STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175531	A. Building B. Wing	04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Atchison Senior Village	1419 N 6th Street Atchison, KS 66002

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49634 The facility identified a census of 32 residents. The sample included 13 residents with eight residents reviewed for resident rights. Based on observation, interview, and record review, the facility failed to ensure Resident (R)7 was treated with respect and dignity during incontinence care. This deficient practice placed the resident at risk for negative psychosocial outcomes and decreased autonomy and dignity. Findings included: - R7's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of hypertension (elevated blood pressure), obesity (excessive body fat), congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), candidiasis (a fungal infection caused by a yeast), and muscle weakness. The Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS documented R7 was dependent on staff for toileting and was frequently incontinent. R7's Care Area Assessment (CAA) dated 10/15/23 documented R7 was incontinent of bladder and wore a brief. R7 received diuretic (medication used to promote the formation and excretion of urine) medications as ordered, which increased her need to be toileted or have her brief changed. R7's Care Plan dated 04/08/24 documented she used disposable briefs. The plan directed staff to provide R7 with good peri-care and brief changes as needed. On 04/17/24 at 09:34 AM R7 reported an incident with Certified Nurse Aide (CNA) N. R7 said CNA N told the resident she was not allowed to wear her incontinence brief throughout the night. R7 stated this made her very uncomfortable and embarrassed at night when she did not get to wear a brief to bed. On 04/17/24 at 10:17 AM Licensed Nurse (LN) G stated R7 told her that CNA N did not allow her to wear a brief at night. LN G stated she forgot to report this information to anyone. LN G stated if R7 wanted to wear a brief at night, she should be allowed. LN G stated she would let CNA N know R7 had the right to wear a brief at night. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/17/24 at 01:13 PM in an interview, CNA M stated she felt R7's brief was left off because CNA N wanted to leave R7's skin to be open to air. CNA M stated if a resident wanted to wear a brief to bed, the resident should be allowed to do so. CNA M stated staff should respect the residents' rights. On 04/17/24 at 02:33 Administrative Nurse D stated he was unaware staff required R7 to sleep without a brief. Administrative Nurse D stated R7 should wear a brief to bed if that is what she wanted. The facility's Resident Rights policy revised on 10/2015 documented it is the policy of the facility that all residents be treated with kindness, dignity, and respect. The facility failed to ensure R7 was treated with respect and dignity and failed to ensure staff respected the resident's choices. This deficient practice placed R7 at risk for negative psychosocial outcomes and decreased autonomy and dignity.

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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. 45668 The facility identified a census of 32 residents. The sample included 13 residents with eight residents reviewed for resident rights. Based on observation, interview and record review, the facility failed to ensure Resident (R)22 was allowed to exercise her right for self-determination without intimidation. This deficient practice placed the resident at risk for negative psychosocial outcomes related to decreased autonomy and impaired rights. Findings Included: - On 04/17/24 at 11:00 AM R22 stated she felt pressured by the facility to switch pharmacy services during the facility's ownership changeover. She stated R21 (her spouse) and she were told by the facility their medications may be difficult to obtain by their previous pharmacy once the facility switched to the new one. She stated she was afraid of not receiving her medications due to her existing medical problems. R22 stated after she changed pharmacy, she had to wait two days for clotrimazole (medication used to treat a fungal infection) cream to be delivered by the new pharmacy. R22 stated she and R21 would not have changed pharmacies if the facility had not told them the medications would be difficult to obtain from the local pharmacy, where they had been receiving their medications from before the change of ownership. A review of the facility's new Admission Agreement indicated if the resident preferred a different vender than the facility's contracted vendor, this must be communicated to the facility administrator at the time of admission or at a care plan meeting. The agreement indicated the facility must be given a 30-day notice to ensure services can be arranged. The agreement indicated both services and charges from non-contracted providers would need to be managed by the resident or their representative. On 04/17/24 at 02:34 PM Administrative Nurse D stated a letter was sent out to all the residents two weeks in advance with the provided pharmacy information. He stated he met with the resident council and received no concerns at that time. He stated no one in the facility was forced to switch pharmacies or pressured into changing. He stated R22's medications should have not been delayed because the new pharmacy delivered medications seven days a week instead of five. The facility's Resident Rights policy revised 03/2024 indicated the facility will inform each resident in a manner that is both clear and understandable. The facility failed to ensure support R22's right to self-determine healthcare providers and services including pharmacy services. This deficient practice placed R22 at risk for negative psychosocial outcomes related to decreased autonomy and impaired rights.

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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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. 45668 The facility identified a census of 32 residents. The sample included 13 residents with seven reviewed for maintaining activities of daily living. Based on observation, record review, and interviews, the facility failed to assist Resident (R)16 with maintaining her amplified hearing device. This deficient practice placed R16 at risk for a decline in communication and psychosocial well-being. Findings Included: - The Medical Diagnosis section within R16's Electronic Medical Records (EMR) included diagnoses of an anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), insomnia (difficulty sleeping), and gastro-esophageal reflux disorder (GERD-backflow of stomach contents to the esophagus). R16's Annual Minimum Data Set (MDS) completed 03/04/24 noted a Brief Interview for Mental Status score of 14 indicating intact cognition. The MDS indicated she required substantial to maximal assistance for bathing, dressing, and toileting. The MDS indicated she had moderate difficulty hearing but did not use hearing aids. R16's Communication Care Area Assessment (CAA) completed 03/05/24 indicated she was hard of hearing in both ears and opted to utilize no hearing devices. The CAA noted she had an amplifier, but she chose to utilize this most of the time. The CAA noted the amplifier did assist with her hearing. R16's Functional Abilities CAA completed 03/05/24 indicated she required substantial assistance from staff to complete her activities of daily living (ADLs). The CAA indicated she chose to eat meals in her room. The CAA indicated staff will assist her with her needs and a care plan will be updated to indicate her changing needs. R16's Care Plan initiated 03/07/24 indicated she was at risk for impaired communication related to her hearing deficit. The plan instructed staff to be conscious of her positioning when in groups to promote proper communication. The plan indicated she used a sound amplifier but refused auxiliary aids most of the time. The plan instructed staff to validate communication verbally aloud. The plan directed she required substantial assistance with showering, bed mobility, dressing, and transfers. On 04/15/24 at 08:50 AM R16 sat in her recliner in her room. R16 stated she needed to put her hearing amplifier headphones on. R16's headphones did not function upon putting them on her head. She stated she could barely hear without them. An inspection of the headphones revealed the batteries were dead. R16 was able to communicate but struggled to hear the questions being asked. She stated that staff do not check her headphones very often and she did not get frequent visits due to most of the residents moving to a different hallway for remodeling. She reported staff did not always come around and check on her as often as they should. She stated she was not sure when her headphones worked last. On 04/15/24 at 02:30 PM, R16's amplifier headphones were still not functioning. