, Nutritional, Urinary Incontinence Falls Psychotropic Drug Use and the Pressure Ulcer CAAs were all documented as the same note for analysis and care plan consideration for R21. She was admitted for skilled services fall with pelvic fracture she required assistance with ADL's and transfers related to impaired mobility. R21 was at risk for falls and skin breakdown related to impaired mobility and incontinence. Received antipsychotic (class of medications used to treat major mental conditions which cause a break from reality) medication. The [DATE] Quarterly MDS, documented a BIMS score of 15, indicating intact cognition. R21 required total assistance with most ADLs. R21 required oxygen. On [DATE] at 03:20 PM, Administrative Nurse C reported the MDS's are completed off site by Consultant Nurse J. Administrative Nurse C reported the Consultant Nurse J calls the facility every day at the morning meeting and a tele-conference completed with the Interdisciplinary team. On [DATE] at 09:57 AM, Administrative Nurse B revealed she expected the MDS information to be completed correctly. On [DATE] at 03:02 PM, Consultant Nurse J was called on her phone number provided and did not answer the call. Review of facility's policy Resident Assessment Instrument Completion of the RAI dated [DATE], documented: The MDS completion is comprised of many individuals known as the Interdisciplinary Team and that there are many sections that are completed. The policy lacked any documentation about the CAAs. The facility failed to accurately complete the CAAs for (R)21 related to functional abilities, urinary incontinence, nutritional status and pressure ulcer/injury. This placed the resident at risk for uncommunicated care needs. 46960 - Review of the Electronic Health Record (EHR) for Resident (R)8 included the diagnoses of osteoporosis (abnormal loss of bone density and deterioration of bone tissue with an increased fracture risk), history of falling, repeated falls, generalized muscle weakness, lack of coordination and dementia (a progressive mental disorder characterized by failing memory, confusion). (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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Significant Change Minimum Data Set (MDS) dated [DATE], documented R8 was unable to complete the Brief Interview for Mental Status (BIMS) assessment and staff assessed R8 to have severely impaired cognition. The assessment documented R8 required substantial or maximal assistance from staff for cares. R8 was dependent on staff to perform oral hygiene. R8 required supervision and setup for eating. R8 was frequently incontinent of bladder and always incontinent of bowel. The assessment documented R8 had no falls since the previous assessment. The Cognitive Loss / Dementia Care Area Assessment (CAA) dated [DATE], documented R8 as deceased although resident was observed in the facility on [DATE], [DATE], [DATE] and [DATE]. The Visual Function CAA dated [DATE], documented R8 as deceased although resident was observed in the facility on [DATE], [DATE], [DATE] and [DATE]. The Communication CAA dated [DATE], documented R8 as deceased although resident was observed in the facility on [DATE], [DATE], [DATE] and [DATE]. The Urinary Incontinence and Indwelling Catheter (a hollow flexible tube that collects urine and leads to a drainage bag) CAA dated [DATE], documented R8 as deceased although resident was observed in the facility on [DATE], [DATE], [DATE] and [DATE]. The Psychosocial Well-Being CAA dated [DATE], documented R8 as deceased although resident was observed in the facility on [DATE], [DATE], [DATE] and [DATE]. The Behavioral Symptoms CAA dated [DATE], documented R8 as deceased although resident was observed in the facility on [DATE], [DATE], [DATE] and [DATE]. The Falls CAA dated [DATE], documented R8 as deceased although resident was observed in the facility on [DATE], [DATE], [DATE] and [DATE]. The Pressure Ulcer/Injury CAA dated [DATE], documented R8 as deceased although resident was observed in the facility on [DATE], [DATE], [DATE] and [DATE]. The Psychotropic Drug Use CAA dated [DATE], documented R8 as deceased although resident was observed in the facility on [DATE], [DATE], [DATE] and [DATE]. The Pain CAA dated [DATE], documented R8 as deceased although resident was observed in the facility on [DATE], [DATE], [DATE] and [DATE]. The Quarterly MDS dated [DATE], documented R8 was unable to complete the BIMS assessment and staff assessed R8 to have severely impaired cognition. The assessment documented R8 was dependent on staff for toileting, bathing and all forms of hygiene and required substantial or maximal assistance for all other cares except eating which was required supervision/setup. R8 was frequently incontinent of bowel and always incontinent of bladder. The assessment documented that R8 had fallen since the previous assessment. (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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility Fall Investigation revealed on [DATE], R8 fell and obtained a minor injury. The facility's root cause analysis determined R8's limited safety awareness caused the fall. The fall report documented that the immediate intervention was that staff would perform more close monitoring with one-on-one supervision as much as possible. The fall investigation report documented the permanent care plan intervention was to ask R8's family to bring a television to her room so staff would place the television on a music channel, then wait to see if she was willing to lay and watch television and/or sleep. The Progress Notes for R8 lacked documentation related to this fall. The resident's Care Plan included an intervention dated [DATE], which documented family would bring R8 in a television and staff were to put it on a music channel which would allow her to watch, relax, and sleep. Review of the Progress Note dated [DATE] at 03:22 AM, staff documented a witnessed fall when R8 attempted to stand unassisted from a wheelchair without additional injuries; however, the facility lacked a fall investigation related to this fall. The resident's Care Plan included an intervention dated [DATE], which indicated staff had a meeting with family regarding additional interventions to prevent R8 from falling again with suggestions made that staff would implement with the goal to keep R8 calm; however, no additional information was provided. Observation on [DATE] at 12:50 PM, revealed R8 in a powered lift chair recliner in the common area near the nurses' station with her eyes closed. Observation on [DATE] at 07:40 AM, revealed R8 in a powered lift chair recliner in the common area near the nurses' station with her eyes closed. Observation on [DATE] at 10:00 AM, revealed R8 in a powered lift chair recliner in the common area near the nurses' station with her eyes closed. Observation on [DATE] at 12:00 PM, revealed R8 in a powered lift chair recliner in the common area near the nurses' station with her eyes closed. Two unknown CNA staff assisted R8 to an upright seated position using the powered mechanism of the lift chair, then performed a two-person pivot-transfer from recliner to R8's wheelchair and assisted R8 to the dining area for the noon meal. On [DATE] at 03:20 PM, Administrative Nurse C reported the MDS's are completed off site by Consultant Nurse J. Administrative Nurse C reported the Consultant Nurse J calls the facility every day at the morning meeting and a tele-conference completed with the Interdisciplinary team. On [DATE] at 09:57 AM, Administrative Nurse B revealed she expected the MDS information to be completed correctly. On [DATE] at 03:02 PM, Consultant Nurse J was called on phone number provided and did not answer the call. Review of facility's Resident Assessment Instrument Completion of the RAI dated [DATE] documented: (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The MDS completion is comprised of many individuals known as the Interdisciplinary Team and that there are many sections that are completed. An accurate assessment requires collecting information from multiple sources, some of which are mandated by regulations. The facility failed to accurately complete the CAAs for (R)8 related to cognitive loss / dementia, visual function, communication, urinary incontinence and indwelling catheter, psychosocial well-being, behavioral symptoms, pressure ulcer/injury, psychotropic drug use or pain. This placed the resident at risk for uncommunicated care needs.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50659 The facility reported a census of 40 residents with 12 residents selected for review. Based on observation, interview, and record review, the facility failed to accurately complete the [NAME] Data Set for two residents, Resident (R)7 and R8 related to falls. Additionally, R7 for dentition (the arrangement or condition of the teeth). This placed the resident at risk for uncommunicated care needs. Findings included: - Resident (R)7's medical diagnoses included diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made, or the body cannot respond to the insulin), end stage renal disease (ESRD-a terminal disease of the kidneys) and anxiety. The [DATE] Admission Minimum Data Set (MDS), documented a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. R7 had a total mood severity score of 00, indicating no depression and there were no behaviors. R7 required total assistance with activities of daily living (ADLs), with toileting hygiene, bathing, dressing, personal care, and transfers. R7 required set up for eating. R7 was occasionally incontinent of bladder. R7 required oxygen and dialysis (procedure where impurities or wastes were removed from the blood). No concerns with dentition. The [DATE] Functional Abilities Care Area Assessment (CAA), documented R7 admitted to the facility for skilled services. R7 required assistance with ADLs and transfers related to impaired mobility and was at risk for falls and skin breakdown related to incontinence. The [DATE] Quarterly MDS, documented a BIMS score of 15, indicating intact cognition. R7 required total assistance with ADLs, and he had no falls. No concerns with dentition. The [DATE] Care Plan documented staff were instructed to monitor for any signs or symptoms of bleeding. Additionally, staff were instructed to observe and report any signs and symptoms of anemia (inadequate number of healthy red blood cells to carry adequate oxygen to body tissues): pallor (unhealthy pale appearance), fatigue, dizziness, headache, palpitations (irregular or rapid heartbeat that can feel like fluttering, pounding, or skipping a beat), weakness or feeling cold, dated [DATE]. The [DATE] Physician Orders lacked any orders for falls or oral care. Review of the Progress Notes from [DATE] to [DATE] documented the following: On [DATE] a Progress Note at 01:36 PM, R7 had a fall when the transportation van ramp had a mechanical malfunction. R7's wheelchair tipped back and R7 hit the back of his head and he sustained a laceration (wound to the skin) on back of head and an abrasion on his left elbow. R7 was transported to hospital. On [DATE] a Progress Note at 05:44 PM, R7 transported back to facility from hospital, laceration was glued, and hospital instructed to keep area dry. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 07:21 AM, R7 reported the wheelchair transportation van ramp collapsed and he had a fall. R7 stated he hit the back of his head and had to go to the hospital. On [DATE] at 07:52 AM, R7 reported he would need to see a dentist. However, he had not said anything to the staff about the need. Observation revealed R7 had several discolored and missing/broken natural teeth. On [DATE] at 03:20 PM, Administrative Nurse C reported the MDS's are completed off site by Consultant Nurse J. Administrative Nurse C reported the Consultant Nurse J calls the facility every day at the morning meeting and a tele-conference completed with the Interdisciplinary team. On [DATE] at 09:57 AM, Administrative Nurse B revealed she expected the MDS information to be completed correctly. On [DATE] at 03:02 PM, Consultant Nurse J was called on phone number provided and did not answer the call. Review of facility's Resident Assessment Instrument Completion of the RAI dated [DATE] documented: The MDS completion is comprised of many individuals known as the Interdisciplinary Team and that there are many sections that are completed. An accurate assessment requires collecting information from multiple sources, some of which are mandated by regulations. The facility failed to accurately complete the MDS for (R)7 related to falls and dentition. This placed the resident at risk for uncommunicated care needs. 46960 - Review of the Electronic Health Record (EHR) for Resident (R)8 included the diagnoses of osteoporosis (abnormal loss of bone density and deterioration of bone tissue with an increased fracture risk), history of falling, repeated falls, generalized muscle weakness, lack of coordination and dementia (a progressive mental disorder characterized by failing memory, confusion). The Significant Change Minimum Data Set (MDS) dated [DATE], documented R8 was unable to complete the Brief Interview for Mental Status (BIMS) assessment and staff assessed R8 to have severely impaired cognition. The assessment documented R8 required substantial or maximal assistance from staff for cares. R8 was dependent on staff to perform oral hygiene. R8 required supervision and setup for eating. R8 was frequently incontinent of bladder and always incontinent of bowel. The assessment documented R8 had no falls since the previous assessment. The Cognitive Loss / Dementia Care Area Assessment (CAA) dated [DATE], documented R8 as deceased although resident was observed in the facility on [DATE], [DATE], [DATE] and [DATE]. The Visual Function CAA dated [DATE], documented R8 as deceased although resident was observed in the facility on [DATE], [DATE], [DATE] and [DATE]. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Communication CAA dated [DATE], documented R8 as deceased although resident was observed in the facility on [DATE], [DATE], [DATE] and [DATE]. The Urinary Incontinence and Indwelling Catheter (a hollow flexible tube that collects urine and leads to a drainage bag) CAA dated [DATE], documented R8 as deceased although resident was observed in the facility on [DATE], [DATE], [DATE] and [DATE]. The Psychosocial Well-Being CAA dated [DATE], documented R8 as deceased although resident was observed in the facility on [DATE], [DATE], [DATE] and [DATE]. The Behavioral Symptoms CAA dated [DATE], documented R8 as deceased although resident was observed in the facility on [DATE], [DATE], [DATE] and [DATE]. The Falls CAA dated [DATE], documented R8 as deceased although resident was observed in the facility on [DATE], [DATE], [DATE] and [DATE]. The Pressure Ulcer/Injury CAA dated [DATE], documented R8 as deceased although resident was observed in the facility on [DATE], [DATE], [DATE] and [DATE]. The Psychotropic Drug Use CAA dated [DATE], documented R8 as deceased although resident was observed in the facility on [DATE], [DATE], [DATE] and [DATE]. The Pain CAA dated [DATE], documented R8 as deceased although resident was observed in the facility on [DATE], [DATE], [DATE] and [DATE]. The Quarterly MDS dated [DATE], documented R8 was unable to complete the BIMS assessment and staff assessed R8 to have severely impaired cognition. The assessment documented R8 was dependent on staff for toileting, bathing and all forms of hygiene and required substantial or maximal assistance for all other cares except eating which was required supervision/setup. R8 was frequently incontinent of bowel and always incontinent of bladder. The assessment documented that R8 had fallen since the previous assessment. Review of the facility Fall Investigation revealed on [DATE], R8 fell and obtained a minor injury. The facility's root cause analysis determined R8's limited safety awareness caused the fall. The fall report documented that the immediate intervention was that staff would perform more close monitoring with one-on-one supervision as much as possible. The fall investigation report documented the permanent care plan intervention was to ask R8's family to bring a television to her room so staff would place the television on a music channel, then wait to see if she was willing to lay and watch television and/or sleep. The Progress Notes for R8 lacked documentation related to this fall. The resident's Care Plan included an intervention dated [DATE], which documented family would bring R8 in a television and staff were to put it on a music channel which would allow her to watch, relax, and sleep. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Progress Note dated [DATE] at 03:22 AM, staff documented a witnessed fall when R8 attempted to stand unassisted from a wheelchair without additional injuries; however, the facility lacked a fall investigation related to this fall. The resident's Care Plan included an intervention dated [DATE], which indicated staff had a meeting with family regarding additional interventions to prevent R8 from falling again with suggestions made that staff would implement with the goal to keep R8 calm; however, no additional information was provided. Observation on [DATE] at 12:50 PM, revealed R8 in a powered lift chair recliner in the common area near the nurses' station with her eyes closed. Observation on [DATE] at 07:40 AM, revealed R8 in a powered lift chair recliner in the common area near the nurses' station with her eyes closed. Observation on [DATE] at 10:00 AM, revealed R8 in a powered lift chair recliner in the common area near the nurses' station with her eyes closed. Observation on [DATE] at 12:00 PM, revealed R8 in a powered lift chair recliner in the common area near the nurses' station with her eyes closed. Two unknown CNA staff assisted R8 to an upright seated position using the powered mechanism of the lift chair, then performed a two-person pivot-transfer from recliner to R8's wheelchair and assisted R8 to the dining area for the noon meal. On [DATE] at 03:20 PM, Administrative Nurse C reported the MDS's are completed off site by Consultant Nurse J. Administrative Nurse C reported the Consultant Nurse J calls the facility every day at the morning meeting and a tele-conference completed with the Interdisciplinary team. On [DATE] at 09:57 AM, Administrative Nurse B revealed she expected the MDS information to be completed correctly. On [DATE] at 03:02 PM, Consultant Nurse J was called on phone number provided and did not answer the call. Review of facility's Resident Assessment Instrument Completion of the RAI dated [DATE] documented: The MDS completion is comprised of many individuals known as the Interdisciplinary Team and that there are many sections that are completed. An accurate assessment requires collecting information from multiple sources, some of which are mandated by regulations. The facility failed to accurately complete the MDS for R8 related to falls. This placed the resident at risk for uncommunicated care needs.