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/16/24 at 10:10 AM R16 sat in her recliner in her room. R16 stated she had not seen staff since breakfast. She stated her amplifier headphone batteries were finally changed out the previous evening. She stated it was so much easier to communicate with her headphones. On 04/17/24 at 12:45 PM, Licensed Nurse (LN) G stated R16 was very hard of hearing. LN G stated R16 had amplifier headphones but often did not use them. She was not sure if the staff was supposed to make sure the headphones were functioning. LN G stated staff usually just talked loudly to R16 while standing in front of her. She stated R16 uses the headphones while at activities. On 04/17/24 at 01:08 PM, Certified Nurse's Aide (CNA) M stated R16 could hear if standing directly in front of her and talking in a loud voice. She was not sure how often or if staff checked R16 headphones daily for function. On 04/17/24 at 02:34 PM Administrative Nurse D stated he changed out R16's headphone batteries the previous evening. He stated staff were expected to check on the functioning of the headphones each shift to ensure she could use them if she wanted. The facility's Services to carry out ADLs policy dated 03/01/24 documented it was the policy of the facility that residents were given the appropriate treatment and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident in accordance with a written plan of care. If a resident was unable to carry out activities of daily living, the necessary services to maintain good nutrition, grooming, and personal oral hygiene would be provided by staff as documented on the Care Plan. Residents would be involved in decision-making and given choices related to ADL activities as much as possible and interventions added to the Care Plan for staff assistance. ADL care provided would be documented in the medical record accordingly. The facility failed to assist R16 with charging or changing the batteries on her amplified hearing device. This deficient practice placed R16 at risk for a decline in communication and psychosocial well-being.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41037 The facility identified a census of 32 residents. The sample included 13 residents with seven residents reviewed for activities of daily living (ADL) for dependent residents. Based on observation, record review, and interviews, the facility failed to ensure a shower/bath was consistently provided for Resident (R) 30, R22, R18, R7, and R16 who were dependent on staff assistance with ADLs. The facility also failed to ensure R16 was assisted with dressing. This deficient practice had the potential to cause skin breakdown and/or skin complications due to poor personal hygiene and impaired psychosocial well-being. Findings included: - R30's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of need for assistance with personal care, muscle weakness, chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), and Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure). The Significant Change Minimum Data Set (MDS) dated [DATE] documented a staff interview that indicated severely impaired cognition. The MDS documented R30 received oxygen therapy during the observation period. The MDS documented R30 required substantial to maximal assistance with bathing. The Quarterly MDS dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of six which indicated severely impaired cognition. The MDS documented R30 required substantial to maximal assistance with bathing. R30's Falls Care Area Assessment (CAA) dated 11/22/23 documented R30 remained cognitively impaired and was no longer aware of safety. R30's Care Plan dated 03/21/24 documented R30 was dependent on staff assistance for all her bathing needs. A review of R30's EMR under the Documentation Survey Reports tab for bathing reviewed from 03/01/24 to 04/15/24 (46 days) revealed one Shower (SH) on 03/11/24, one Full Bath (FB) on 04/01/24, two Sponge Bath (SB) on 03/05/24 and 03/25/24. Two Resident Refused (RR) on 03/04/24 and 03/06/24. Five Not Applicable (NA) on 03/05/24, 03/14/24, 04/04/24, 04/08/24, and 04/15/24 were recorded. On 04/16/24 at 01:33 PM, R30 sat upright in her Broda chair (specialized wheelchair with the ability to tilt and recline) with her lower extremities elevated. On 04/17/24 at 09:15 AM, Certified Medication Aide (CMA) S stated each resident had a scheduled bath/shower day assigned. CMA S stated R30 had not refused her baths/showers that she was aware of. On 04/17/24 at 10:17 AM Licensed Nurse (LN) G stated staffing was hectic in March 2024. LN G stated some of the residents did not receive their baths. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/17/24 at 01:13 PM, Certified Nurse Aide (CNA) M stated the restorative aide and the bathing aide usually did most of the showers. CNA M stated the facility no longer staffed those positions. CNA M stated normally if a shower or bed bath was not done on the day shift, the evening shift would be notified, and perform that duty. On 04/17/24 at 02:33 PM Administrative Nurse D stated the facility was staffed enough to provide bathing as scheduled. The facility's Services to carry out ADLs policy dated 03/01/24 documented it was the policy of the facility that residents were given the appropriate treatment and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident in accordance with a written plan of care. If a resident was unable to carry out activities of daily living, the necessary services to maintain good nutrition, grooming, and personal oral hygiene would be provided by staff as documented on the Care Plan. Residents would be involved in decision-making and given choices related to ADL activities as much as possible and interventions added to the Care Plan for staff assistance. ADL care provided would be documented in the medical record accordingly. The facility failed to provide consistent bathing for R30, who was dependent on staff assistance for bathing. This deficient practice placed R30 at risk for complications related to poor hygiene and impaired dignity. - R22's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of obesity (excessive body fat), muscle weakness, need for assistance for personal care, history of urinary tract infection, and diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made, or the body cannot respond to the insulin). The Annual Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 12 which indicated moderately impaired cognition. The MDS documented R22 required supervision to touch assistance with bathing. The Quarterly MDS dated [DATE] documented a BIMS score of 15 which indicated intact cognition. The MDS documented that R22 required substantial to maximal assistance from staff for bathing. R22's Functional Abilities Care Area Assessment (CAA) dated 11/17/23 documented R22 required assistance from the staff for ADLs. R22's Care Plan dated 11/26/23 documented R22 required substantial to extensive assistance with bathing. R22's EMR under the Documentation Survey Reports tab for bathing reviewed from 03/01/24 to 04/15/24 (46 days) revealed two Resident Refused (RR) on 03/19/24 and 03/22/24. Six Not Applicable (NA) on 03/05/24, 03/06/24, 03/12/24, 03/15/24, 04/02/24, and 04/09/24 were recorded. The EMR lacked evidence a bath/shower was provided for R22 for the 46 days reviewed. On 04/16/24 at 10:26 AM R22 sat in her wheelchair in her room next to her husband. R22 stated she would never refuse a bath unless she was ill. R22 stated she always appreciated getting her bath. She stated it made her feel better. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/17/24 at 10:17 AM Licensed Nurse (LN) G stated staffing was hectic in March 2024. LN G stated some of the residents did not receive their baths. On 04/17/24 at 01:13 PM, Certified Nurse Aide (CNA) M stated the restorative aide and the bathing aide usually did most of the showers. CNA M stated the facility no longer staffed those positions. CNA M stated normally if a shower or bed bath was not done on the day shift, the evening shift would be notified, and perform that duty. On 04/17/24 at 02:33 PM Administrative Nurse D stated the facility was staffed enough to provide bathing as scheduled. The facility's Services to carry out ADLs policy dated 03/01/24 documented it was the policy of the facility that residents were given the appropriate treatment and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident in accordance with a written plan of care. If a resident was unable to carry out activities of daily living, the necessary services to maintain good nutrition, grooming, and personal oral hygiene would be provided by staff as documented on the Care Plan. Residents would be involved in decision-making and given choices related to ADL activities as much as possible and interventions added to the Care Plan for staff assistance. ADL care provided would be documented in the medical record accordingly. The facility failed to provide consistent bathing for R22, who required extensive assistance from staff for bathing. This deficient practice placed R22 at risk for complications related to poor hygiene and impaired dignity. - R18's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of obesity (excessive body fat), muscle weakness, need for assistance with personal care, and lymphedema (swelling caused by accumulation of lymph). The Annual Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS documented R18 required substantial to maximal assistance from staff for bathing. R18's Functional Abilities Care Area Assessment (CAA) dated 04/02/24 documented R18 could stand and pivot. R18's Care Plan dated 03/22/24 documented R18 required substantial assistance from staff for bathing. R18's EMR under the Documentation Survey Reports tab for bathing reviewed from 03/01/24 to 04/15/24 (46 days) revealed three Showers (SH) on 04/01/24, 04/04/24, and 04/11/24; two Resident Refused (RR) on 03/06/24 and 03/14/24. Five Not Applicable (NA) on 03/05/24, 03/07/24, 03/26/24, 04/08/24, and 04/15/24 were recorded. On 04/17/24 at 08:05 AM R18 sat in her recliner in her room with her lower extremities elevated. R18 stated she would never refuse a bath. R18 stated she had been informed by staff there was not enough staff to provide her with a bath on occasion. R18 stated she felt dirty when she missed her bath or shower. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/17/24 at 10:17 AM Licensed Nurse (LN) G stated staffing was hectic in March 2024. LN G stated some of the residents did not receive their baths. On 04/17/24 at 01:13 PM, Certified Nurse Aide (CNA) M stated the restorative aide and the bathing aide usually did most of the showers. CNA M stated the facility no longer staffed those positions. CNA M stated normally if a shower or bed bath was not done on the day shift, the evening shift would be notified, and perform that duty. On 04/17/24 at 02:33 PM Administrative Nurse D stated the facility was staffed enough to provide bathing as scheduled. The facility's Services to carry out ADLs policy dated 03/01/24 documented it was the policy of the facility that residents were given the appropriate treatment and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident in accordance with a written plan of care. If a resident was unable to carry out activities of daily living, the necessary services to maintain good nutrition, grooming, and personal oral hygiene would be provided by staff as documented on the Care Plan. Residents would be involved in decision-making and given choices related to ADL activities as much as possible and interventions added to the Care Plan for staff assistance. ADL care provided would be documented in the medical record accordingly. The facility failed to provide consistent bathing for R18, who required extensive assistance from staff for bathing. This deficient practice placed R18 at risk for complications related to poor hygiene and impaired dignity. 49634 - R7's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of hypertension (elevated blood pressure), obesity (excessive body fat), congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), candidiasis (a fungal infection caused by a yeast), and muscle weakness. The Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS documented that R7 was dependent on one staff for all bathing. R7's Care Area Assessment (CAA) dated 10/15/23 documented R7 needed substantial assistance from staff to complete her bathing. R7 was not able to reach all areas, so that was completed by staff. She often refused to get in the shower and staff would give her a good bed bath. R7's Care Plan dated 04/08/24 documented R7 needed substantial assistance from staff for all her bathing tasks. R7's EMR under the Documentation Survey Reports tab for bathing documented that she was to have a shower on Tuesdays, Thursdays, and Sundays on the day shift. On 03/02/24 R7's bathing was documented as not applicable (NA). On 03/04/24 the bathing event was documented as NA. R7 received a shower on 03/09/24. The bathing was recorded as refused on 03/11/24. The time from 03/12/24-03/31/24 lacked evidence a shower/bath was provided, offered, or refused. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/17/24 at 09:34 AM, R7 reported that in the month of March 2024, she did not receive a bath or shower. R7 stated she usually refused a shower, but she never refused a bed bath. R7 states she was told the facility did not have enough staff to give baths. On 04/17/24 at 10:17 AM Licensed Nurse (LN) G stated staffing was hectic in March 2024. LN G stated R7 usually refused showers but never refused a bed bath. LN G stated if R7 told you she did not receive a bath at all last month, she probably did not. On 04/17/24 at 01:13 PM in an interview, Certified Nurse Aide (CNA) M stated the restorative aide and the bathing aide usually did most of the showers. CNA M stated the facility no longer staffed those positions. CNA M stated that she was unsure if R7 was offered a shower or bed bath in March 2024. CNA M stated normally if a shower or bed bath was not done on the day shift, the evening shift would be notified, and perform that duty. On 04/17/24 at 02:33 PM Administrative Nurse D stated the facility was staffed enough to provide bathing as scheduled. The facility's Services to carry out ADLs policy dated 03/01/24 documented it was the policy of the facility that residents were given the appropriate treatment and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident in accordance with a written plan of care. If a resident was unable to carry out activities of daily living, the necessary services to maintain good nutrition, grooming, and personal oral hygiene would be provided by staff as documented on the Care Plan. Residents would be involved in decision-making and given choices related to ADL activities as much as possible and interventions added to the Care Plan for staff assistance. ADL care provided would be documented in the medical record. The facility failed to provide consistent bathing for R7 who required assistance with bathing. This deficient practice placed R7 at risk for complications related to poor hygiene and impaired dignity. 45668 - The Medical Diagnosis section within R16's Electronic Medical Records (EMR) included diagnoses of an anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), insomnia (difficulty sleeping), and gastro-esophageal reflux disorder (GERD-backflow of stomach contents to the esophagus). R16's Annual Minimum Data Set (MDS) completed 03/04/24 noted a Brief Interview for Mental Status score of 14 indicating intact cognition. The MDS indicated she required substantial to maximal assistance for bathing, dressing, and toileting. The MDS indicated she had moderate difficulty hearing but did not use hearing aids. R16's Communication Care Area Assessment (CAA) completed 03/05/24 indicated she was hard of hearing in both ears and opted to utilize no hearing devices. The CAA noted she had an amplifier, but she chose to utilize this most of the time. The CAA noted the amplifier did assist with her hearing. (continued on next page)

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Atchison Senior Village	1419 N 6th Street Atchison, KS 66002

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R16's Functional Abilities CAA completed 03/05/24 indicated she required substantial assistance from staff to complete her activities of daily living (ADLs). The CAA indicated she chose to eat meals in her room. The CAA indicated staff will assist her with her needs and a care plan will be updated to indicate her changing needs. R16's Care Plan initiated 03/07/24 indicated she was at risk for impaired communication related to her hearing deficit. The plan instructed staff to be conscious of her positioning when in groups to promote proper communication. The plan indicated she used a sound amplifier but refused auxiliary aids most of the time. The plan instructed staff to validate communication verbally aloud. The plan directed she required substantial assistance with showering, bed mobility, dressing, and transfers. R16's Documentation Survey Report for bathing from 03/01/24 through 04/17/24 indicated she received bathing on six occasions (03/02/24, 03/09/24, 03/13/23, 03/20/24, 04/03/24, and 04/06/24). The report noted not applicable was noted on four occasions (03/03/24, 03/06/24, 03/31/24, 03/04/24, and 04/07/23). The report indicated she refused on three occasions (03/01/24, 03/23/24, and 03/30/24). On 04/15/24 at 08:50 AM R16 sat in her recliner in her room. R16 stated she needed to put her hearing amplifier headphones on. R16's headphones did not function upon putting them on her head. She stated could barely hear without them. An inspection of the headphones revealed the batteries were dead. R16 was able to communicate but struggled to hear the questions being asked. She stated that staff do not check her headphones very often and she didn't get frequent visits due to most of the residents moving to a different hallway for remodeling. She reported staff don't always come around and check on her as often as they should. R16 stated her bathing days were Wednesday and