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46960 The facility identified a census of 40 residents, which included 12 residents sampled. Based on interviews, observations, and record review, the facility failed to review and revise the care plans with appropriate interventions for four of the sampled residents; Resident (R) 20 related to physician ordered interventions, R2 related to treatment of an area of pressure ulcer/injury, R22 and R8 related to development and implementation of appropriate interventions to prevent multiple falls for R22 related to continued use of a powered lift chair, or develop any new interventions for R8. These deficient practices resulted in uncommunicated care needs. Findings included: - Review of the Electronic Health Record (EHR) for Resident (R) 8 included diagnoses of osteoporosis (abnormal loss of bone density and deterioration of bone tissue with an increased fracture risk), history of falling, repeated falls, generalized muscle weakness, lack of coordination, and dementia (a progressive mental disorder characterized by failing memory, confusion). The Significant Change Minimum Data Set (MDS) dated [DATE], documented R8 as unable to complete the Brief Interview for Mental Status (BIMS) assessment and staff assessed R8 to have severely impaired cognition. The assessment documented R8 required substantial or maximal assistance from staff for cares. R8 was frequently incontinent of bladder and always incontinent of bowel. The assessment documented R8 had no falls since the previous assessment. The Cognitive Loss / Dementia Care Area Assessment (CAA) dated [DATE], documented R8 as deceased ; however, the surveyor observed R8 in the facility on [DATE], [DATE], [DATE], and [DATE]. The Quarterly MDS dated [DATE], documented R8 as unable to complete a BIMS assessment and staff assessed R8 to have severely impaired cognition. The assessment documented R8 as dependent on staff for toileting, bathing, and all forms of hygiene and required substantial or maximal assistance for all other cares except eating, which was required supervision/setup. R8 was frequently incontinent of bowel and always incontinent of bladder. The assessment documented that R8 had a fall since the previous assessment. The [DATE] Care Plan documented R8 was at risk for falls and listed the following interventions: On [DATE], staff would monitor for changes in R8's condition that may warrant increased supervision or assistance and notify the charge nurse. On [DATE], staff would provide frequently used items within easy reach. On [DATE], family reported R8 was forgetful and would benefit from consistency in her room. She was unable to use a walker due to difficulty remembering to use it. On [DATE], staff would request physical/occupational therapy to evaluate and treat the resident as needed. (continued on next page)

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	175459	A. Building B. Wing	09/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wheatridge Park Care Center	1501 S Holly Dr Liberal, KS 67901

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE], staff would encourage the resident to visually survey the area prior to stepping away to walk. On [DATE], activities staff would provide mid-morning and mid-afternoon activities, one on one to keep R8 busy and mobile. On [DATE], staff placed a night light in R8's room so she was able to see after dark. Review of the EHR Safety Device Consent dated [DATE], documented a safety assessment for turn bars only and lacked safety assessment for a powered lift chair. Review of the EHR Fall Risk assessments revealed on [DATE], the facility documented a fall risk score of 22, which indicated R8 was a high risk for falls. The Progress Notes dated [DATE] documented R8 experienced a witnessed fall and landed on her left side, she then repositioned herself to her back. Review of the facility Fall Investigation revealed on [DATE] at 05:20 PM, R8 fell without injury. The facility's root cause analysis determined R8 had a lack of safety awareness, which caused the fall. The fall investigation report documented the immediate and permanent care plan interventions were that staff would provide a smaller recliner that was a better fit for R8. The resident's Care Plan documented on [DATE] staff would provide a smaller recliner that was a more appropriate fit for R8; however, the facility lacked evidence of the implementation of this intervention. The Progress Notes dated [DATE] documented R8 was found sitting on the floor near the bed with bed linens wrapped around her legs. The fall investigation report documented the immediate and permanent care plan interventions were that staff would provide more frequent rounding. Review of the facility Fall Investigation revealed on [DATE] at 10:06 PM, R8 fell and obtained a minor injury. The facility's root cause analysis lacked determination causal factors for the fall. The fall investigation report documented the immediate and permanent care plan interventions were that staff would provide more frequent rounding. The resident's Care Plan documented on [DATE] that staff would provide frequent rounding however, the facility lacked evidence of the implementation of this intervention. Review of the EHR Fall Risk assessments revealed [DATE], the facility documented a fall risk score of 15, which indicated R8 was a moderate risk for falls. The Progress Notes for R8 lacked an entry with a description related to fall on [DATE]. The fall investigation report lacked an immediate intervention to mitigate fall risk for the remainder of the shift. The fall investigation report documented the permanent care plan documented staff would cue and sit with R8 to ensure that R8 ate the meal or snack provided. (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 facility Fall Investigation revealed on [DATE], R8 fell and obtained a minor injury. The facility's root cause analysis determined that R8 was hungry and attempted to ambulate without staff assistance. The fall investigation report lacked an immediate intervention to mitigate fall risk for the remainder of the shift. The fall investigation report documented the permanent care plan documented staff would cue and sit with R8 to ensure that R8 ate the meal or snack provided. The resident's Care Plan documented on [DATE] that staff would sit with R8 to provide cues and assistance with any snacks or meals provided. The Progress Notes dated [DATE] documented staff discovered R8 at approximately 05:30 AM, on the ground on her knees, and noted she had a minor injury to the left elbow. The facility's fall investigation report documented that the immediate intervention was that staff would close monitoring for remainder of shift. The facility's fall investigation report permanent care plan documented staff would unplug recliner and switch to a manual recliner when possible. Review of the facility Fall Investigation revealed on [DATE], R8 fell and obtained a minor injury. The facility's root cause analysis determined R8 raised a powered lift chair to its full height and fell . The facility's fall investigation report documented that the immediate intervention was that staff would closely monitor the resident for the remainder of the shift. The facility's fall investigation report permanent care plan documented staff would unplug recliner and switch to a manual recliner when possible. The resident's Care Plan documented manual recliner on [DATE]; however, the surveyor observed R8 resting in powered lift chairs on [DATE], [DATE], [DATE], and [DATE]. Review of the EHR Fall Risk assessments revealed the on [DATE], the facility documented a fall risk score of 25, which indicated R8 was a high risk for falls. The Progress Notes dated [DATE] at 09:25 PM documented staff discovered R8 on the ground on her left side in her doorway, with a minor injury to the left elbow. Review of the facility Fall Investigation revealed on [DATE], R8 fell and obtained a minor injury. The facility's root cause analysis determined R8 had limited safety awareness. The fall investigation report documented the immediate intervention was that staff would perform more close monitoring of the resident. The fall investigation report documented the permanent care plan intervention was staff would offer toileting with all bed checks. The resident's Care Plan documented on [DATE] staff would offer toileting with all bed checks to prevent the resident from attempting to ambulate without assistance from staff. Review of the EHR Fall Risk assessments revealed on [DATE], the facility documented a fall risk score of 22, which indicated R8 was a high risk for falls. The Progress Note dated [DATE] at 01:27 AM, documented R8 was given pain medication for the fall that occurred on [DATE] at 09:25 PM and lacked documentation of the location or severity of the pain. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Progress Note dated [DATE] at 03:24 PM, revealed an unknown Certified Nurse Aide (CNA) staff reported to the nurse R8 had pain and swelling to the left shoulder. The nurse assessed R8 and documented swelling and bruising from R8's shoulder to her elbow on the left arm, documented she notified R8's primary care physician (PCP), and noted she left a message for the PCP. The Progress Note dated [DATE] at 03:55 PM, revealed R8's PCP returned the phone message and gave a telephone order to obtain an x-ray of the resident's left upper arm and left shoulder. The Progress Note dated [DATE] at 09:14 PM, revealed the consultant x-ray provider notified the facility that R8 had a displaced fracture (a traumatic bone break where two ends of the bone separate out of their normal positions) of the left humerus and a fractured left fourth rib. The facility staff notified R8's PCP and received orders to maintain current treatment to maintain R8's comfort and notify the PCP if R8 became uncomfortable. Review of the Progress Note dated [DATE] at 05:48 PM, revealed staff called the hospital and were advised that R8 admitted to the medical floor due to a fracture of the left humerus. The Progress Notes lacked additional documentation related to how, when, or why the resident was transferred to the hospital. Review of the Progress Note dated [DATE] at 03:00 PM, revealed R8 arrived to the facility with a report from the hospital noting R8 was not a candidate for surgical repair of the left arm and orders to apply ice to the affected area as needed for pain or swelling, R8 was to wear a sling on the left side at all times for four weeks, and staff were not to use the left arm to assist the resident with cares. Review of the facility Fall Investigation revealed on [DATE], R8 fell and obtained a minor injury. The facility's root cause analysis determined that R8's limited safety awareness caused the fall. The fall report documented that the immediate intervention was that staff would perform more close monitoring with one-on-one supervision as much as possible. The fall investigation report documented the permanent care plan intervention was documented as staff asked R8's family to bring a TV to her room so staff would place the TV on a music channel then wait to see if she was willing to lay and watch television and sleep. The Progress Notes for R8 lacked documentation related to the [DATE] fall. The resident's Care Plan included an intervention dated [DATE], which documented family would bring R8 in a television and staff were to put it on a music channel which would allow her to watch, relax, and sleep. Review of the Progress Note dated [DATE] at 03:22 AM, staff documented a witnessed fall when R8 attempted to stand unassisted from a wheelchair without additional injuries; however, the facility lacked a fall investigation related to this fall. The resident's Care Plan included an intervention dated [DATE], which indicated staff had a meeting with family regarding additional interventions to prevent R8 from falling again with suggestions made that staff would implement with the goal to keep R8 calm; however, no additional information was provided. (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 EHR Fall Risk assessments revealed on [DATE], the facility documented a fall risk score of 26, which indicated a high risk for falls. The resident's Care Plan included an intervention dated [DATE], which directed staff would offer to take R8 to the bathroom during all overnight bed checks to prevent her from self-ambulation attempts. The Progress Notes dated [DATE] at 04:19 PM, revealed staff documented a witnessed fall without injury when R8 attempted to stand from a recliner with the footrest in the up position. The fall investigation report documented the immediate and permanent care plan interventions were that staff would offer snacks/drinks frequently. Review of the facility Fall Investigation revealed on [DATE], R8 fell without injury. The facility's root cause analysis determined R8 attempted to stand without staff assistance. The fall investigation report documented the immediate and permanent care plan interventions were that staff would offer snacks/drinks frequently. The resident's Care Plan documented on [DATE] staff would frequently offer snacks/drinks to R8 however, the facility lacked evidence of the implementation of this intervention. Review of the EHR Fall Risk assessments revealed on [DATE], the facility documented a fall risk score of 23, which indicated a high risk for falls. The Progress Notes revealed on [DATE] at 05:28 PM, staff documented a fall without injury when R8 attempted to ambulate without staff assistance. Review of the facility Fall Investigation revealed on [DATE], R8 fell without injury. The facility's root cause analysis determined that R8 attempted to stand without staff assistance. The fall report lacked an immediate intervention performed by staff to mitigate the risk of falls for the remainder of the shift. The permanent care plan intervention was staff should monitor for items left on the floor or any items the resident may have dropped and assist with picking them up. Review of the resident's Care Plan revealed the following interventions: On [DATE], staff would perform rounds frequently and offer R8 toileting assistance. On [DATE], staff would maintain an environment that was clutter-free, provide adequate lighting, and ensure personal items were within reach. On [DATE], staff would provide assistive devices as needed. On [DATE], staff would review information on past falls to determine causes of falls. Review of the EHR Fall Risk assessments revealed on [DATE], the facility documented a fall risk score of 15, which indicated R8 was a moderate risk for falls. Observations on [DATE] at 12:50 PM, [DATE] at 07:40 AM, and [DATE] at 10:00 AM revealed R8 in a powered lift chair recliner in the common area near the nurses' station with her eyes closed. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on [DATE] at 12:00 PM, revealed R8 in a powered lift chair recliner in the common area near the nurses' station with her eyes closed. Two unknown CNA staff assisted R8 to an upright seated position using the powered mechanism of the lift chair, then performed a two-person pivot-transfer from recliner to R8's wheelchair and assisted R8 to the dining area for the noon meal. On [DATE] at 12:04 PM, CNA F stated when a resident fell , CNA staff should ensure the resident was safe, then alert other staff that assistance was required, and would notify the nurse. Upon the arrival of the nurse, then CNA staff would follow the instructions of the nurse. CNA F was unable to recall specific interventions for R8 and stated that they would refer to the CNA book at the nurses' station or R8's care plan on the EHR for guidance. On [DATE] at 12:14 AM, CNA E stated that when a resident fell , CNA staff would ensure the resident was safe and call for help, which included calling the nurse. Once the nurse arrived, then CNA staff would follow the instructions of the nurse. CNA E was unable to recall any information specific to R8's falls and stated that interventions to prevent falls for R8 could be found in the resident's care plan, which was accessible in the EHR on either the computers or tablets or in the CNA book in the nurses' station. On [DATE] at 12:24 PM, Licensed Nurse (LN) D stated after a fall, the CNA staff would ensure the resident was safe and call for help, which included the nurse. When the nurse arrived, they would assess the resident for injuries and give aid if appropriate. Immediately following the fall, the nurse would notify the PCP, the resident's representative, Administrative Nurse B and/or Administrative Staff A. Immediately after the required notifications were made, the nurse would fill out a fall report in the EHR and collect witness statements from all nursing (CNA, Certified Medication Aides [CMA], LN) personnel on duty at the time of the fall. The nurse would then hold a fall huddle with the staff to initiate an investigation to determine the root cause of the fall and develop an immediate intervention to mitigate the risk of falls for the remainder of the shift. The nurse would also perform and document ongoing assessments for fall follow up which may or may not include neurological (pertaining to the brain) assessments if needed for 72 hours (3 days) after the fall. On the next business day, Administrative Nurse B would review the documentation and add a permanent care plan intervention on the resident's care plan and place the update in the CNA book at the nurses' station. Additionally, LN D stated that she was unsure if residents were assessed for safety related to the safe operation of powered lift chairs. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Administrative Nurse B on [DATE] at 12:36 PM revealed after a resident fell , she expected staff to perform a huddle to discuss what happened, develop an immediate intervention to prevent further falls, then staff would complete a risk management module. All nursing staff were expected to fill out a witness statement, then make appropriate notifications. The Director of Nursing (DON) reviewed fall charting and added interventions to the individual resident care plans after a fall. Administrative Nurse B reported resident cares were driven by the care plan and stated it was her expectation the care plan would be revised with a new and unique intervention related to each specific fall. Administrative Nurse B further confirmed if the facility did not identify the cause of a fall they could not say if interventions in place for fall were appropriate. Administrative Nurse B stated duplicate or similar care plan interventions were unacceptable and confirmed the resident had duplicate/similar care planned interventions for multiple falls. Administrative Nurse B stated care planned interventions should be new, unique to the fall, and measurable. She also confirmed the facility lacked appropriate follow up for all falls in the resident's progress notes. The nurse should initiate and document ongoing assessments for 72 hours (3 days) for fall follow up and include neurological assessments if needed. Administrative Nurse B stated that the previous DON was responsible for the information prior to the [DATE] fall and she was unable to provide an explanation as to why the expectations were not met. Administrative Nurse B stated that all residents who use powered lift chairs should have a Safety Device Consent assessment in their EHR to determine whether they could safely utilize a piece of powered equipment. She confirmed R8 had severely impaired cognition and could not be assessed for safe use of a powered lift chair. Further, confirmed that the Safety Device Consent in R8's EHR, dated [DATE] lacked a safety assessment for a powered lift chair. The facility's undated Comprehensive Care Plan Policy documented that the facility developed, implemented and periodically reviewed (quarterly, annually and with a significant change in condition) a comprehensive person-centered care plan that included measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs. The policy documented that care plan interventions were chosen after careful data gathering, proper sequencing of events, careful analysis of problem areas and their causes and relevant clinical decisions. Further documented that care plans were revised as the residents' conditions changed or when the desired outcome was not met. The facility failed to review, revise and implement appropriate interventions after multiple falls to provide an environment free of accident hazards for a dependent resident with severely impaired cognition and a known history of repeated falls. R8 fell twice on [DATE] and was injured, fell on [DATE] and was injured, fell on [DATE] and was injured, fell on [DATE] and was injured (two fractures and a hospitalization), fell on [DATE] and was injured, fell on [DATE] and was not injured, and fell on [DATE] and was not injured. This deficient practice resulted in actual harm to the physical and psychosocial well-being of R8 as well as uncommunicated needs. - Review of the Electronic Health Record (EHR) for Resident (R) 22 included diagnoses of history of falling, chronic obstructive pulmonary disease (COPD - a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing) and bipolar disorder (a major mental illness that caused people to have episodes of severe high and low moods). (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Significant Change Minimum Data Set (MDS) dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The assessment documented that R22 utilized a walker or wheelchair for locomotion and required extensive assistance of all cares of two staff members except eating which was performed independently. R22 was always incontinent of urine and occasionally incontinent of bowel. R22 received opioid (class of drug used to treat moderate to severe pain) five of the seven days in the look-back-period and received oxygen. The assessment documented that R22 did not fall since the previous assessment. The Falls Care Area Assessment (CAA) dated [DATE], documented that R22 had a history of falls related to her need for assistance with transfers. The Quarterly MDS dated [DATE], documented a BIMS score of 10, which indicated moderately impaired cognition. The assessment documented that R22 was dependent on staff for bathing and toileting and required substantial/maximal assistance for all other cares except eating which required partial assistance. R22 was always incontinent of urine and occasionally incontinent of bowel and received an antidepressant (a class of medications used to treat mood disorders and relieve symptoms of depression) and oxygen. The assessment documented that R22 fell since the previous assessment. The [DATE] Care Plan documented R22 was at risk for falls related to poor safety awareness, unsteadiness, COPD, and hospice/end-of-life care and listed the following interventions: On [DATE] documented staff should place non-skid surface in chair to prevent her from sliding out of chair, initiated on [DATE] and revised dated [DATE]. Staff would maintain a clutter free environment; free from spills with adequate lighting and place personal items within reach, initiated on [DATE]. Staff would ensure items are within reach, initiated on [DATE]. Staff would ensure the call light is within reach and encourage the resident to call for help, initiated on [DATE]. On [DATE], staff educated to ensure that water pass performed on both shifts and placed within reach of residents, initiated on [DATE]. Staff would provide appropriate footwear with transfers and ambulation, initiated on [DATE]. Staff would provide assistive devices as needed, initiated on [DATE]. Staff would refer R22 to physical/occupational therapy as needed, initiated on [DATE]. Staff would remind resident to use call light for safety, initiated: [DATE]. Staff would review information on past falls and attempt to determine cause of falls as indicated, initiated on [DATE]. Review of the EHR lacked a Safety Device Consent safety assessment for a powered lift chair for R22. (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 EHR Fall Risk assessments revealed on [DATE], the facility documented a fall risk score of 15 which indicated R22 was a moderate risk for falls. Review of the EHR Fall Risk assessments revealed on [DATE], the facility documented a fall risk score of 12, which indicated R8 was a moderate risk for falls. The Progress Notes dated [DATE] documented R22 experienced an unwitnessed fall and was found seated on the floor in front of her recliner with her legs extended in front of her. Review of the facility Fall Investigation revealed on [DATE] at 10:00 PM, R22 fell without injury. The facility's root cause analysis determined staff had left R22 unattended with the powered lift chair in the full upright position to retrieve a pillow which caused R22's fall. The fall investigation report lacked an immediate intervention to mitigate the fall risk for the remainder of the shift. The fall investigation report documented the permanent care plan intervention staff would ensure the chair was in the low position before the resident was left alone. The resident's Care Plan documented on [DATE] staff should make sure that after R22 was returned to her room that R22 was positioned in her powered lift chair recliner with the chair in the down position before leaving the area, initiated on [DATE] and revised on [DATE]. however, the facility lacked evidence of the implementation of this intervention. Review of the EHR Fall Risk assessments revealed on [DATE], the facility documented a fall risk score of 17, which indicated that R22 was a high risk for falls. The Progress Notes dated [DATE] documented R22 was found seated on the floor near the lift chair with a report from R22's roommate that R22 had slipped out of her lift chair. The fall investigation report documented the immediate intervention staff would assist residents up to the dining area for meals or provide assistance in the room if the resident did not want to go to the dining area and lacked a permanent care plan intervention. Review of the facility Fall Investigation revealed on [DATE] at 05:30 PM, R22 fell without injury. The facility's root cause analysis lacked determination causal factors for the fall. The fall investigation report documented the immediate intervention staff would assist residents up to the dining area for meals or provide assistance in the room if the resident did not want to go to the dining area. The resident's Care Plan lacked an intervention related to the fall on [DATE]. Review of the EHR Fall Risk assessments revealed [DATE], the facility documented a fall risk score of 27, which indicated R22 was a high risk for falls. The Progress Notes dated [DATE] at 05:30 PM documented R22 was found seated on the floor in front of the lift chair that was in the full upright position. The fall investigation report documented an immediate intervention staff would ensure resident wore non-skid footwear and documented the permanent care plan interventions documented staff would ensure resident wore non-skid footwear and that the lift chair was unplugged when not in use. (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 facility Fall Investigation revealed on [DATE] at 05:30 PM, R22 fell without injury. The facility's root cause analysis determined that R22 was not wearing non-skid footwear and had raised the lift chair to the full upright position without staff assistance which caused the fall. The fall investigation report documented an immediate intervention staff would ensure R22 wore non-skid footwear. The fall investigation report documented the permanent care plan documented staff would ensure R22 wore non-skid footwear and that the lift chair was unplugged when not in use. The resident's Care Plan documented on [DATE], staff would keep the recliner unplugged to prevent R22 from raising it all the way up which would prevent R22 from sliding out of the lift chair, initiated on [DATE]. The Progress Notes dated [DATE] at 03:59 AM documented staff discovered R22 on [DATE] at 08:20 PM seated on the ground with her legs extended and held the remote to the lift chair. The facility's fall investigation report documented that the immediate intervention was that staff would check on R22 every 30 minutes for remainder of shift. The facility's fall investigation report lacked a permanent care plan intervention. Review of the facility Fall Investigation revealed on [DATE] at 08:20 PM, R22 fell without injury. The facility's root cause analysis determined R22 raised a powered lift chair to its full height and fell . The facility's fall investigation report documented that the immediate intervention was that staff would perform 30-minute checks for the remainder of the shift. The facility's fall investigation report lacked a permanent care plan intervention. The resident's Care Plan lacked an intervention related to the fall on [DATE] at 08:20 PM. Observations on [DATE] at 11:04 AM, R22 resting in her recliner which is a power chair with her eyes closed and the remote was in the pocket of chair on residents right hand side. On [DATE] at 12:04 PM, CNA F stated when a resident fell , CNA staff should ensure the resident was safe, then alert other staff that assistance was required, and would notify the nurse. Upon the arrival of the nurse, then CNA staff would follow the instructions of the nurse. CNA F was unable to recall specific interventions for R8 and stated that they would refer to the CNA book at the nurses' station or R8's care plan on the EHR for guidance. On [DATE] at 12:14 AM, CNA E stated that when a resident fell , CNA staff would ensure the resident was safe and call for help, which included calling the nurse. Once the nurse arrived, then CNA staff would follow the instructions of the nurse. CNA E was unable to recall any information specific to R8's falls and stated that interventions to prevent falls for R8 could be found in the resident's care plan, which was accessible in the EHR on either the computers or tablets or in the CNA book in the nurses' station. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wheatridge Park Care Center	1501 S Holly Dr Liberal, KS 67901

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 12:24 PM, Licensed Nurse (LN) D stated after a fall, the CNA staff would ensure the resident was safe and call for help, which included the nurse. When the nurse arrived, they would assess the resident for injuries and give aid if appropriate. Immediately following the fall, the nurse would notify the PCP, the resident's representative, Administrative Nurse B and/or Administrative Staff A. Immediately after the required notifications were made, the nurse would fill out a fall report in the EHR and collect witness statements from all nursing (CNA, Certified Medication Aides [CMA], LN) personnel on duty at the time of the fall. The nurse would then hold a fall huddle with the staff to initiate an investigation to determine the root cause of the fall and develop an immediate intervention to mitigate the risk of falls for the remainder of the shift. The nurse would also perform and document ongoing assessments for fall follow up which may or may not include neurological (pertaining to the brain) assessments if needed for 72 hours (3 days) after the fall. On the next business day, Administrative Nurse B would review the documentation and add a permanent care plan intervention on the resident's care plan and place the update in the CNA book at the nurses' station. Additionally, LN D stated that she was unsure if residents were assessed for safety related to the safe operation of powered lift chairs. During an interview with Administrative Nurse B on [DATE] at 12:36 PM revealed after a resident fell , she expected staff to perform a huddle to discuss what happened, develop an immediate intervention to prevent further falls, then staff would complete a risk management module. All nursing staff were expected to fill out a witness statement, then make approp [TRUNCATED]

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. 50659 The facility identified a census of 40 residents, with 12 residents sampled, and one resident reviewed for discharge planning. The facility failed to implement a discharge plan for Resident (R)144 being discharged from the facility. The discharge planner failed to involve R144 with the discharge planning process. Findings included: - Resident (R)144's medical diagnoses included sleep apnea (disorder of sleep characterized by periods without respirations) and chronic respiratory failure (a condition that results in the inability to effectively exchange carbon dioxide and oxygen). The 09/03/24 Admission Minimum Data Set (MDS), documented a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. The resident had a total mood severity score of four, indicating no to minimal depression and R144 had no behaviors. R144 required total assistance with activities of daily living (ADLs), with transfers and wheelchair mobility. Maximal assistance with toileting, dressing and bed mobility. Frequently incontinent of bladder. R144 required oxygen. discharge date is more than three months away. The 09/05/24 Functional Abilities Care Area Assessment (CAA), documented R144 admitted to the facility for skilled services. R144 required assistance with ADLs and transfers related to impaired mobility and was at risk for falls. The CAA lacked any documentation regarded to respiratory. The Return to Community Referral CAA was not triggered on the MDS. The 09/10/24 Care Plan documented interventions which included: On 08/28/24, staff were instructed to encourage R144 to discuss feelings and concerns with impending discharge. Additionally, establish pre-discharge plan with R144 and evaluate progress and revise as needed. Staff instructed to provide discharge teaching and make arrangements with required community resources to support independence post-discharge. The 09/10/24 Physician Orders lacked orders for a discharge. Review of the Progress Notes from 08/27/24 to 09/10/24 lacked documentation regarding a planned discharge. On 09/10/24 at 09:07 AM, R144 reported no staff at the facility has talked to him about his discharge plan. R144 reported he was nervous and concerned about discharge as he required a lot of care. He stated the insurance company would tell him he would have to leave, and he stated he did not have the money to pay and did want to go home. On 09/11/24 at 07:30 AM, R144 reported he received a call from the insurance company yesterday afternoon (09/10/24) and had not spoken to any facility staff member about discharge. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/12/24 at 03:15 PM, R144 reported he was being discharged home on 09/13/24 and was concerned about discharge as he had not received information. R144 reported he did not know about any appeal process for discharge. On 09/12/24 at 09:50 AM, Social Service Designee (SSD) K reported that R144's discharge to home was planned for 09/13/24. SSD K confirmed there were no progress notes in EHR, and she revealed that she felt R144 discharge home was not a safe discharge home. SSD K reported the Interdisciplinary Team (IDT) had discussed this unsafe discharge a few times in morning meeting. SSD K reported she opened R144's discharge summary in the EHR today (09/12/24), and revealed she was not aware if R144 had oxygen at home or if he completed an appeal to the insurance company. On 09/12/24 at 09:57 AM, Administrative Nurse B reported the IDT had discussed in morning meetings R144 could be an unsafe discharge. She stated the insurance company is denying his stay and she was not aware of any appeal process being completed. Administrative Nurse B confirmed there were no progress notes in EHR for discharge planning. On 09/12/24 at 10:49 AM, Administrative Staff A reported that he was not aware if R144 completed a second appeal for denial of insurance funds. He also revealed he was unsure of the unsafe discharge had been mentioned. Administrative Staff A confirmed R144 should have had progress notes about discharge in the EHR. On 09/12/24 at 02:57 PM, Physical Therapy Staff A revealed no home evaluation was completed at R144's house. She stated that an internet image was obtained of R144's stairs that entered his home and worked on the stairs in the therapy room. Physical Therapy Staff A reported R144 had oxygen at home, and that he would ambulate over 160 feet at the facility. She stated that R144 would not have home health or therapy at home when discharged as the insurance company would not cover. On 09/12/24 at 02:57 PM, Occupational Therapy Staff Z reported that R144 had made comments about his concerns when he discharged as he required staff to assist with incontinent care. She then stated R144 reported he walked around his home naked so he would not have to worry about changing his clothes. The facility's policy Discharge Summary and Plan dated October 2022 documented when a resident's discharge is anticipated, a discharge summary and post-discharge plan is developed to assist the resident with discharge. The resident is involved in the discharge plan and post-discharge plan and is informed of the final plan. The facility failed to implement a discharge plan for Resident (R) 144 being discharged from the facility. The discharge planner failed to involve R144 with the discharge planning process. This deficient practice placed the resident at risk for decreased psychosocial well-being and uncommunicated needs.

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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** 50659 The facility identified a census of 40 residents, with 12 residents sampled, and one resident reviewed for pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction). Based on observations, interviews, and record review, the facility failed to provide a pressure reducing device on the bed to prevent a pressure injury for Resident (R) 2. On 07/11/24 the facility noted R2's previous pressure injuries were all closed. On 07/12/24, R2 was moved to a different room and the facility failed to move his air mattress for his bed to the new room. On 07/24/24, R2's left heal pressure injury re-opened and was identified as a stage three pressure injury (full thickness pressure injury extending through the skin into the tissue below). This placed the resident at risk to worsen his pressure ulcers and delayed healing. Findings included: - Resident (R) 2 's Electronic Health Record (EHR) revealed diagnoses of diabetes mellitus type two (DM2-when the body cannot use glucose, not enough insulin made, or the body cannot respond to the insulin) and reduced mobility. The Significant Change Minimum Data Set (MDS) dated [DATE], documented a Brief Interview for Mental Status (BIMS) of 99, indicating severely impaired cognition. The resident had a total mood severity score of 02, indicating no depression and R2 had no behaviors. R2 required total assistance with activities of daily living (ADLs), which included bed mobility, toileting, dressing, and bathing. R2 was always incontinent of bladder. R2 had a stage two pressure ulcer (partial-thickness skin loss into but no deeper than the dermis including intact or ruptured blisters) on admission. There was a pressure relieving device on the bed and the chair. The Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) did not trigger on the 10/25/23 MDS. The Pressure Ulcer CAA dated 11/02/23, documented an actual skin breakdown and R2 was at risk for further skin breakdown due to incontinence. Treatment and preventative measures were in place and the facility consulted a wound care physician. The facility would proceed with care planning to ensure that interventions were in place to heal an existing wound and prevent new skin breakdown. The Quarterly MDS dated [DATE], documented a BIMS of 99. R2 required total assistance of staff with ADLs. R2 had two stage three pressure ulcers, which were facility acquired and had pressure relieving devices on the bed and the chair. The 09/10/24 Care Plan documented interventions which included: On 08/04/22, staff were instructed to float R2's heels with pillows while in bed. Staff applied an air mattress to R2's bed. On 12/27/23, staff were instructed to apply podus boots (lightweight plastic shell with a liner to help treat and prevent lower extremity disorders) at all times. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The Physician Orders dated 08/09/24 included instruction to staff not to provide whirlpool baths for R2 and if showers were done, they were to wrap the resident's left foot. The physician orders lacked any orders for treatment for R2's left foot pressure ulcers. Review of the Progress Notes from 01/01/24 to 09/10/24 documented the following: On 03/28/24 at 09:23 AM the Interdisciplinary Team (IDT) Wound Note revealed a stage three pressure wound to the left heel that measured 2.4 centimeter (cm) by 1.5 cm and 0.2 cm depth. The wound edges were irregular and noted a current treatment plan in place. On 04/16 /24, a Progress Note at 11:08 AM, wound care clinic staff had R2 admitted to a hospital for a worsened foot ulcer and noted the left heel wound required debridement (medical removal of dead, damaged, or infected tissue to improve the healing potential for the remaining healthy tissue). On 4/18/24, a Progress Note at 01:44 PM, R2 readmitted back to facility. On 05/07/24, a Wound Consult Note, revealed the left heel wound measured 1.9 cm by 2.6 cm by 0.4 cm, the left lateral (pertaining to the side, away from the middle) foot wound measured 1.2 cm by 1 cm by 0.3 cm. Staff were to maintain heel foam pad at all times. On 06/20/24 , a Wound Consult Note revealed the resident's left heel wound measured 1 cm by 1.5 cm by 0. 5 cm. The area was debrided by the physician. On 07/11/24, a Wound Consult Note revealed all of the resident's wounds were closed. Staff were to continue to off load the resident's heel and remove the Podus boot to prevent pressure to dorsal (back) and lateral foot. The resident would have a heel foam pad in place at all times, which was to be changed every two weeks. Staff were to monitor the areas daily and call if worsening. On 07/11/24 at 09:08 AM, Social Services Designee (SSD) K spoke with R2's family member to move R2 into a new room with a roommate, and the family agreed. On 07/17/24 at 10:55 AM, six days after the wounds closed, a Skin/Wound Note revealed the left foot dorsum (upper surface of the foot) wound measured 5 cm by 4 cm, the left heel wound measured 2 cm by 1. 5 cm, the left side of the foot with a scabbed area that measured 1 cm by 1.5 cm with redness to the surrounding area that measured 8.5 cm by 2 cm. On 07/22/24 at 07:39 AM, a Skin/Wound Note revealed the left foot dorsum wound measured 4 cm by 2.2 cm, the left heel measured 2.5 cm by 1.7 cm, the left side of foot wound measured 2 cm by 1.3 cm, with no redness noted. On 08/01/24 at 08:17 AM, a Skin/Wound Note revealed the left foot dorsum had redness that measured 4 cm by 2.2 cm by 0.1 cm, the left heel wound measured 3 cm by 3 cm by 0.3 cm with yellow drainage, the left side of the foot wound measured 1.8 cm by 1.5 cm by 0.1 cm with blood- tinged drainage. On 08/08/24 at 04:39 PM, a Wound Consultation Note revealed the resident's left heel re-opened and measured 2.5 cm by 2.5 cm by 0.7 cm, and the left lateral foot wound measured 1.5 cm by 2 cm. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 08/12/24 at 12:08 PM, a Skin/Wound Note revealed the left heel measured 2 cm by 1.7 cm by 0.2 cm and the wound to the left lateral foot measured 0.1 cm by 0.1 cm by 0.1 cm. There was moderate amount of purulent (producing or containing pus) drainage noted from the left heel. On 08/15/24 at 03:59 PM, a Wound Care Note revealed the left heel wound measured 2 cm by 2 cm by 0.3 cm and the wound to the left lateral foot wound measured 1.4 cm by 2 cm by 0.2 cm. Staff were to cleanse the wound with wound wash, pat dry and cover the heel and lateral foot with Aquacel Ag (dressing is indicated for the management of a variety of at risk/infected chronic and acute wounds) extra absorbent dressing. Staff would cover the top of the left foot with a foam pad and change the dressing two times a week. On 09/05/24 at 12:07 PM, a Wound Care Note revealed the left heel wound measured 1.7 cm by 1.8 cm by 0. 1 cm and the left side of the foot wound measured 1 cm by 1 cm by 0.1 cm. The left dorsum wound measured 0.5 cm by 2 cm by 0.1 cm. Staff were to leave the dressing intact until the follow-up appointment. During an observation on 09/10/24 at 12:46 PM, R2 was in the dining room seated in wheelchair and had no seat cushion in the wheelchair. R2 had a blue foot bootie on his left foot with a brown dressing covering the foot, the right foot had a sock and both feet were placed in a foot cradle (cushioned back and side panels that are designed to help control foot drop). Observation revealed R2's bed lacked an air mattress. During an observation on 09/11/24 at 07:54 AM, R2 was in the dining room. R2 had a left heel bootie on his foot, a sock on the right foot and both feet were in a foot cradle. The wheelchair lacked a seat cushion and R2's bed lacked an air mattress. An interview on 09/11/24 at 08:00 AM revealed Licensed Nurse (LN) H confirmed R2's EHR lacked an order for the left foot wound received by the wound care clinic on 09/05/24. LN H revealed R2 should have both heels off loaded per physician's order and confirmed R2 had only a left foot bootie placed. An interview on 09/11/24 at 08:09 AM revealed Certified Nurse Aide (CNA) F confirmed R2 did not have a seat cushion under him on the wheelchair and stated that R2 only required a bootie on his left foot and never wore a right foot bootie. An interview on 09/11/24 at 10:20 AM revealed CNA F stated he assisted R2 to bed at approximately 10:00 AM and placed afoot bootie on the right foot and he placed the left foot bootie under the left heel. CNA F stated R2 did not have extra pillows in his room, and he placed R2's heel on the left bootie instead of in the bootie to off load the left heel, then CNA F confirmed that the bootie was not on correctly and was going to get pillows to off-load the heels. CNA F confirmed that R2 did not have an air mattress on his bed and stated that he had never seen one on R2's bed. An interview on 09/11/24 at 03:10 PM revealed Administrative Nurse B confirmed R2 should have had both heels off-loaded in the correct manner. Administrative Nurse B stated that R2's left heel wounds were chronic, non-pressure ulcers, that R2 had since admission. Administrative Nurse B was asked to clarify what stage, type of ulcer, and if the areas were facility acquired as documentation on the 07/28/24 MDS revealed two stage three facility acquired pressure ulcers. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	An interview on 09/11/24 at 03:43 PM revealed Administrative Nurse B confirmed R2 did not have an air mattress on his bed. Administrative Nurse B stated that R2's room had been changed a few weeks prior, and R2 always had an air mattress on his bed for at least a year. An interview on 09/11/24 at 04:00 PM revealed Administrative Nurse B confirmed R2 had facility acquired stage three pressure ulcers after she spoke to the wound care clinic nurse. Administrative Nurse B revealed that the areas were closed and healed on 07/11/24, and the pressure ulcers were facility acquired. On 09/11/24 at 04:40 PM, SSD K verified R2 moved to room his previous room on 07/12/24. Administrative Nurse B confirmed R2 did not have an air mattress when he moved to a different room and commented the facility had extra air mattresses and did not know why R2 was without an air mattress. The facility's policy Pressure Ulcer/Skin Breakdown dated April 2013 documented: Physicians shall help prevent and manage pressure ulcers, consistent with established guidelines. Incidence of new pressure ulcers will be minimized to the extent possible. Healing of existing pressure ulcers will be optimized to the extent as possible. The facility will be able to show failure of a pressure ulcer to heal was medically unavoidable. The facility failed to place interventions to prevent pressure injuries for R2, who developed two preventable, facility acquired, stage 3 pressure injuries. This placed the resident at risk to worsen his current pressure ulcer or develop more skin issues.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46960 The facility identified a census of 40 residents, which included 12 residents sampled and three reviewed for accidents and accident hazards. Based on interviews, observations, and record review, the facility failed to provide an environment free of accident hazards for the residents of the facility when the facility failed to properly store chemicals in an unlocked cabinet in an unlocked room and when the facility stored chemicals along a rail in the hallway. Additionally, the facility failed to ensure R26, who was identified by the facility as confused and independently mobile with aggressive and wandering behaviors, remained free of accident hazards when R26 put scissors in his pocket and wandered inside the facility. Furthermore, the facility failed to ensure that two residents, Resident (R) 22 and R8, remained free of accident hazards related to falls when the facility failed to appropriately investigate, develop, and implement appropriate interventions to prevent multiple falls for R22 related to continued use of a powered lift chair, or develop any new interventions for R8. These deficient practices resulted in R8 falling and sustaining a fracture (broken bone) to her left humerus (upper arm bone) and left fourth rib which required a hospitalization . Findings included: - Review of the Electronic Health Record (EHR) for Resident (R) 8 included diagnoses of osteoporosis (abnormal loss of bone density and deterioration of bone tissue with an increased fracture risk), history of falling, repeated falls, generalized muscle weakness, lack of coordination, and dementia (a progressive mental disorder characterized by failing memory, confusion). The Significant Change Minimum Data Set (MDS) dated [DATE], documented R8 as unable to complete the Brief Interview for Mental Status (BIMS) assessment and staff assessed R8 to have severely impaired cognition. The assessment documented R8 required substantial or maximal assistance from staff for cares. R8 was frequently incontinent of bladder and always incontinent of bowel. The assessment documented that R8 had no falls since the previous assessment. The Cognitive Loss / Dementia Care Area Assessment (CAA) dated [DATE], documented R8 as deceased ; however, the surveyor observed R8 in the facility on [DATE], [DATE], [DATE], and [DATE]. The Quarterly MDS dated [DATE], documented R8 as unable to complete a BIMS assessment and staff assessed R8 to have severely impaired cognition. The assessment documented R8 as dependent on staff for toileting, bathing, and all forms of hygiene and required substantial or maximal assistance for all other cares except eating, which was required supervision/setup. R8 was frequently incontinent of bowel and always incontinent of bladder. The assessment documented that R8 had a fall since the previous assessment. The [DATE] Care Plan documented R8 was at risk for falls and listed the following interventions: On [DATE], staff would monitor for changes in R8's condition that may warrant increased supervision or assistance and notify the charge nurse. On [DATE], staff would provide frequently used items within easy reach. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On [DATE], family reported R8 was forgetful and would benefit from consistency in her room. She was unable to use a walker due to difficulty remembering to use it. On [DATE], staff would request physical/occupational therapy to evaluate and treat the resident as needed. On [DATE], staff would encourage the resident to visually survey the area prior to stepping away to walk. On [DATE], activities staff would provide mid-morning and mid-afternoon activities, one on one to keep R8 busy and mobile. On [DATE], staff placed a night light in R8's room so she was able to see after dark. Review of the EHR Safety Device Consent dated [DATE], documented a safety assessment for turn bars only and lacked safety assessment for a powered lift chair. Review of the EHR Fall Risk assessments revealed on [DATE], the facility documented a fall risk score of 22, which indicated R8 was a high risk for falls. The Progress Notes dated [DATE] documented R8 experienced a witnessed fall and landed on her left side, she then repositioned herself to her back. Review of the facility Fall Investigation revealed on [DATE] at 05:20 PM, R8 fell without injury. The facility's root cause analysis determined R8 had a lack of safety awareness, which caused the fall. The fall investigation report documented the immediate and permanent care plan interventions were that staff would provide a smaller recliner that was a better fit for R8. The resident's Care Plan documented on [DATE] staff would provide a smaller recliner that was a more appropriate fit for R8; however, the facility lacked evidence of the implementation of this intervention. The Progress Notes dated [DATE] documented R8 was found sitting on the floor near the bed with bed linens wrapped around her legs. The fall investigation report documented the immediate and permanent care plan interventions were that staff would provide more frequent rounding. Review of the facility Fall Investigation revealed on [DATE] at 10:06 PM, R8 fell and obtained a minor injury. The facility's root cause analysis lacked determination causal factors for the fall. The fall investigation report documented the immediate and permanent care plan interventions were that staff would provide more frequent rounding. The resident's Care Plan documented on [DATE] that staff would provide frequent rounding however, the facility lacked evidence of the implementation of this intervention. Review of the EHR Fall Risk assessments revealed [DATE], the facility documented a fall risk score of 15, which indicated R8 was a moderate risk for falls. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The Progress Notes for R8 lacked an entry with a description related to fall on [DATE]. The fall investigation report lacked an immediate intervention to mitigate fall risk for the remainder of the shift. The fall investigation report documented the permanent care plan documented staff would cue and sit with R8 to ensure that R8 ate the meal or snack provided. Review of the facility Fall Investigation revealed on [DATE], R8 fell and obtained a minor injury. The facility's root cause analysis determined that R8 was hungry and attempted to ambulate without staff assistance. The fall investigation report lacked an immediate intervention to mitigate fall risk for the remainder of the shift. The fall investigation report documented the permanent care plan documented staff would cue and sit with R8 to ensure that R8 ate the meal or snack provided. The resident's Care Plan documented on [DATE] that staff would sit with R8 to provide cues and assistance with any snacks or meals provided. The Progress Notes dated [DATE] documented staff discovered R8 at approximately 05:30 AM, on the ground on her knees, and noted she had a minor injury to the left elbow. The facility's fall investigation report documented that the immediate intervention was that staff would close monitoring for remainder of shift. The facility's fall investigation report permanent care plan documented staff would unplug recliner and switch to a manual recliner when possible. Review of the facility Fall Investigation revealed on [DATE], R8 fell and obtained a minor injury. The facility's root cause analysis determined R8 raised a powered lift chair to its full height and fell . The facility's fall investigation report documented that the immediate intervention was that staff would closely monitor the resident for the remainder of the shift. The facility's fall investigation report permanent care plan documented staff would unplug recliner and switch to a manual recliner when possible. The resident's Care Plan documented manual recliner on [DATE]; however, the surveyor observed R8 resting in powered lift chairs on [DATE], [DATE], [DATE], and [DATE]. Review of the EHR Fall Risk assessments revealed the on [DATE], the facility documented a fall risk score of 25, which indicated R8 was a high risk for falls. The Progress Notes dated [DATE] at 09:25 PM documented staff discovered R8 on the ground on her left side in her doorway, with a minor injury to the left elbow. Review of the facility Fall Investigation revealed on [DATE], R8 fell and obtained a minor injury. The facility's root cause analysis determined R8 had limited safety awareness. The fall investigation report documented the immediate intervention was that staff would perform more close monitoring of the resident. The fall investigation report documented the permanent care plan intervention was staff would offer toileting with all bed checks. The resident's Care Plan documented on [DATE] staff would offer toileting with all bed checks to prevent the resident from attempting to ambulate without assistance from staff. Review of the EHR Fall Risk assessments revealed on [DATE], the facility documented a fall risk score of 22, which indicated R8 was a high risk for falls. (continued on next page)