Saturday. She stated recent assistance for her grooming and bathing had gotten worse. She stated she had missed baths due to no one checking on her. On 04/16/24 07:34 AM R16 sat in her recliner in her room and ate her breakfast. On 04/16/24 at 10:10 AM R16 sat in her recliner in her room. R16 stated she had not seen staff since breakfast. Her breakfast tray remained on her bedside table next to her door. She stated she was still waiting for assistance to get dressed. R16 was still wearing her nighttime pajamas. She stated she did not know why it took this long to get dressed. She stated her amplifier headphone batteries were finally changed out the previous evening. On 04/16/24 at 11:34 AM R16 sat in her recliner. She stated staff finally assisted her with personal hygiene and changing her clothing. R16's green button-up blouse shirt was on inside-out. On 04/17/24 at 12:45 PM, Licensed Nurse (LN) G stated the direct care staff should offer bathing multiple times and document the refusals in the EMR. She stated if a resident refused staff should offer another time or a later date. She stated March was a struggle for bathing due to low staffing. She stated that sometimes showers did not get completed. She stated the direct care staff and nurses should work together to complete bathing. On 04/17/24 at 01:08 PM, Certified Nurse's Aide (CNA) M stated each resident was scheduled for two baths a week. She stated refusals would be reported to the nurse. She stated the nurse would attempt to bathe the resident. She stated refusals would be documented in the EMR and attempted at a later date. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/17/24 at 02:34 PM Administrative Nurse D stated staff were expected to provide bathing as scheduled. He stated refusals should be reported to the nurse and attempted at a later time or date. The facility's Services to carry out ADLs policy dated 03/01/24 documented it was the policy of the facility that residents were given the appropriate treatment and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident in accordance with a written plan of care. If a resident was unable to carry out activities of daily living, the necessary services to maintain good nutrition, grooming, and personal oral hygiene would be provided by staff as documented on the Care Plan. Residents would be involved in decision-making and given choices related to ADL activities as much as possible and interventions added to the Care Plan for staff assistance. ADL care provided would be documented in the medical record accordingly. The facility failed to provide consistent assistance for R16 related to bathing and dressing. This deficient practice placed R16 at risk for infections and decreased psychosocial well-being.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 45668 The facility reported a census of 32 residents. The sample included 13 residents with two 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) care. Based on record review, interviews, and observations, the facility failed to ensure Resident (R)25's pressure-reducing device was in her recliner as care planned. This deficient practice placed the resident at risk for complications related to skin breakdown and pressure ulcers. Findings Included: - The Medical Diagnosis section within R25's Electronic Medical Records (EMR) included diagnoses of repeated falls, muscle weakness, insomnia (difficulty sleeping), dementia (a progressive mental disorder characterized by failing memory, and confusion), and congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid). R25's Annual Minimum Data Set (MDS) completed 02/24/24 noted a Brief Interview for Mental Status score of zero indicating severe cognitive impairment. The MDS indicated she required maximal assistance with transfers, bed mobility, bathing, personal hygiene, dressing, and mobility. The MDS indicated she used a manual wheelchair. The MDS indicated she was at risk for pressure ulcers but had no unhealed wounds. The MDS indicated she had pressure-reducing devices for her wheelchair and bed. R25's Pressure Ulcer Care Area Assessment (CAA) completed 03/03/24 indicated she was at risk for pressure injuries and required regular repositioning/turning and seat cushion to reduce or relieve pressure. R25's Care Plan initiated on 12/01/23 indicated she had a deficit related to her functional activities of daily living (ADLs). The plan indicated she had severe cognitive impairment and was dependent on staff assistance for transfers, dressing, bathing, toileting, and personal hygiene. The plan indicated she was dependent on staff for mobility but could propel herself. The plan noted R25 had a history of attempting to pick up non-existent objects off the floor due to her severe cognitive impairment. R25's plan instructed staff to bring her to the dining room only once her meal was ready and sit with her. The plan indicated she had a history of sliding out of her wheelchair due to her cognitive impairment. The plan indicated she was at risk for pressure injuries related to poor skin integrity and her medical diagnoses. The plan indicated she utilized a pressure-relieving cushion for her wheelchair and recliner. On 04/16/24 at 08:17 AM R25 sat in a recliner in front of the television in the day room. R25's pressure-reducing cushion remained in her wheelchair. R25 had no pressure relieving device on the recliner. On 04/17/24 at 10:20 AM R25 slept in the day room recliner in front of the television in the day room. Her pressure-reducing cushion remained in her wheelchair. R25 had no pressure relieving device on the recliner. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/17/24 at 12:54 PM, Licensed Nurse (LN) G stated that R25 was at high risk for skin breakdown and pressure ulcers due to her immobility. She stated therapy had been making improvements during transfers, but staff still should be inspecting her for skin breakdown and applying barrier cream during peri-cares. She stated staff should ensure R25's pressure cushion was in place when she sat in the recliner. On 04/17/24 at 01:08 PM Certified Nurse Aide (CNA) M stated R25 had a cushion for her wheelchair and staff should move it to the recliner during transfers. She stated R25 was a high fall risk and required staff assistance for all transfers. She stated staff might not be moving the cushion over during transfers to the recliners. On 04/17/24 at 02:34 PM Administrative Nurse D stated staff were expected to follow the care plan interventions for each resident. He stated staff should ensure the pressure-reducing devices were in place for each resident. He stated staff was expected to move R25's cushion during her transfer between chairs. The facilities provided Skin and Wound Monitoring policy revised 03/2024 indicated the facility will implement and ensure practices that prevent and promote healing related to injuries. The policy indicated the facility would educate staff and ensure implemented interventions were followed to prevent avoidable impairments and wounds. The facility failed to utilize R25's pressure-reducing device in her recliner as care planned. This deficient practice placed R25 at risk for preventable pressure injuries.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 45668 The facility had a census of 32 residents. The sample included 13 residents with five residents reviewed for accidents and/or hazards. Based on observation, record review, and interview the facility failed to secure hazardous materials out of reach of five cognitively impaired, independently mobile residents. The facility also failed to ensure Resident (R)25's fall interventions were implemented per her plan of care at mealtime. This deficient practice placed the affected residents at risk for preventable injuries and accidents. Findings Included: - On 04/18/2024 at 07:11 AM a walkthrough of the facility was completed. An inspection of the facility's 100 and 200 unsecured laundry rooms revealed accessible containers of sanitary bleach wipes. The wipes contained a Keep out of reach from children warning. An inspection of the 300 hallway's unsecured laundry room revealed sanitary bleach wipes and a bottle of tuberculocidal (bacterial infection of the lungs) disinfectant spray. The wipes contained a Keep out of reach from children warning. On 04/17/24 at 12:45 PM, Licensed Nurse (LN) G stated hazardous chemicals were supposed to be locked out of the resident's reach. She stated the residents should not be in the laundry rooms and said she was not sure why the rooms did not lock. On 04/17/24 at 01:08 PM Certified Nurse's Aide (CNA) M stated cleaning products should always be in a locked area or cabinet away from the residents. On 04/17/24 at 02:34 PM Administrative Nurse D stated staff were expected to ensure hazardous cleaning products remained locked away from the residents. The facility's provided Hazardous Chemical Storage policy revised 03/2024 indicated all potentially hazardous materials will be stored in secured areas out of reach from the resident population. The