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	175459	A. Building B. Wing	09/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wheatridge Park Care Center	1501 S Holly Dr Liberal, KS 67901

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The Progress Note dated [DATE] at 01:27 AM, documented R8 was given pain medication for the fall that occurred on [DATE] at 09:25 PM and lacked documentation of the location or severity of the pain. The Progress Note dated [DATE] at 03:24 PM, revealed an unknown Certified Nurse Aide (CNA) staff reported to the nurse R8 had pain and swelling to the left shoulder. The nurse assessed R8 and documented swelling and bruising from R8's shoulder to her elbow on the left arm, documented she notified R8's primary care physician (PCP), and noted she left a message for the PCP. The Progress Note dated [DATE] at 03:55 PM, revealed R8's PCP returned the phone message and gave a telephone order to obtain an x-ray of the resident's left upper arm and left shoulder. The Progress Note dated [DATE] at 09:14 PM, revealed the consultant x-ray provider notified the facility that R8 had a displaced fracture (a traumatic bone break where two ends of the bone separate out of their normal positions) of the left humerus and a fractured left fourth rib. The facility staff notified R8's PCP and received orders to maintain current treatment to maintain R8's comfort and notify the PCP if R8 became uncomfortable. Review of the Progress Note dated [DATE] at 05:48 PM, revealed staff called the hospital and were advised that R8 admitted to the medical floor due to a fracture of the left humerus. The Progress Notes lacked additional documentation related to how, when, or why the resident was transferred to the hospital. Review of the Progress Note dated [DATE] at 03:00 PM, revealed R8 arrived to the facility with a report from the hospital noting R8 was not a candidate for surgical repair of the left arm and orders to apply ice to the affected area as needed for pain or swelling, R8 was to wear a sling on the left side at all times for four weeks, and staff were not to use the left arm to assist the resident with cares. Review of the facility Fall Investigation revealed on [DATE], R8 fell and obtained a minor injury. The facility's root cause analysis determined that R8's limited safety awareness caused the fall. The fall report documented that the immediate intervention was that staff would perform more close monitoring with one-on-one supervision as much as possible. The fall investigation report documented the permanent care plan intervention was documented as staff asked R8's family to bring a TV to her room so staff would place the TV on a music channel then wait to see if she was willing to lay and watch television and sleep. The Progress Notes for R8 lacked documentation related to the [DATE] fall. The resident's Care Plan included an intervention dated [DATE], which documented family would bring R8 in a television and staff were to put it on a music channel which would allow her to watch, relax, and sleep. Review of the Progress Note dated [DATE] at 03:22 AM, staff documented a witnessed fall when R8 attempted to stand unassisted from a wheelchair without additional injuries; however, the facility lacked a fall investigation related to this fall. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The resident's Care Plan included an intervention dated [DATE], which indicated staff had a meeting with family regarding additional interventions to prevent R8 from falling again with suggestions made that staff would implement with the goal to keep R8 calm; however, no additional information was provided. Review of the EHR Fall Risk assessments revealed on [DATE], the facility documented a fall risk score of 26, which indicated a high risk for falls. The resident's Care Plan included an intervention dated [DATE], which directed staff would offer to take R8 to the bathroom during all overnight bed checks to prevent her from self-ambulation attempts. The Progress Notes dated [DATE] at 04:19 PM, revealed staff documented a witnessed fall without injury when R8 attempted to stand from a recliner with the footrest in the up position. The fall investigation report documented the immediate and permanent care plan interventions were that staff would offer snacks/drinks frequently. Review of the facility Fall Investigation revealed on [DATE], R8 fell without injury. The facility's root cause analysis determined R8 attempted to stand without staff assistance. The fall investigation report documented the immediate and permanent care plan interventions were that staff would offer snacks/drinks frequently. The resident's Care Plan documented on [DATE] staff would frequently offer snacks/drinks to R8 however, the facility lacked evidence of the implementation of this intervention. Review of the EHR Fall Risk assessments revealed on [DATE], the facility documented a fall risk score of 23, which indicated a high risk for falls. The Progress Notes revealed on [DATE] at 05:28 PM, staff documented a fall without injury when R8 attempted to ambulate without staff assistance. Review of the facility Fall Investigation revealed on [DATE], R8 fell without injury. The facility's root cause analysis determined that R8 attempted to stand without staff assistance. The fall report lacked an immediate intervention performed by staff to mitigate the risk of falls for the remainder of the shift. The permanent care plan intervention was staff should monitor for items left on the floor or any items the resident may have dropped and assist with picking them up. Review of the resident's Care Plan revealed the following interventions: On [DATE], staff would perform rounds frequently and offer R8 toileting assistance. On [DATE], staff would maintain an environment that was clutter-free, provide adequate lighting, and ensure personal items were within reach. On [DATE], staff would provide assistive devices as needed. On [DATE], staff would review information on past falls to determine causes of falls. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the EHR Fall Risk assessments revealed on [DATE], the facility documented a fall risk score of 15, which indicated R8 was a moderate risk for falls. Observations on [DATE] at 12:50 PM, [DATE] at 07:40 AM, and [DATE] at 10:00 AM revealed R8 in a powered lift chair recliner in the common area near the nurses' station with her eyes closed. Observation on [DATE] at 12:00 PM, revealed R8 in a powered lift chair recliner in the common area near the nurses' station with her eyes closed. Two unknown CNA staff assisted R8 to an upright seated position using the powered mechanism of the lift chair, then performed a two-person pivot-transfer from recliner to R8's wheelchair and assisted R8 to the dining area for the noon meal. On [DATE] at 12:04 PM, CNA F stated when a resident fell , CNA staff should ensure the resident was safe, then alert other staff that assistance was required, and would notify the nurse. Upon the arrival of the nurse, then CNA staff would follow the instructions of the nurse. CNA F was unable to recall specific interventions for R8 and stated that they would refer to the CNA book at the nurses' station or R8's care plan on the EHR for guidance. On [DATE] at 12:14 AM, CNA E stated that when a resident fell , CNA staff would ensure the resident was safe and call for help, which included calling the nurse. Once the nurse arrived, then CNA staff would follow the instructions of the nurse. CNA E was unable to recall any information specific to R8's falls and stated that interventions to prevent falls for R8 could be found in the resident's care plan, which was accessible in the EHR on either the computers or tablets or in the CNA book in the nurses' station. On [DATE] at 12:24 PM, Licensed Nurse (LN) D stated after a fall, the CNA staff would ensure the resident was safe and call for help, which included the nurse. When the nurse arrived, they would assess the resident for injuries and give aid if appropriate. Immediately following the fall, the nurse would notify the PCP, the resident's representative, Administrative Nurse B and/or Administrative Staff A. Immediately after the required notifications were made, the nurse would fill out a fall report in the EHR and collect witness statements from all nursing (CNA, Certified Medication Aides [CMA], LN) personnel on duty at the time of the fall. The nurse would then hold a fall huddle with the staff to initiate an investigation to determine the root cause of the fall and develop an immediate intervention to mitigate the risk of falls for the remainder of the shift. The nurse would also perform and document ongoing assessments for fall follow up which may or may not include neurological (pertaining to the brain) assessments if needed for 72 hours (3 days) after the fall. On the next business day, Administrative Nurse B would review the documentation and add a permanent care plan intervention on the resident's care plan and place the update in the CNA book at the nurses' station. Additionally, LN D stated that she was unsure if residents were assessed for safety related to the safe operation of powered lift chairs. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview with Administrative Nurse B on [DATE] at 12:36 PM revealed after a resident fell , she expected staff to perform a huddle to discuss what happened, develop an immediate intervention to prevent further falls, then staff would complete a risk management module. All nursing staff were expected to fill out a witness statement, then make appropriate notifications. The Director of Nursing (DON) reviewed fall charting and added interventions to the individual resident care plans after a fall. Administrative Nurse B reported resident cares were driven by the care plan and stated it was her expectation the care plan would be revised with a new and unique intervention related to each specific fall. Administrative Nurse B further confirmed if the facility did not identify the cause of a fall they could not say if interventions in place for fall were appropriate. Administrative Nurse B stated duplicate or similar care plan interventions were unacceptable and confirmed the resident had duplicate/similar care planned interventions for multiple falls. Administrative Nurse B stated care planned interventions should be new, unique to the fall, and measurable. She also confirmed the facility lacked appropriate follow up for all falls in the resident's progress notes. The nurse should initiate and document ongoing assessments for 72 hours (3 days) for fall follow up and include neurological assessments if needed. Administrative Nurse B stated that the previous DON was responsible for the information prior to the [DATE] fall and she was unable to provide an explanation as to why the expectations were not met. Administrative Nurse B stated that all residents who use powered lift chairs should have a Safety Device Consent assessment in their EHR to determine whether they could safely utilize a piece of powered equipment. She confirmed R8 had severely impaired cognition and could not be assessed for safe use of a powered lift chair. Further, confirmed that the Safety Device Consent in R8's EHR, dated [DATE] lacked a safety assessment for a powered lift chair. The facility's undated Fall Guidelines - Assessing Falls and Their Causes documented staff were to observe a resident who fell for delayed complications for approximately forty-eight (72) hours and would document the findings in the resident's EHR. Additionally, staff would, in collaboration with the interdisciplinary team (IDT - a team of facility staff consisting of members of various departments including but not limited to; dietary, nursing, maintenance, therapy, etc.), identify possible or likely causes of the incident and lacked instructions for staff to follow to correct the causes of the incident. The facility failed to implement interventions after multiple falls to provide an environment free of accident hazards for a dependent resident with severely impaired cognition and a known history of repeated falls. R8 fell twice on [DATE] and was injured, fell on [DATE] and was injured, fell on [DATE] and was injured, fell on [DATE] and was injured (two fractures and a hospitalization), fell on [DATE] and was injured, fell on [DATE] and was not injured, and fell on [DATE] and was not injured. This deficient practice resulted in actual harm to the physical and psychosocial well-being of R8. - Observation on [DATE] at 10:45 AM, revealed a container of sanitizer wipes for surfaces and reusable medical equipment sat on top of the handrail in the 200 hall. The sanitizer wipes container was labeled Keep out of reach of children. On [DATE] at 11:42 AM, Housekeeping Supervisor X, unknown housekeeper and unknown laundry aide observed walking past the container of sanitizer wipes stored on the top of the handrail in the 200 hall. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 12:10 PM, Licensed Nurse (LN) H identified the sanitizer wipes as hazardous chemicals since the manufacturer's label documented to keep out of reach of children and stated that the container of wipes should be stored in the medication room, in the supply room, or in a (unsecured) bag hanging from mechanical lifts. LN H then removed the container of wipes and placed it in an unsecured bag and hung it from a mechanical lift that was stored in the hallway. On [DATE] at 01:51 PM, during an environmental tour with Maintenance Director O in the activities room, a large metal cabinet with two full-length doors was unlocked and contained the following hazardous chemicals with Keep out of reach of children on the manufacturer's labels: 1. One container of Germicidal (sanitizing) wipes. 2. Two cans of paint plus primer. 3. One can of spray adhesive. 4. One can of extra hold hairspray. 5. One container of mosaic stone cement. 6. Two containers of nail polish remover. In addition, there was assorted nail care accessories which included nail polish, clippers and scissors. On [DATE] at 03:00 PM, Administrative Nurse B confirmed the above findings and stated that her expectation was for all chemicals and sharp objects to be secured behind a locked door or cabinet. Administrative Nurse B identified four residents who were independently mobile and had cognitive impairment that included confusion. The facility's undated Poisonous and Toxic Materials documented that all containers of poisonous and toxic materials would be prominently marked or labeled for easy identification and when not in use would be stored on shelves that were used for no other purpose. The policy lacked documentation related to keeping chemicals away from residents and/or secured behind a locked door or cabinet. The facility failed to provide an environment free of accident hazards when the facility failed to appropriately store hazardous chemicals. - Review of the Electronic Health Record (EHR) for Resident (R) 26 included diagnoses of altered mental status (state of awareness that was different from the normal awareness of a person), dementia (a progressive mental disorder characterized by failing memory, confusion) and Wernicke's encephalopathy (a brain and memory disorder that causes confusion, ataxia [impaired ability with muscle coordination], eye problems and memory loss). (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The Admission Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of seven, which indicated severely impaired cognition. The assessment documented that R26 had a PHQ-9 score of 0, which indicated no indications for depression and no behaviors documented. R26 required partial/moderate assistance of staff for dressing and footwear, and supervision for all other cares except eating which required setup and supervision. R26 performed toileting independently. The Cognitive Loss / Dementia Care Area Assessment (CAA) dated [DATE], documented that R26 had a diagnosis of dementia with cognitive loss. The [DATE] Care Plan documented R26 displayed wandering behaviors and included multiple interventions for staff to promote safety. The [DATE] Care Plan documented R26 had a history of inappropriate behaviors that included agitation and aggression and intermittent refusal of care and provided the following interventions: Staff would reorient and redirect R26 as needed, dated [DATE]. Staff would allow R26 time to calm down and reapproach at a later time, and monitor for and document each behavioral event, dated [DATE]. Staff would evaluate the need for a referral to psychological services and offer psychosocial support, dated [DATE]. Staff would interact in an empathetic and supportive manner, dated [DATE]. Staff would attempt to allow resident time then reapproach, regarding verbal aggression to staff, dated [DATE]. The Physician's Orders documented the following: Monitor the resident for target behaviors including yelling at staff, resisting cares, hitting others and inappropriate behaviors, two times per day for behavior monitoring, dated [DATE]. Monitor the resident for inappropriate behaviors, wandering, verbal aggression, two times per day for behavior monitoring, dated [DATE]. The Assessments reviewed and lacked safety assessment for R26 to keep or have access to sharp/dangerous objects. The [DATE] to [DATE] Medication Administration Record (MAR) and Treatment Administration Record (TAR) documented monitoring of behaviors. The Progress Notes reviewed [DATE] to [DATE] revealed multiple entries where staff documented rejection of cares, aggression, and agitation towards staff and wandering behavior that included wandering into other resident's rooms. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 11:45 AM, an observation revealed R26 in his room with scissors and nail clippers. R26 became verbally aggressive with survey team when an interview attempted. R26 placed the scissors in the front pocket of his trousers and walked angrily from the room down the hallway. On [DATE] at 07:46 AM, R26 wandered in the hallway with a furrowed brow and scowl expression. On [DATE] at 12:04 PM, Certified Nurse Aide (CNA) F stated that all dangerous items such as chemicals and sharp objects (knives, scissors, etc.) should be locked up and should not be accessible to residents. On [DATE] at 12:14 PM, CNA E stated that dangerous objects such as chemicals, knives or scissors should be locked up and inaccessible to residents. On [DATE] at 12:24 PM, Licensed Nurse (LN) D stated that dangerous items such as chemicals, knives or scissors should be secured in such a way that prevents residents from having access to them. On [DATE] at 03:00 PM, Administrative Nurse B stated that her expectation was for all dangerous items which included chemicals, knives, scissors, and nail clippers to be secured and not available to residents. Administrative Nurse B identified four residents in the facility that were independently mobile and confused, that included R26. Further, Administrative Nurse B identified R26 as a resident who displayed intermittently aggressive behaviors and should not have access to sharp objects. The facility lacked a policy related to securing potentially hazardous objects. The facility failed to ensure that R26, a resident that the facility identified as confused and independently mobile with aggressive and wandering behaviors when R26 put scissors in his pocket and wandered inside the facility. This put this resident at risk for self -injury as well as the residents of the facility at risk for potential of harm related to unsecured sharp objects. - Review of the Electronic Health Record (EHR) for Resident (R) 22 included diagnoses of history of falling, chronic obstructive pulmonary disease (COPD - a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing) and bipolar disorder (a major mental illness that caused people to have episodes of severe high and low moods). The Significant Change Minimum Data Set (MDS) dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The assessment documented that R22 utilized a walker or wheelchair for locomotion and required extensive assistance of all cares of two staff members except eating which was performed independently. R22 was always incontinent of urine and occasionally incontinent of bowel. R22 received opioid (class of drug used to treat moderate to severe pain) five of the seven days in the look-back-period and received oxygen. The assessment documented that R22 did not fall since the previous assessment. The Falls Care Area Assessment (CAA) dated [DATE], documented that R22 had a history of falls related to her need for assistance with transfers. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The Quarterly MDS dated [DATE], documented a BIMS score of 10, which indicated moderately impaired cognition. The assessment documented R22 was dependent on staff for bathing and toileting and required substantial/maximal assistance for all other cares except eating, which required partial assistance. R22 was always incontinent of urine and occasionally incontinent of bowel and received an antidepressant (a class of medications used to treat mood disorders and relieve symptoms of depression) and oxygen. The assessment documented that R22 fell since the previous assessment. The [DATE] Care Plan documented R22 was at risk for falls related to poor safety awareness, unsteadiness, COPD and hospice/end-of-life care and listed the following interventions: On [DATE] documented staff should place non-skid surface in a chair to prevent her from sliding out of chair, initiated on [DATE] and revised date of [DATE]. Staff would maintain a clutter free environment; free from spills with adequate lighting and place personal items within reach, initiated on [DATE]. Staff would ensure items are within reach, initiated on [DATE]. Staff would ensure the call light was within reach and encourage the resident to call for help, initiated on [DATE]. On [DATE], staff educated to ensure that water pass performed on both shifts and placed within the reach of resident, initiated on [DATE]. Staff would provide appropriate footwear with transfers and ambulation, initiated on [DATE]. Staff would provide assistive devices as needed, initiated on [DATE]. Staff would refer R22 to physical/occupational therapy as needed, initiated on [DATE]. Staff would remind resident to use the call light for safety, initiated on [DATE]. Staff would review information on past falls and attempt to determine the cause of falls as indicated, initiated on [DATE]. Review of the EHR lacked a Safety Device Consent safety assessment for a powered lift chair for R22. Review of the EHR Fall Risk assessment on [DATE], revealed the facility documented a fall risk score of 15, which indicated R22 was a moderate risk for falls. Review of the EHR Fall Risk [TRUNCATED]

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50659 The facility reported a census of 40 residents with 12 residents sampled, including five residents reviewed for respiratory care. Based on observations, record reviews, and interviews, the facility failed to properly clean, label and store the nebulizer (a device for administering inhaled medications) for Resident (R)7 in accordance with the standards of care and failed to follow up on a bilevel positive airway pressure (BiPAP-medical device which helps with breathing) physician order. In addition, the facility failed to date the oxygen tubing for R144. R7, R21, R22 and R144. Findings included: - Resident (R)7's medical diagnoses included chronic respiratory failure (a long-term condition that occurs when the body's respiratory system is unable to exchange oxygen and carbon dioxide properly) and morbid obesity (excessive body fat). The 04/29/24 Admission Minimum Data Set (MDS), documented a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. R7 required total assistance with activities of daily living (ADLs), with toileting hygiene, bathing, dressing, personal care, and transfers. R7 required oxygen and dialysis (procedure where impurities or wastes were removed from the blood). The 05/06/24 Functional Abilities Care Area Assessment (CAA), documented R7 admitted to the facility for skilled services. R7 required assistance with ADLs and transfers related to impaired mobility and was at risk for falls and skin breakdown related to incontinence. The CAA lacked any documentation regarded to respiratory. The 07/29/24 Quarterly MDS, documented a BIMS score of 15, indicating intact cognition. R7 required total assistance with ADLs. R7 required oxygen and dialysis. The 09/10/24 Care Plan documented interventions which included: On 04/24/24, staff were instructed to administer oxygen as ordered, monitor for signs and symptoms of upper respiratory infection. Provide aerosol treatments as per orders. Apply BiPAP as ordered, ensure settings followed per physician orders. Staff were instructed to educate the resident to use breathing techniques: purse lips, cough and deep breathing. Staff were instructed to notify the physician of increased complaints of difficulty in breathing. The Physician Orders reviewed on 09/10/24 included the following: Ipratropium-Albuterol (a combination is used to help control the symptoms of lung diseases, such as asthma, chronic bronchitis, and emphysema) Inhalation Solution 0.5-2.5 (3) milligram (mg)/3 milliliter (ml). Administer 3 ml four times a day inhale orally for shortness of breath, ordered on 04/24/24. Pulmicort Inhalation Suspension (medication used to manage and treat inflammatory diseases, mainly affecting the airways) administer 0.25 mg/2 ml, two times a day, inhale orally for shortness of breath, ordered on 04/24/24. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Change nebulizer mask and tubing one time a day, for one day, every month, date ordered 05/05/24. To have Bi-PAP to be placed on hold. To have new sleep study and arterial blood gases (a test measures the oxygen and carbon dioxide levels in your blood) to determine the need for bi-pap and or non-invasive ventilator (a machine that helps you breathe by delivering oxygen into your lungs), dated 06/06/24. Change oxygen tubing and bags monthly and as needed, date ordered 08/27/24. Clean oxygen filters twice a month, once on the first, and once on the 15th of each month, date ordered 08/27/24. Administer oxygen via nasal cannula at three liters per minute continuously, to maintain oxygen saturation above 90 percent, date ordered 08/27/24. Review of the Progress Notes from 04/17/24 to 09/10/24 documented the following: On 05/29/24 a Progress Note at 10:55 PM, physician contacted as R7 requested a BiPAP. The physician was updated that R7 had used that device years ago and his last sleep study (is a test used to diagnose sleep disorders) was completed five years ago. Received order for a sleep study to be performed. On 06/28/24 a Progress Note at 04:58 PM, nurse to physician communication form faxed on 06/19/24 for a sleep study to determine the need for a BiPAP or non-invasive ventilator. The Physician signed. On 09/10/24 at 08:52 AM, observed R7's nebulizer mask with clear liquid substance in the chamber draped over the positioning bar on the bed by the tubing, the nebulizer mask touched the floor. Additionally, no date or label on the tubing or the mask. R7 had an oxygen nasal cannula noted on the wheelchair seat in the bathroom that was connected to the portable tank and oxygen tubing connected to the oxygen concentrator, and neither nasal cannula tubing was labeled with a date. The prefilled humidifier bottle was empty and not labeled. On 09/10/24 at 08:52 AM, R7 stated he was not sure when the oxygen supplies are changed out. R7 stated he had never seen the nebulizer mask or chamber rinsed after medication administered. R7 commented he had not received a BiPAP that the physician at the facility gave an order and the facility has not assisted with obtaining one. On 09/11/24 at 10:46 AM, R7 was in his room preparing to leave for dialysis. Observed new oxygen prefilled humidified bottle, bag for oxygen tubing and oxygen tubing dated 09/10/24. On 09/11/24 at 01:30 PM, Administrative Nurse B confirmed R7 had not completed a sleep study, and no appointment had been made for the sleep study. (continued on next page)

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	175459	A. Building B. Wing	09/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wheatridge Park Care Center	1501 S Holly Dr Liberal, KS 67901

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 09/12/24 at 10:35 AM, Licensed Nurse (LN) G reported that the oxygen tubing and supplies should be changed out the first of every month, and all the tubing and supplies are to be labeled with the date. Additionally, LN G reported a black bag is to be taped to the oxygen concentrator and on the back of residents' wheelchairs, labeled with a date for nasal cannula and mask to be placed when not in use. LN G confirmed it was not acceptable to place nasal cannulas and nebulizer masks on the floor or on the residents' wheelchairs. LN G was unsure of the policy for nebulizer care after medication was administered. LN G reported the treatment administration record (TAR) did not have any direction to check the humidified bottles on the concentrator, she stated the bottles should be changed and dated when emptied. On 09/12/24 at 11:15 AM, Administrative Nurse B confirmed all oxygen supplies and nebulizer supplies should be labeled with a date, and the nasal cannulas should be placed in the black bag to keep the items clean. Additionally, the nebulizer masks and medication chambers should be rinsed out and air dried after each use. Administrative Nurse B expected nurses to change the humidified bottles on the concentrators when they were close to being empty and verified that is not on the TAR as an order. The facility lacked a policy for respiratory care supplies. The facility failed to provide respiratory care consistent with professional standards of care for R7, regarding the use and cleaning of the nebulizer equipment and oxygen supplies were not labeled. - Resident (R)21 's Electronic Health Record (EHR) revealed diagnoses of chronic obstructive pulmonary disease (COPD- progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing) and sleep apnea (disorder of sleep characterized by periods without respirations). The 05/20/24 Admission Minimum Data Set (MDS), documented a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The resident had a total mood severity score of 00, indicating no depression and no behaviors. R21 required total assistance with activities of daily living (ADLs), with toileting hygiene. Maximal assistance dressing and transfers. The 05/27/24 Care Area Assessment (CAA) lacked analysis of findings documented for respiratory. The 08/05/24 Quarterly MDS, documented a BIMS score of 15, indicating intact cognition. R21 required total assistance with most ADLs. R21 required oxygen. The 09/10/24 Care Plan documented interventions which included: On 05/15/24 staff were instructed to administer oxygen as ordered, apply continuous positive airway pressure (CPAP- ventilation device that blows a gentle stream of air into the nose to keep airway open during sleep) as ordered. Staff were instructed to educate the resident to use breathing techniques: purse lips, cough, and deep breathing. Staff were instructed to notify the physician of increased complaints of difficulty in breathing and head of bed to be elevated due to shortness of breath when lying flat. Staff were instructed to notify the physician of increased complaints of difficulty in breathing. The Physician Orders reviewed on 09/10/24 included the following: (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Oxygen check and replace or refill distilled water bottle as needed, dated 07/08/24. Apply CPAP at three liters of oxygen at bedtime for sleep apnea, date ordered 08/01/24. Administer oxygen via nasal cannula at three liters per minute at all times, date ordered 08/26/24. CPAP humidifier cleaning to be done once weekly. Cleanse the humidifier with warm soapy water, rinse thoroughly and dry with a clean cloth or allow to air dry, date ordered 08/27/24. Clean the CPAP tube with mild detergent that is not anti-bacterial (a substance that kills bacteria or stops them from growing and causing disease) in warm water. Dry the interior of the hose, connect it to the CPAP machine and allow it to run for approximately 15 minutes or until moisture has evaporated weekly, dated ordered 08/27/24. For the CPAP humidifier water- empty the distilled water each morning from the CPAP machine. After cleaning, refill with distilled water, dated ordered 08/27/24. CPAP mask and nasal pillows must be cleaned in the morning. Clean CPAP mask using warm water and a cloth daily. Place mask in bag, date ordered 08/27/24. Change the nebulizer mask and tubing monthly, date ordered 08/27/24. Change the oxygen tubing and bags monthly and as needed, date ordered 08/27/24. Clean oxygen filters monthly, dated ordered 08/27/24. On 09/10/24 at 09:46 AM, observed R21's oxygen tubing not date or labeled. R21 had an oxygen nasal cannula noted over the positioning bar on the bed by the tubing, the nasal cannula touched the floor. The CPAP mask laid face down on the nightstand and the prefilled humidifier bottle was empty and labeled with a date of 09/01/24. On 09/10/24 at 09:46 AM, R21 stated she was not sure when the oxygen supplies were to be changed out and the CPAP mask is usually placed on the nightstand. On 09/12/24 at 10:35 AM, Licensed Nurse (LN) G reported that the oxygen tubing and supplies should be changed out the first of every month, and all the tubing and supplies are to be labeled with the date. Additionally, LN G reported a black bag is to be taped to the oxygen concentrator and on the back of residents' wheelchairs, labeled with a date for nasal cannula and mask to be placed when not in use. LN G confirmed it was not acceptable to place nasal cannulas and nebulizer masks on the floor or on the residents' wheelchairs. LN G was unsure of the policy for nebulizer care after medication was administered. LN G reported the treatment administration record (TAR) did not have any direction to check the humidified bottles on the concentrator, she stated the bottles should be changed and dated when emptied. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 09/12/24 at 11:15 AM, Administrative Nurse B confirmed all oxygen supplies and nebulizer supplies should be labeled with a date, and the nasal cannulas should be placed in the black bag to keep the items clean. Additionally, the nebulizer masks and medication chambers should be rinsed out and air dried after each use. Administrative Nurse B expected nurses to change the humidified bottles on the concentrators when they were close to being empty and verified that is not on the TAR as an order. The facility lacked a policy for respiratory care supplies. The facility failed to provide respiratory care consistent with professional standards of care for R21, regarding the use and cleaning of the CPAP equipment and oxygen supplies were not labeled. - Resident (R)144's medical diagnoses included sleep apnea (disorder of sleep characterized by periods without respirations) and chronic respiratory failure (a condition that results in the inability to effectively exchange carbon dioxide and oxygen). The 09/03/24 Admission Minimum Data Set (MDS), documented a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. The resident had a total mood severity score of four, indicating no to minimal depression and R144 had no behaviors. R144 required total assistance with activities of daily living (ADLs), with transfers and wheelchair mobility. Maximal assistance with toileting, dressing and bed mobility. Frequently incontinent of bladder. R144 required oxygen. The 09/05/24 Functional Abilities Care Area Assessment (CAA), documented R144 admitted to the facility for skilled services. R144 required assistance with ADLs and transfers related to impaired mobility and was at risk for falls. The CAA lacked any documentation regarded to respiratory. The 09/10/24 Care Plan documented interventions which included: On 08/28/24, staff were instructed to administer oxygen as ordered and elevate had of bed due to shortness of breath. Staff were instructed to educate the resident to use breathing techniques: purse lips, cough and deep breathing and monitor for signs and symptoms of upper respiratory infection Staff were instructed to notify the physician of increased complaints of difficulty in breathing. The Physician Orders reviewed on 09/10/24 included the following: Head of bed elevated, resident is unable to lay flat due to shortness of breath every shift to promote ease of breathing, date ordered 08/26/24. Change the oxygen tubing monthly and as needed, date ordered 08/28/24. Check and replace or refill the distilled water bottle as needed, date ordered 08/28/24. Oxygen at two liters per nasal cannula at all times, date ordered 08/28/24. Clean the oxygen filters twice a month, once on the first, and once on the 15th of each month, date ordered 08/28/24. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	09/10/24 at 07:15 AM, R144 laid in his bed with eyes shut, the prefilled humidifier bottle was empty and dated 09/01/24. R144 had an oxygen nasal cannula positioned on the wheelchair footrest on the wheelchair seat that was connected to the portable tank and oxygen tubing connected to the oxygen concentrator, and neither nasal cannula tubing was labeled with a date. On 09/11/24 at 07:30 AM, observed new oxygen prefilled humidified bottle, bag for oxygen tubing and oxygen tubing dated 09/10/24. On 09/12/24 at 10:35 AM, Licensed Nurse (LN) G reported that the oxygen tubing and supplies should be changed out the first of every month, and all the tubing and supplies are to be labeled with the date. Additionally, LN G reported a black bag is to be taped to the oxygen concentrator and on the back of residents' wheelchairs, labeled with a date for nasal cannula to be placed when not in use. LN G confirmed it was not acceptable to place nasal cannulas on the floor or on the residents' wheelchairs. LN G reported the treatment administration record (TAR) did not have any direction to check the humidified bottles on the concentrator, she stated the bottles should be changed and dated when emptied. On 09/12/24 at 11:15 AM, Administrative Nurse B confirmed all oxygen supplies and nebulizer supplies should be labeled with a date, and the nasal cannulas should be placed in the black bag to keep the items clean. Administrative Nurse B expected nurses to change the humidified bottles on the concentrators when they were close to being empty and verified that is not on the TAR as an order. The facility lacked a policy for respiratory care supplies. The facility failed to provide respiratory care consistent with professional standards of care for R144, regarding the use of oxygen supplies that were not labeled. 46960 - Review of the Electronic Health Record (EHR) for Resident (R) 22 included diagnoses of history of falling, chronic obstructive pulmonary disease (COPD - a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing) and bipolar disorder (a major mental illness that caused people to have episodes of severe high and low moods). The Significant Change Minimum Data Set (MDS) dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The assessment documented that R22 received oxygen. The Care Area Assessment (CAA) dated 09/13/23, lacked documentation related to oxygen use. The Quarterly MDS dated [DATE], documented a BIMS score of 10, which indicated moderately impaired cognition. The assessment documented that R22 received oxygen. The 09/11/24 Care Plan documented R22 received oxygen and listed the following interventions: Staff would administer oxygen as ordered at two liters per minute (LPM), dated 07/01/21. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Staff would monitor the resident and inform the physician if R22 complained of increased difficulty breathing, dated 07/01/21. Staff would administer oxygen as ordered via nasal cannula at 3 LPM, dated 12/14/22. The Physician Orders documented the following: Check and replace or refill distilled water bottle as needed, every 12 hours as needed for oxygen therapy maintenance, dated 01/16/24. Oxygen via nasal cannula at 2 LPM continuously, every day and night shift, dated 09/04/24. Clean oxygen filters, every day shift on the first and 15th of the month, dated 09/01/24 Change oxygen tubing and black bags monthly, every day shift on the first of the month, dated 09/01/24. Change nebulizer (device which changes liquid medication into a mist easily inhaled into the lungs) mask and tubing, every day shift on the first of the month, dated 09/01/24. On 09/10/24 at 11:04 AM, R22 was observed resting in her recliner with her eyes closed, oxygen tubing lacked date and distilled water bottle that was connected inline with the oxygen tubing contained no water. On 09/11/24 at 07:42 AM, R22 was observed resting in bed with her eyes closed, oxygen tubing lacked a date. On 09/11/24 at 08:30 AM, R22 was observed in the dining area seated at a table with her peers and staff, oxygen tubing lacked a date. On 09/12/24 at 10:35 AM, Licensed Nurse (LN) G reported that the oxygen tubing and supplies should be changed out the first of every month, and all the tubing and supplies are to be labeled with the date. Additionally, LN G reported a black bag is to be taped to the oxygen concentrator and on the back of residents' wheelchairs, labeled with a date for nasal cannula and mask to be placed when not in use. LN G confirmed it was not acceptable to place nasal cannulas on the floor or on the residents' wheelchairs. LN G reported the treatment administration record (TAR) did not have any direction to check the humidified bottles on the concentrator, she stated the bottles should be changed and dated when emptied. On 09/12/24 at 11:15 AM, Administrative Nurse B confirmed all oxygen supplies and nebulizer supplies should be labeled with a date, and the nasal cannulas should be placed in the black bag to keep the items clean. Administrative Nurse B expected nurses to change the humidified bottles on the concentrators when they were close to being empty and verified that is not on the TAR as an order. The facility lacked a policy for respiratory care supplies. The facility failed to provide respiratory care consistent with professional standards of care for R22, regarding oxygen supplies that were not labeled.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. 46960 The facility reported a census of 40 residents. Based on interview and record review, the facility failed to complete an annual performance review at least once every 12 months for five Certified Nurse Aides (CNAs) reviewed, to ensure adequate appropriate cares and services provided to the residents of the facility. The facility identified five CNAs employed over 12 the month period. Findings included: - Review of employee files on 09/12/24 at 2:00 PM revealed a lack of performance evaluations signed by management for five of five Certified Nurse's Aides (CNAs), that had been employed over one year, that included Certified Nurse's Aide CNA P, CNA Q, CNA R, CNA S and CNA T. On 09/12/24 at 2:00 PM, Administrative Staff A reported that producing the requested performance evaluations for CNA staff would be difficult and stated that he did not know that annual performance evaluations for CNA staff was a requirement. The facility's In-Service Training, Nurse Aide policy dated 09/2022, documented that the facility completes a performance review of the nurse aides at least every 12 months. The facility failed to complete an annual performance review at least once every 12 months for five CNAs reviewed, to ensure adequate appropriate cares and services provided to the residents of the facility. This deficient practice had the potential to negatively affect the physical and psychosocial well-being of all the residents in the facility.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 46960 The facility reported a census of 40 residents. Based on observation, interview, and record review, the facility failed to display accurate and identifiable staffing formation daily, for the 40 residents in the facility. Findings included: - On 09/12/24 at 11:40 AM, daily staffing sheets observed to be hanging on the wall near the nurse's station. The nurse staffing information form lacked the facility name and the daily resident census. Review of the Daily Schedule Nursing Hours sheets from 09/05/24 through 09/11/24, revealed the information sheets lacked the facility name and the resident census. On 09/12/24 at 11:49 AM, Administrative Nurse B confirmed posting sheets were not complete due to missing the facility name and the daily resident census. She reported she was not aware of a Federal requirement to have daily staffing sheets completed containing the required elements. The facility lacked a policy for posting nurse staffing information. The facility failed to display accurate and identifiable staffing formation daily, for the 40 residents in the facility.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 46960 The facility census totaled 40 residents on three halls with a commons area where residents gathered for meals and activities. The facility had one medication cart and one nurse treatment cart that services the facility. Based on observation, interview, and record review, the facility failed to provide a safe environment by the failure to ensure a nurse treatment cart that contained insulin (a medication used to treat diabetes [a disease when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin]), topical ointments and creams, and narcotics that were in a locked box within the nurse's treatment cart, remained locked when not in direct line of vision of the nurse, in an area where residents could access it. Findings included: - Observation on 09/11/24 at 07:47 AM, revealed a treatment cart unlocked and unattended in the hallway where residents could access it. Observation on 09/11/24 at 02:20 PM, revealed a treatment cart in the residents' hallway, unlocked and unattended. On 09/11/24 at 07:50 AM, Licensed Nurse (LN) G identified the unlocked and unattended cart as the treatment cart and confirmed it contained insulins, topical ointments, medicated creams, wound care supplies and narcotics that were in a separate locked box within the cart. LN G verified the treatment cart should be locked when not within arms reach of staff. On 09/11/24 at 08:10 AM, Administrative Nurse B stated it was her expectation staff should lock all medication and treatment carts when not in line of sight of the staff responsible for the cart. On 09/11/24 at 2:20 PM, LN G confirmed the treatment cart was left unattended. LN G confirmed the treatment cart should be locked when unattended. On 09/11/24 at 02:30 PM, Administrative Nurse B confirmed that the Medication and treatment carts should be locked when not in the line of sight of the person responsible for the cart. The facility's Security of Medication Cart policy, revised 4/2007, documented the nurse must secure the medication cart during medication pass. The cart must be locked and parked in the doorway outside the resident's room during the medication pass. When the cart is out of view of the nurse, it must be locked and parked at the nurses' station. The facility failed to provide a safe environment for the residents by the failure to ensure a treatment cart remained locked when not in direct line of vision of the licensed nurse passing medications from their carts.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 46960 The facility reported a census of 40 residents. Based on observation, interview, and record review, the facility failed to provide sanitary conditions for food storage and dishes to prevent the spread of food borne illness to the residents of the facility. Findings included: - Initial tour of the kitchen on 09/10/24 at 08:32 AM with Dietary Manager L, revealed the following areas of concerns: 1. In the serving area, several stacks of bowls and plates stored in the upright position that had the potential to be exposed to splash, dust or other contamination. 2. In the dry storage area, a box of pancake mix opened to air and undated, a large bag of long grain rice opened to air and undated, a large container of Japanese breadcrumbs opened to air and undated, and a box of white cake mix opened to air and undated. 3. In an upright stand-alone refrigerator was a container of white cheese opened to air. 4. The facility utilized a three basin sink system for low-temp washing of dishes. Dietary Manager L was unable to provide current sanitation documentation and produced a package of testing strips to test appropriate concentration of sanitizer. Dietary Manager L placed the test strip in the sanitizer water but did not change color which indicated an insufficient amount of sanitizer present. 5. In the main kitchen there were two cutting boards that had deep gouges and were identified as an uncleanable surface by Dietary Manager L. 6. Upright stand-alone refrigerator temperature measured 50 degrees Fahrenheit (F) and contained a partially empty gallon of milk, several dozen eggs, one large tray of raw chicken, several packages of luncheon meats and other assorted foods. On 09/12/24 at 11:01 AM, a follow-up tour with Dietary Manager L, Dietary Staff M, and Resource Staff N revealed the following areas of concerns: 1. Multiple stacks of bowls and plates stored in the upright position that had the potential to be exposed to splash, dust or other contamination. 2. On 09/12/24 at approximately 11:15 AM, dietary staff M obtained food temperatures and poked a thermometer probe through the foil overwrap and into the mashed potatoes. Dietary Staff M stated it was acceptable to test food temperatures without removing the aluminum foil cover. Review of sanitization check logs for 07/01/24 thru 08/31/24 revealed the following: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	1. Staff documented a water temperature of 300 degrees F for 56 out of 124 opportunities to document sanitization concentration in the sink (measured in parts per million [PPM - a measurement of the concentration of a substance in a larger solution]). 