policy indicated products in use will be monitored. The policy indicates all housekeeping products will be stored in a clean and safe manner. The facility failed to secure hazardous materials out of reach of five cognitively impaired, independently mobile residents. This deficient practice placed affected residents at risk for preventable injuries and accidents. - The Medical Diagnosis section within R25's Electronic Medical Records (EMR) included diagnoses of repeated falls, muscle weakness, insomnia (difficulty sleeping), dementia (a progressive mental disorder characterized by failing memory, and confusion), and congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R25's Annual Minimum Data Set (MDS) completed 02/24/24 noted a Brief Interview for Mental Status score of zero indicating severe cognitive impairment. The MDS indicated she required maximal assistance with transfers, bed mobility, bathing, personal hygiene, dressing, and mobility. The MDS indicated she used a manual wheelchair. The MDS indicated she had two non-injury falls since admission. R25's Care Plan initiated on 12/01/23 indicated she had a deficit related to her functional activities of daily living (ADLs). The plan indicated she had severe cognitive impairment and was dependent on staff assistance for transfers, dressing, bathing, toileting, and personal hygiene. The plan indicated she was dependent on staff for mobility but could propel herself. The plan noted R25 had a history of attempting to pick up non-existent objects off the floor due to her severe cognitive impairment. The plan indicated she had a history of sliding out of her wheelchair due to her cognitive impairment. R25's plan instructed staff to bring her to the dining room only once her meal was ready and staff were to sit with her. On 04/16/24 at 08:35 AM R25 was in the dining room alone at a table. R25 pushed her wheelchair away from the table and attempted to stand several times before staff intervened. On 04/16/24 at 11:54 AM R25 was brought to the dining room. R25's food plate was not ready to be served. R25 sat alone at the center dining room table. R25 pushed herself away from the table. R25 placed her feet in between her wheelchair's foot pedals. From 11:54 AM to 12:07 PM, R25 attempted to stand up from her wheelchair multiple times without staff in the immediate area to intervene. On 04/17/24 at 12:54 PM, Licensed Nurse (LN) G stated that R25 was at high risk for falls due to her severe cognitive impairment. She stated staff should be with R25 during mealtimes to prevent her from falling. She stated staff should take R25 to her meals only when the meal was ready. On 04/17/24 at 01:08 PM Certified Nurse's Aide (CNA) M stated staff were not supposed to take R25 to the dining room until her meal was ready. She stated R25 wanders and had previous falls due to her confusion. On 04/17/24 at 02:34 PM Administrative Nurse D stated staff were expected to bring R25 to the dining room when her meals were ready and stay with her. The facilities provided a Fall Management System policy revised on 03/01/24 that indicated the facility will provide an environment that remains free from accident hazards. The policy indicated the residents would be assessed for potential risk and provided care planned interventions. The facility failed to ensure a safe environment related to R25's care-planned fall interventions when staff brought her to the dining area before her meal was served. This deficient practice placed R25 at risk for preventable falls and related injuries.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41037 The facility identified a census of 32 residents. The sample included 13 residents with one resident reviewed for respiratory care. Based on observation, record review, and interviews, the facility failed to ensure the nebulizer (a device that changes liquid medication into a mist easily inhaled into the lungs) mask was stored in a sanitary manner to decrease exposure and contamination for Resident (R) 30. This placed R30 at increased risk for respiratory infection and complications. Findings included: - R30's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of need for assistance with personal care, muscle weakness, chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), and Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure). The Significant Change Minimum Data Set (MDS) dated [DATE] documented a staff interview that indicated severely impaired cognition. The MDS documented R30 received oxygen therapy during the observation period. The Quarterly MDS dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of six which indicated severely impaired cognition. R30's Falls Care Area Assessment (CAA) dated 11/22/23 documented R30 remained cognitively impaired and was no longer aware of safety. R30's Care Plan dated 03/21/24 documented staff would monitor R30 for difficulty with breathing on exertion. R30's EMR under the Orders tab revealed the following physician orders: Albuterol sulfate inhalation (medication used to open the airway) nebulization solution (2.5 milligrams (mg)/3 milliners (ml) 0.083% (albuterol sulfate) one vial inhaled orally via nebulizer every four hours as needed for COPD or shortness of air dated 04/01/24. On 04/15/24 at 10:32 AM R30 lay on her right side in the bed. R30's undated and unbagged nebulizer mask lay directly on the nebulizer machine. On 04/16/24 at 08:01 AM R30 lay on her left side awake in the bed. R30's undated and unbagged nebulizer mask was laid directly on the dresser. On 04/17/24 at 09:15 AM, Certified Medication Aide (CMA) S stated R30's nebulizer mask should be stored in a plastic bag when not in use. On 04/17/24 at 11:06 AM, Licensed Nurse (LN) G stated nebulizer masks were changed out weekly. LN G stated R30's nebulizer mask should be dated and stored in a plastic bag when not in use. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/17/24 at 02:29 PM, Administrative Nurse D stated nebulizer masks should be dated and stored in a plastic bag. Administrative Nurse D stated he had replaced all the respiratory equipment and ensured there was a plastic bag for items to be stored in when not in use. The facility did not provide a policy related to sanitary storage of respiratory equipment. The facility failed to ensure R30's nebulizer mask was stored in a sanitary manner to decrease exposure and contamination. This placed R30 at increased risk for respiratory infection and complications.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 41713 The facility identified a census of 32 residents. Based on observation, record review, and interview, the facility failed to ensure nursing staff demonstrated the appropriate competencies and skill sets to provide nursing services to care for resident's needs when staff lacked knowledge related to dosing and administering diclofenac gel (a topical ointment used to relieve arthritis pain) for Resident (R) 17. This deficient practice placed R17 at risk of adverse side effects. Findings included: - On 04/16/24 at 09:38 AM Certified Medication Aide (CMA) R prepared and dispensed medications for R17. CMA R performed hand hygiene and applied clean gloves. CMA R then opened the tube of diclofenac gel and squeezed an unmeasured amount onto her glove. CMA R did not review R17's diclofenac gel order for a dosage amount before she applied the medication. On 04/16/24 at 09:40 AM CMA R stated she was not aware that the diclofenac even had a dosage amount. CMA R stated she had always been told to just squeeze out an amount either on the finger of a glove or to squeeze some into a medication cup. CMA R stated she had not known the order stated a dosage amount and that the box for the medication had a plastic measuring chart used to measure the medication amount to dispense from the tube until she was informed by the surveyor. On 04/17/24 at 02:28 PM Administrative Nurse D stated that CMA R and other nursing staff had been educated on the proper dosage and administration for diclofenac. Administrative Nurse D stated that all residents who had an order for diclofenac had the physician-ordered dosage amount on their orders. The Nursing Staff Competency policy last revised in March 2024 documented it was the policy of this facility to have sufficient nursing staff with the appropriate competencies and skill sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Competency in skills and techniques necessary to care for resident's needs included medication management. Staff would demonstrate competency by demonstrating the ability to use tools, devices, or equipment that were subject to training and used to care for residents. Staff would demonstrate the ability to perform activities that were in the scope of practice that an individual was licensed or certified to perform. All nursing staff must meet the specific competency requirements as part of their license and certification requirements defined under State law or regulations. The facility failed to ensure staff demonstrated the appropriate competencies and skill sets to provide nursing services to care for residents' needs when staff lacked knowledge on how to administer diclofenac gel for R17. This deficient practice placed residents at risk of adverse side effects.