2. Staff left 56 out of 124 opportunities blank. 3. Staff documented 170 degrees F on seven out of 124 opportunities to document sanitization concentration in the sink in PPM. 4. Staff documented 200 degrees F on four out of 124 opportunities to document sanitization concentration in the sink in PPM. 5. The facility did not provide a sanitization log for 09/2024. Review of refrigerator temperature logs for 07/01/24 thru 08/31/24 revealed the following: 1. Staff failed to document 26 out of 124 opportunities to document the temperature in degrees F. 2. Staff documented 35 out of 124 opportunities to document the temperature in degrees F temperature readings between 42 degrees F and 56 degrees F and started on 07/27/24. 3. The facility did not provide a temperature log for the affected refrigerator for 09/2024. On 09/10/24 at 09:00 AM, Dietary Manager L stated sanitizer levels were to be checked before and after meals and could not recall the minimum sanitizer concentration to be considered safe. Stated that the facility would immediately begin to utilize the high-temperature dish washing machine located in a different room across the hall where the wash and rinse temperatures were 180 degrees F. Additionally, Dietary Manager L reported that his expectation that food should be dated and covered. Further, stated refrigerator temperature checks were to be performed by the staff twice daily and the staff should have reported to him when the refrigerator temperatures were above 41 degrees F. Additionally, confirmed findings discovered by survey team regarding the temperature log for the affected refrigerator. On 09/12/24 at 11:10 AM, Dietary Manager L stated that the correct procedure to obtain temperature readings of food was to remove a corner on the overwrap and not poke the thermometer through the overwrap as the overwrap could potentially be contaminated. The facility's undated Food Storage (Dry, Refrigerated, and Frozen) policy documented that all foods in the kitchen would be labeled and include the name of the food and expiration date. Additionally, all refrigerator temperature settings must ensure that internal food temperature is 41 degrees F or lower. Staff were to place thermometer in the warmest part of the refrigerator to monitor the air temperature and never leave food uncovered or unlabeled. The facility's Refrigerator and Freezer policy, dated 11/2022, documents that refrigerators and freezers will are maintained in good working condition. Refrigerators will keep foods at or below 41 degrees F. (continued on next page)

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	175459	A. Building B. Wing	09/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wheatridge Park Care Center	1501 S Holly Dr Liberal, KS 67901

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility failed to provide sanitary food preparation and storage of food. This deficient practice had the potential to cause the spread of food borne illness to 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. 46960 The facility reported a census 40 residents. Based on observation, interview, and record review, the facility failed to maintain and/or dispose of garbage and refuse properly in a sanitary condition to prevent the harborage and feeding of pests. Findings included: - Initial tour of the outside trash dumpsters on 09/10/24 at 08:32 AM with Dietary Manager L, revealed two dumpsters had the lids in the open position, one of which had trash debris that stuck out of the dumpster. Both lids were broken and failed to completely cover the trash cans. On 09/10/24 at 08:40 AM, Dietary Manager L revealed he was not aware of the requirement to have trash covered. On 09/10/24 at 10:29 AM, Administrative Staff A stated that the dumpsters belonged to the city. The facility lacked a policy related to garbage and refuse handling and disposal. The facility failed to provide sanitary garbage and refuse containers that were maintained with lids closed or otherwise covered. This deficient practice had the potential to lead to harborage and feeding of pest animals.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 46960 The facility reported 40 residents with 12 residents included in the sample. Based on observation, interview, and record review the facility failed to use Enhanced Barrier Precautions (EBP is a risk -based approach to use protective personal equipment to reduce the spread of multidrug resistant organism, consisting of gown and gloves). for Resident (R)39 during wound care and R26 during urinary catheter care. This placed the residents at risk for infection. Findings Included: - R39's Electronic Medical Record (EMR) recorded the following diagnosis: acquired absence of left leg below the knee (BTKA), infection of the amputation stump of the left lower extremity, and Methicillin Resistant Staphylococcus Aureus Infection (MRSA, bacteria that is resistant to many treatments and can cause very serious and life-threatening infections). The 08/02/24 Admission Minimum Data Set (MDS), revealed the resident had a Brief Interview for Mental Status score of 15, which indicated intact cognition. R39 utilized a walker/wheelchair for transportation, required substantial to maximum assistance with toileting. R39 had an amputation with a diagnosis of osteomyelitis (local or generalized infection of the bone and bone marrow). The 08/02/24 Care Area Assessment (CAA) for pressure ulcer revealed R39 had a below the knee amputation and required assistance with Activities of Daily Living (ADL) related to impaired mobility and the resident was at risk for pain, falls and skin breakdown related to impaired mobility. R39's Care Plan dated 07/30/24 revealed staff were to use Personal Protective Equipment (PPE- clothing and equipment that is worn or used in order to provide protection against hazardous substances or environments) when interacting with the resident, to follow physician order, place signage on the door. The care plan indicated staff and resident were educated on EBP. The EMR documented the following orders: 08/05/24 revealed EBP due to surgical wounds with a history of MRSA, two times a day. 08/16/24 revealed R39 had a left BTKA. Staff were to cleanse wound, pat dry, apply Medi honey (medical grade honey used to aid wound healing), and wrap with gauze and Coban daily. 09/11/24 indicated that R39 was to utilize EBP with PPE when high direct care activities were provided to the resident. Indications were listed as wounds, indwelling medical devices, due to infection and or Multidrug-resistant Organism (MDRO) status, to be utilized day and night. During an observation on 09/11/24 at 07:40 AM, R39 rested in bed and watched television. Further observation revealed lack of visual evidence of PPE for the EBP in F39's room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 09/11/24 at 09:24 AM, Licensed Nurse (LN) G gathered supplies from the treatment cart, performed hand hygiene and donned gloves. LN G did not utilize appropriate PPE for EBP. LN G entered the resident's room and placed supplies on a clean paper towel on the over the bed table. R39 lifted his leg to provide access to LN G. LN G removed gloves, performed hand hygiene, and donned new gloves. LN G removed the ace wrap and old dressing to both surgical wounds. LN G cleansed both wounds with wound cleanser. LN G did not remove dirty gloves, perform hand hygiene, and don new gloves prior to cleansing wounds. After cleansing the wounds, LN G removed gloves and performed hand hygiene. LN failed to bring scissors into the room to do the wound care dressing, so she removed gloves, performed hand hygiene and left the room. R39 lowered his leg to the pillow he had previously utilized and placed the cleansed wound on the dirty surface. LN G returned to the room, performed hand hygiene, and donned gloves. LN G did not cleanse the wounds again prior to placing clean dressing on them after they had encountered a dirty surface. LN G placed Medi honey ointment into the wound beds with a cotton tipped applicator. LN G then places the dressing over the wounds, Coban and ace wrap coverings. Interview 09/11/24 at 09:40 AM, LN G confirmed the EBP PPE should have been worn for the dressing change. She further confirmed she should have removed gloves and performed hand hygiene when moving from dirty to clean phases of the dressing change. LN G confirmed she should have cleansed the wound after it encountered the pillow when she left the room. During an interview on 09/11/24 at 02:57 PM, Administrative Nurse B stated that residents who require EBP should have a yellow sticker on the sign outside their room to alert staff to wear the proper PPE before providing direct cares. Administrative Nurse B revealed the PPE should be stored inside the resident's room, but not necessarily within the first six feet of the entering a room. She confirmed the PPE for EBP included gowns, gloves, and face shield or goggles. Administrative Nurse B said she expected staff to change gloves and perform hand hygiene when transitioning between dirty and clean phase of wound care, and to recleanse if the wound became contaminated during the wound care. The undated Enhanced Barrier Precautions Policy revealed Enhanced Barrier Precautions (EBP) referred to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities. The policy further revealed the EBP is used in conjunction with standard precautions and would be required for all residents with a MDRO and wounds regardless of MDRO colonization status. The facility failed to utilize the proper PPE for EBP for R39 who had a history of a MDRO during wound care. - R26's EMR revealed diagnoses of infection and inflammatory reaction due to urethral catheter (a flexible tube inserted through a narrow opening into a body cavity, particularly the bladder, for removing fluid). The 11/28/23 Admission Minimum Data Set (MDS) revealed the resident had a Brief Interview for Mental Status (BIMS) score of seven, which indicated severe cognitive impairment. R26 was independent with toileting and had an indwelling catheter. The 11/28/2023 Urinary Care Area Assessment (CAA) revealed R26 had a long-term catheter in place and had recently been treated for a catheter associated infection and was prone to further infections. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Care Plan dated 11/27/23 documented the resident required catheter care each shift and as needed. Staff were to change the catheter monthly and as needed per physician order. Staff should change R26 to a leg bag during the day and ensure tubing was kept free from kinks. Staff were to report to the physician any signs or symptoms of urinary tract infection such as burning, pain, blood-tinged urine, cloudy urine, no output, increased pulse or temperature, urinary frequency, foul smelling urine, fever, chills or change in mental status, behavior or eating patterns. A Care Plan revision on 04/18/24 revealed Enhanced Barrier Precautions (EBP) for R26. The staff were to utilize PPE when interacting with the resident, place signage on the resident's door, and educate both the resident and staff on EBP. A Physician's Order dated 05/14/24 included Enhanced Barrier Precautions and PPE required for high direct care resident contact activities for R26, indicated by wounds, indwelling medical devices related to infection and/or MDRO status. During an observation on 09/11/24 at 02:46 PM, Licensed Nurse H requested to provide catheter care to the resident. R26 ambulated into the spa room and stood over the commode. R26 lowered his pants and began to empty the leg bag into the commode. Hand hygiene was not performed by either the resident or LN H. LN H donned gloves and cleaned R26's genitals with wipes. LN H cleansed the catheter tubing, removed gloves and then both the resident and LN H performed hand hygiene. LN H did not don PPE for EBP. During an interview on 09/11/24 at 02:50 PM, LN H confirmed she did not wear the PPE for EBP and further confirmed neither she nor the resident performed hand hygiene. During an interview on 09/11/24 at 02:57 PM, Administrative Nurse B stated that residents who require EBP should have a yellow sticker on the sign outside their room to alert staff to don the proper PPE before providing direct cares. Administrative Nurse B revealed the PPE should be stored inside the resident's room, but not necessarily within the first six feet of the entering a room. She confirmed the PPE for EBP included gowns, gloves, and face shield or goggles. The undated Enhanced Barrier Precautions Policy revealed Enhanced Barrier Precautions (EBP) referred to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities. The policy further revealed the EBP is used in conjunction with standard precautions and would be required for all residents with a MDRO and urinary catheter regardless of MDRO colonization status. The facility failed to utilize the proper PPE for EBP for R26 who had a history of a MRSA during catheter care.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. 46960 The facility reported a census of 40 residents. The sample included 12 residents, with five reviewed for immunizations. The facility failed to provide proper documentation of vaccination or declination of vaccines for COVID-19 (vaccines designed to prevent COVID-19 [highly contagious respiratory virus]) or pneumococcal (vaccines designed to prevent pneumonia [inflammation of the lungs which can be debilitating or lethal in the elderly]) for one of the five residents reviewed, Resident (R)5. Findings included: - Review of the Electronic Health Record (EHR) for Resident (R) 2 lacked documentation of any pneumococcal vaccine being given or declination of the vaccine(s). - Review of the Electronic Health Record (EHR) for Resident (R) 2 lacked proper documentation that the COVID vaccine was declined. A declination was present but was undated and unsigned. On 09/16/24 at 2:25 PM, Administrative Nurse B confirmed the requested proof of vaccines or declinations could not be found. Administrative Nurse B stated a valid consent or declination form should be dated and double witnessed and one of the witnesses should be a licensed healthcare provider. The facility policy Pneumococcal Vaccine revised 08/2016, documented that all residents would be offered vaccines unless medically contraindicated, resident has already been vaccinated or resident refused. Further documented that if vaccines was refused, it would be documented in the medical record. If the resident received the vaccine, it would be documented in the medical record. The facility policy COVID-19 Infection Control Policy revised 05/11/2023, documented residents would be educated on and offered vaccines and boosters if eligible. Consent/declination forms are required and serve as evidence education was provided and shall be maintained in the medical record. The facility failed to provide proof of vaccination or declination of vaccines for the COVID vaccine and pneumococcal vaccines for R2.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. 46960 The facility reported a census of 40 residents. Based on observation, interview, and record review, the facility failed to ensure the kitchen's double-door oven was in safe operating condition. Findings included: - On 09/12/24 at 11:01 AM, observation revealed a double-door oven was held closed with a folding metal chair. Interview on 09/12/24 at 11:01 AM with Dietary Manager L, confirmed that the oven doors would not stay closed and must be propped closed with a metal folding chair. The facility failed to provide a policy related to maintaining properly functioning equipment. The facility failed to maintain mechanical equipment in safe operating condition.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 46960 The facility reported a census of 40 residents. Based on interview and record review, the facility failed to develop, implement, and permanently maintain an in-service training program for Certified Nurse Aide (CNAs) with the required topics and no less than 12 hours per year. Two of the five nurse aides sampled lacked the required training topics. Two of five nurse aides sampled lacked the required 12 hours per year of in-service training. Findings included: - On 09/12/24 at 12:30 PM, review of training records for five CNAs employed by the facility for more than one year revealed two CNAs had less than 12 hours of documented in-service training for the previous 12 months. CNA S had eight hours of documented training and CNA T had 10.5 of documented training. On 09/12/24 at 12:30 PM, review of training records for five CNAs employed by the facility for more than one year revealed two CNAs did not have the required topics for in-service training for the previous 12 months. CNA Q lacked dementia care training and CNA R lacked behavior health training. On 09/12/24 at 11:49 AM, Administrative Nurse E confirmed that CNAs were required to have 12 hours of training annually and stated that there were no records of additional training for those CNA's. The facility's In-Service Training, Nurse Aide policy revised August 2022, documented that annual in-services are to be no less than 12 hours a calendar year and are to include required training topics which included dementia care and behavioral health. The facility failed to develop, implement and permanently maintain an in-service training program for CNAs with the required topics and no less than 12 in-service training hours per year.