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 41713 The facility identified a census of 32 residents. The sample included 13 residents. Based on record review and interview, the facility failed to provide a Registered Nurse (RN) for at least eight consecutive hours a day seven days a week. This placed the residents at risk of decreased quality of care. Findings included: - The Payroll Based Journaling (PBJ) report provided by the Centers for Medicare & Medicaid Services (CMS) for Fiscal year (FY) 2023 Quarters 3 and 4 indicated 139 days the facility did not have an RN for eight consecutive hours each 24-hour period. A review of timeclock and payroll data revealed the facility had eight consecutive hours of RN coverage all but four days (04/16/23, 05/06/23, 05/07/23, and 05/21/23). On 04/17/24 at 03:06 PM Administrative Staff A stated she could not say what the previous system was to track and ensure there were eight consecutive RN hours seven days a week before 03/01/24. The Nursing Administrative- Nursing Services policy last revised in February 2024 documented it was the policy of this facility to maintain adequate nursing personnel that ensured the care, treatment, and service needs of all residents and complied with minimum staffing levels mandated by federal and state requirements. The facility would ensure the services of an RN for at least eight consecutive hours a day, seven days a week as required by the regulation. The facility failed to provide an RN for at least eight consecutive hours a day seven days a week. This placed the residents at risk of decreased quality of care.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41713 The facility identified a census of 32 residents. The sample included 13 residents. Four Certified Nurse Aides (CNA) and one Certified Medication [NAME] (CMA) were sampled for performance reviews. Based on record review and interview, the facility failed to complete the required nurse aide performance review at least once every 12 months. This placed the residents at risk for inadequate care. Findings included: - CNA N had a hire date of 01/19/17. The facility lacked evidence a performance review was completed in the last 12 months upon request. CNA O had a hired date of 08/27/17. The facility lacked evidence a performance review was completed in the last 12 months upon request. CNA P had a hire date of 04/19/12. The facility lacked evidence a performance review was completed in the last 12 months upon request. CNA Q had a hire date of 11/07/22. The facility lacked evidence a performance review was completed in the last 12 months upon request. CMA N had a hire date of 06/19/22. The facility lacked evidence a performance review was completed in the last 12 months upon request. On 04/17/24 at 12:54 PM, CMA S stated she worked at the facility for over three years and could not recall ever having a performance review completed since she had been hired. CMA S stated staff completed Relias training and education which was done on the computer. On 04/17/24 at 01:08 PM, CNA M stated she did not recall ever having a performance review done since she had been hired. On 04/17/24 at 02:28 PM Administrative Nurse D stated he had not been able to find where prior management staff completed nurse aide performance reviews as required. Administrative Nurse D stated that he, along with other management staff, would be completing performance reviews on nurse aid staff and would have them scheduled annually going forward. The Nursing Staff Competency policy last March 2024 documented each nursing staff member shall complete an annual competency assessment and additional competency assessments as needed based on the resident population's needs in accordance with the facility assessment. The facility would conduct an annual or bi-annual skills fair or equivalent to facilitate the completion of skills and competency evaluation. The facility failed to complete the required nurse aide performance review at least once every 12 months. This placed the residents at risk for inadequate care.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49634 The facility identified a census of 32 residents. There were 13 residents in the sample. Based on observation, record review, and interview, the facility failed to ensure Resident (R)4's medications were available for administration without missed doses during the facility's change-over to a new pharmacy provider. This deficient practice placed R4 at risk of unnecessary complications and an ineffective medication regimen. Findings included: - R4's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of depressive disorder (a mood disorder that causes a persistent depression feeling of sadness and loss of interest), dementia (a progressive mental disorder characterized by failing memory, confusion), anxiety (an emotion characterized by feelings of tension, worried thoughts, and physical change), weakness, hypertension (HTN-elevated blood pressure), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), and bipolar disorder (major mental illness that caused people to have episodes of severe high and low moods). The Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of five which indicated severely impaired cognition. The MDS documented R4 received antidepressants (medication used to treat depression) during the observation period. R4's Psychotropic Drug Use Care Area Assessment (CAA) dated 11/05/23 documented R4 continued to receive scheduled antidepressant medication for depression and anxiety. R4 was monitored every shift for side effects of her medication. R4 received a medication review monthly. R4's Care Plan dated 01/04/23 documented R4 received an antidepressant and will be free from adverse effects related to antidepressant therapy. The plan directed staff to administer medications as ordered. R4's Care Plan dated 01/05/24 documented a cardiac impairment related to hypertension. The plan directed staff to give antihypertensive medication as ordered and monitor side effects. R4's EMR under the Orders tab dated 04/01/24 documented the following orders: Sertraline (medication for depression) HCl tablet give 50 milligrams (mg) by mouth at bedtime for bipolar disorder. Atorvastatin (medication used to lower cholesterol) 10 mg at bedtime. Trazadone (antidepressant) give 25 mg at bedtime for insomnia related to anxiety and major depression. Depakote (anticonvulsant also used to treat bipolar disorder) tablet delayed release 250 mg give each morning and bedtime for bipolar disorder. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Metformin HCL (medication used to control blood glucose levels) tablet give 500 milligrams every morning and every evening related to diabetes mellitus. A review of R4's Medications Administration Record (MAR) in the EMR revealed on 03/20/24 that the atorvastatin, Trazodone, Depakote, Sertraline, and Metformin were not given. A review of R4's MAR on 03/30/24 revealed the Sertraline was not given. R4's Medication Administration Note dated 03/20/24 documented a hold on all medication until the medications were available. On 04/16/24 at 03:30 PM, Consultant GG stated R4's medications were routinely delivered in February 2024 to the facility. Consultant GG stated R4's maintenance medications would have run out on 03/20/24. Consultant GG stated he was no longer the provider for R4's medications on 03/20/24 and the medications should have come from somewhere else. On 04/17/24 at 07:27 AM Certified Medication Aide (CMA) R stated R4's medication was not available while she was passing medication on 03/20/24. CMA R stated when the medications were delivered from the new pharmacy, the medication was not sorted. She stated the pharmacy delivery person just spread the medications out all over the nurse's station. She stated there was confusion with the medications because the new pharmacy was logging into the old EMR program. CMA R stated the previous nursing procedure would have been to let the nurse know, and she would get the medications from the emergency kit. CMA R stated the facility was supposed to get a delivery twice a day from the new pharmacy but thus far, it had not happened. On 04/17/24 at 12:27 PM, Licensed Nurse (LN) G stated if R4 did not get her medication the nurse should have called the pharmacy to ensure the medication would be on the next pharmacy delivery. LN G stated the nurse on duty should have also looked in the emergency medication kit and called the physician. LN G stated most of the time, the CMAs take care of the medications. On 04/17/24 at 02:33 PM Administrative Nurse D stated he did not realize R4 had gone without medication. He stated staff were trained on the new pharmacy protocol and said the pharmacy would deliver twice daily. Administrative Nurse D stated the nurse on duty should get what medications she could out of the emergency medication kit and then call the physician if there were remaining medications unavailable. The facility provided a policy for Services of a Licensed Pharmacist but did not provide a policy related to pharmacy services as requested. The facility failed to ensure R4's medications were available for administration without missed doses during the facility's change-over to a new pharmacy provider. This deficient practice placed R4 at risk of unnecessary complications and an ineffective medication regimen.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49634 The facility had a census of 32 residents. The sample included 13 residents with five reviewed for unnecessary medications. Based on observation, record review, and interview the facility failed to ensure the multiple unsuccessful attempts for nonpharmacological symptom management were documented including risk versus benefits for the continued use of an antipsychotic (class of medications used to treat a mental disorder characterized by gross impairment in reality testing) for Resident (R) 29, who had a diagnosis of dementia (a progressive mental disorder characterized by failing memory, confusion) and received Risperdal (antipsychotic). This placed the resident at risk for unnecessary psychotropic (alters perception, mood, consciousness, cognition, or behavior) medications and related complications. Findings included: - R29's Electronic Medical Record (EMR) documented the resident had diagnoses of subarachnoid hemorrhage (bleeding in the space just outside the brain), dementia, and hypertension (HTN-elevated blood pressure). The Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of five which indicated severely impaired cognition. The MDS documented that R29 was dependent on staff assistance for activities of daily living (ADLs). The MDS documented R29 received antipsychotic medication during the observation period. The MDS documented a GDR had not been attempted. R29's Psychotropic Drug Use Care Area Assessment (CAA) dated 11/12/23 documented R29 continued her antipsychotic medication for restlessness, agitation, and paranoid personality disorder. R29's Care Plan dated 03/14/23 documented R29 used psychotropic medications and directed staff to administer medication as ordered. The care plan documented the facility should consult with the pharmacy and physician to consider a dosage reduction when clinically appropriate, or at least quarterly. The Physician's Order dated 4/01/24 stated to give Risperdal (antipsychotic medication) 1.5 milligrams (mg) by mouth every morning and at bedtime related to restlessness, agitation, and paranoid disorder. R29's Pharmacy Consult dated 10/30/23, asked for an identified documented clinical rationale for the administration of the Risperdal based on the physician's assessment of R29's condition. R29's EMR lacked any documentation or evidence of nondrug behavioral interventions that were tried and failed before starting the antipsychotic medication. On 04/16/24 at 04:19 PM R29 laid in the recliner in the commons room with her feet elevated. R29 watched television with peers. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/17/24 at 12:27 PM, Licensed Nurse (LN) G stated she was unsure what R29's Risperdal was used for. On 01/22/24 at 11:32 AM Administrative Nurse D indicated there should have been a risk versus benefits completed as well as documentation of non-pharmacological interventions for R29's antipsychotic drug use. The facility's Psychotropic Medication Use policy, revised 03/2024 documented it is the policy of this facility to ensure that residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record. Psychotropic medications shall not be administered for discipline or convenience. Residents who use psychotropic drugs will receive a possible GDR and behavior interventions unless clinically contraindicated. The facility failed to ensure documented multiple unsuccessful attempts for nonpharmacological symptom management before the use of Risperdal for R29. This placed the resident at risk for unnecessary psychotropic medications and related complications.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41037 The facility identified a census of 32 residents. The sample included 13 residents with two residents reviewed for hospice services. Based on observation, record review, and interviews, the facility failed to ensure a communication process was implemented, which included how the communication would be documented between the facility and the hospice provider, for Resident (R) 2 and R30. This deficient practice created a risk for missed or delayed services and impaired physical, and psychosocial care for R2 and R30. Findings included: - R2's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), multiple sclerosis (MS- progressive disease of the nerve fibers of the brain and spinal cord), and congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid). The Significant Change Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of nine which indicated moderately impaired cognition. The MDS documented R2 received hospice services. R2's Functional Abilities Care Area Assessment (CAA) dated 04/10/24 documented staff would continue to assist R2 with her activities of daily living. R2's Care Plan dated 03/29/24 documented the hospice provider would provide a bed with a low air loss mattress and a Broda chair (specialized wheelchair with the ability to tilt and recline). The plan of care documented the hospice nurse would visit approximately two times weekly; a hospice aide would visit approximately one time a week, a social service would visit approximately one time monthly, and the chaplain would visit as needed. The plan of care documented the facility and hospice provider would work to provide maximum comfort for R2. The plan of care documented the facility and hospice provider would work cooperatively to ensure R2's spiritual, emotional, intellectual, physical, and social needs were met. R2's EMR under the Orders tab revealed the following physician orders: Admit to hospice services dated 03/30/24. A review of the book provided by hospice for communication and collaboration of care lacked physician order with a pertinent diagnosis, hospice care plan, list of medication covered by the hospice provider, and frequency of visits from the hospice staff to provide care. On 04/15/24 at 02:45 PM, R2 sat upright in a Broda chair in her room with her pressure-relieving boots on her lower extremities. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/17/24 at 09:15 AM, Certified Medication Aide (CMA) S stated the nurse would let the staff know which residents received hospice services. CMA S stated R2 was currently on hospice services. CMA S stated she was not sure if hospice information of what was provided by hospice was listed on the care plan. On 04/17/24 at 11:06 AM, Licensed Nurse (LN) G confirmed the communication book provided by hospice lacked a care plan, admission paperwork with an admitting order from the physician. LN G stated she visited with hospice when they had come to the facility to provide care for R2 but was not sure if they documented their visit anywhere. LN G stated hospice was no longer able to chart on the facility's EMR for R2. On 04/17/24 at 02:29 PM, Administrative Nurse D stated the hospice providers were not able to document their visits in the facility's EMR system. Administrative Nurse D stated he was working with R2's hospice provider to collaborate on care for R2. Administrative Nurse D stated hospice should provide a care plan and admitting documentation for R2. The facility's End of Life Care; Hospice and/or Palliative Care policy dated 03/01/24 documented it was the policy of the facility to provide dignified and compassionate end-of-life care for terminally ill or dying residents. Through continuing interdisciplinary assessment, individualized plans would be developed and implemented to address the prevention and relief of symptoms and the resident's physical, intellectual, emotional, social, spiritual, and practical needs. Support and reassurance for family and friends close to the resident would be an integral part of the plan. The facility failed to ensure collaboration between the facility and the hospice provider for R2. This deficient practice placed R2 at risk for delayed services which could affect her mental, and psychosocial well-being. - R30's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of need for assistance with personal care, muscle weakness, chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), and Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure). The Significant Change Minimum Data Set (MDS) dated [DATE] documented a staff interview that indicated severely impaired cognition. The MDS documented R30 received oxygen therapy during the observation period. The MDS documented R30 received hospice services. The Quarterly MDS dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of six which indicated severely impaired cognition. The MDS documented R30 received hospice services. R30's Falls Care Area Assessment (CAA) dated 11/22/23 documented R30 remained cognitively impaired and was no longer aware of safety. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R30's Care Plan dated 03/21/24 documented the hospice provider had provided a hospital bed a special mattress overlay, an overbed table, a nebulizer (a device that changes liquid medication into a mist easily inhaled into the lungs), a suction machine, oxygen concentrator, oxygen portable tanks, wheelchair cushion, incontinent supplies, and a Broda chair (specialized wheelchair with the ability to tilt and recline). The plan of care documented hospice nurse would visit one to five times weekly, a hospice aide would visit and bath R30 one time a week, a social worker would visit one to four times monthly, and approximately one time monthly, the hospice volunteer would visit one to four times weekly, and the chaplain would visit one to four times monthly. The plan of care documented the facility and hospice provider would work to provide maximum comfort for R30. The plan of care documented the facility and hospice provider would work cooperatively to ensure R30's spiritual, emotional, intellectual, physical, and social needs were met. R30's EMR under the Orders tab revealed the following physician orders: R30 was admitted to hospice on 11/14/23 for Alzheimer's disease and COPD dated 04/01/24. A review of the book provided by hospice for communication and collaboration of care lacked any documentation of hospice visits and care provided by hospice since February 2024. On 04/16/24 at 01:33 PM, R30 sat upright in her Broda chair with her lower extremities elevated. R30's hair appeared oily. On 04/17/24 at 09:15 AM, Certified Medication Aide (CMA) S stated the nurse would let the staff know which residents received hospice services. CMA S stated R30 was currently on hospice services. CMA S stated she was not sure if hospice information of what was provided by hospice was listed on the care plan. On 04/17/24 at 11:06 AM, Licensed Nurse (LN) G confirmed the communication book provided by the hospice lacked evidence of documentation of any hospice visits since February of 2024. LN G stated she visited with hospice when they had come to the facility to provide care for R30 but was not sure if they documented their visit anywhere. LN G stated hospice was no longer able to chart on the facility's EMR. On 04/17/24 at 02:29 PM, Administrative Nurse D stated the hospice providers were not able to document their visits in the facility's EMR system. Administrative Nurse D stated hospice should provide documentation of the care during their visits with R30. The facility's End of Life Care; Hospice and/or Palliative Care policy dated 03/01/24 documented it was the policy of the facility to provide dignified and compassionate end-of-life care for terminally ill or dying residents. Through continuing interdisciplinary assessment, individualized plans would be developed and implemented to address the prevention and relief of symptoms and the resident's physical, intellectual, emotional, social, spiritual, and practical needs. Support and reassurance for family and friends close to the resident would be an integral part of the plan. The facility failed to ensure collaboration between the facility and the hospice provider for R30. This deficient practice placed R30 at risk for delayed services which could affect her mental, and psychosocial well-being.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 41037 The facility had a census of 32 residents. Based on interview and record review the facility failed to submit complete and accurate staffing information to the federal regulatory agency through Payroll Based Journaling (PBJ) when the facility failed to submit staffing data for all direct care personnel as required one quarter and failed to submit accurate data on others. This placed the residents at risk for impaired care due to unidentified staffing issues. Findings included: - The PBJ report provided by the Centers for Medicare & Medicaid Services (CMS) for Fiscal Year (FY) 2023 Quarter 2 and 2024 Quarter 1 indicated data was suppressed though the facility did not meet the reasons for suppressed data other than inaccurate data or failure to report. The PBJ report indicated 23 days in FY 2023 Quarters 3 and 4 the facility did not have a licensed nurse coverage 24 hours a day. A review of timeclock and payroll data revealed the facility had LN coverage 24 hours a day on the days listed on the PBJ. The PBJ report indicated 139 days in FY 2023 Quarter 3 and 4 the facility did not have a registered nurse (RN) for eight consecutive hours each 24-hour period. A review of timeclock and payroll data revealed the facility had eight consecutive hours of RN coverage on all but four days. On 04/17/24 at 03:06 PM, Administrative Staff A stated the facility had entered the incorrect information into the PBJ. Administrative Staff A stated there was confusion related to the previous staff responsible for reporting and entering the payroll information. Administrative Staff A stated she was now the person who was responsible for ensuring the information was accurately provided to CMS. The facility's Payroll-Based Journal policy dated 03/01/24 documented It was the policy of the facility to submit information every quarter to the Centers for Medicare and Medicaid Services (CMS) as required that detailed the hours the facility staff worked in specific job titles. The facility failed to submit accurate information to CMS PBJ. This placed the residents at risk for impaired care due to unidentified staffing issues.

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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. 41713 The facility identified a census of 32 residents. The sample included 13 residents. Based on observation, record review, and interview, the facility failed to ensure guidelines for enhanced barrier precautions (EBP-infection control interventions designed to reduce transmission of resistant organisms which employ targeted gown and glove use during high contact care) were followed when the facility failed to have personal protective equipment (PPE) readily available for staff use, stored outside the room. The facility failed to ensure staff sanitized resident equipment when it fell on the floor. This placed the residents at risk of infection development. Findings included: - Upon inspection of the facility during the initial tour on 04/15/24 around 07:15 AM observation revealed that the facility did not have PPE readily available for staff usage if needed stored outside the room. The facility had PPE stored in the resident's room and not in a covered cart or storage area. On 04/17/24 at 08:48 AM Licensed Nurse (LN) G was outside of Resident (R) 2's room with her medication cart. LN G grabbed R2's continuous glucose monitor (CGM- a glucose monitoring system that tests glucose levels without finger pricking) and it dropped on the floor. LN G picked the machine up off the floor but failed to properly sanitize the machine or her hands before use on R2. On 04/17/24 at 12:27 PM LN G stated she had not realized until after being observed earlier that morning that she had forgotten to sanitize R2's blood sugar machine after it had fallen on the floor. LN G stated usually she would usually have sanitized the machine afterward or after use. On 04/17/24 at 02:28 PM Administrative Nurse D stated that residents that were on EBP now have PPE available for them. Administrative Nurse D stated PPE was available inside the resident's room in a drawer. Administrative Nurse D stated there were also carts out in the halls that should have PPE stocked in them all the time. Administrative Nurse D stated that he expected staff to clean/sanitize equipment after each use especially if the equipment had fallen onto the floor. On 04/17/24 at 02:55 PM Administrative Staff A stated the facility would ensure that PPE was always available for staff to use on any resident on EBP. The Infection Control Policy/Procedure: Cleaning and Disinfecting of Shared Equipment last revised in May 2007 documented that supplies and equipment would be cleaned immediately after use. Disinfection should be completed by cleansing the equipment with approved cleansing wipes. Allow the item to dry before use on another resident per the wet time specifications. The Infection Prevention and Control Program (IPCP) Standard and Transmission-Based Precautions policy revised in March 2024 documented EBP used in conjunction with standard precautions and expanded the use of PPE with a gown and gloves during high-contact resident care activities. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility failed to ensure the required EBP guidelines were followed when the facility failed to have PPE readily available for staff use outside the residents' rooms. The facility failed to ensure staff sanitized resident equipment when it fell on the floor. This placed the residents at risk of infection development.