STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175532	A. Building B. Wing	08/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avita Health and Rehab at Reeds Cove	2114 N 127th Court East Wichita, KS 67228

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 46960 The facility reported a census of 57 residents with 17 residents sampled. Based on interview, observation, and record review, the facility failed to protect the privacy and dignity of residents that were dependent on staff assistance for eating when staff labeled the residents as feeders. This practice had the potential to lead to negative psychosocial effects related to dignity. Findings included: - On 08/15/24 at 12:40 PM, Certified Nurse Aide (CNA) GG was observed referring to residents who required feeding assistance as feeders. On 08/15/24 at 12:42 PM, CNA GG confirmed that she had referred to residents with a label and that it violated the dignity of the residents as there were other residents around her when she spoke it. On 08/15/24 at 01:58 PM, Licensed Nurse (LN) K stated that residents should be called by their names and not labels. On 08/15/24 at 02:05 PM, Administrative Nurse HH stated that residents should never be referred to with labels. On 08/15/24 at 02:24 PM, Administrative Nurse D stated that the use of labels to refer to residents is a dignity problem. The facility's Right to Dignity policy, dated 12/07/23 documented that the facility would care for the residents in a manner that maintains and enhances the resident's dignity and respect. Further, documented that staff would never call residents by terms or labels. The facility failed to protect the dignity of the residents of the facility that were dependent on the assistance of facility staff to eat, when staff labeled residents as feeders.

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. 50659 The facility reported a census of 57 residents. The sample included 17 residents. Based on observation, interview, and record review, the facility failed to include Resident (R)21 for the development and continued planning of the resident's care plan quarterly. This deficient practice placed the residents at risk for impaired care and services. This practice had the potential to lead to negative psychosocial effects related to safety and uncommunicated needs. Findings included: - Resident 21'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), and osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain) of unspecified shoulder. The 10/30/23 Significant Change Minimum Data Set (MDS), documented a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. R21 had a total mood severity score of 02, indicating minimal depression and there were no behaviors. R21 required supervision assistance with activities of daily living (ADLs), with toileting hygiene, bathing, dressing, personal care, and transfers. R21 required total assistance for mobility. The 10/30/23 Functional Abilities Care Area Assessment (CAA) documented R9 required assist with ADLs. Staff will assist him as needed. The 07/06/24 Quarterly MDS documented a BIMS score of 15, indicating intact cognition. R21 required maximal assistance with ADL's, toileting, transfers, dressing, mobility, and personal hygiene. He required moderated assistance with bathing and was independent with eating. The 08/13/24 Care Plan documented R21 was to be invited to attend all care plan meetings with the facility team and family, date revised 11/10/2023. Review of the Progress Notes from 01/01/24 to 08/13/24 revealed the following: On 02/02/24 at 04:00 PM, Social Service progress note revealed the care plan scheduled for 02/08/24 at 01:30 PM, Social Service staff called family member and confirmed time, she will be attending. On 05/07/24 at 11:04 AM, Social Service progress note revealed the care plan scheduled for 05/09/24 at 02:00 PM, family member and hospice staff will be attending. On 08/13/24 at 09:31 AM, R21 is seated up right in his bed, reported that he has never been invited to a care plan meeting with staff. On 08/15/24 at 11:50 AM, Social service staff U reported that there is no attendance sign in sheet when care plan meetings completed. She confirmed there was no progress note on paper or in EHR that a care plan meeting occurred. (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/15/24 at 11:50 AM, social service staff V confirmed she documented in the EHR, when a care plan meeting was scheduled, and did not document R21 being informed, she stated I thought that would be implied. Social service staff V reported that R21 had intact cognition and a good memory. On 08/15/24 at 12:10 PM, Administrative Nurse D reported residents should be invited to care plan meetings. The facility's Care Conferences Meeting policy dated 01/10/24 documented: Scheduling of care plan conferences would be conducted at least every 90 days and whenever there is a significant change in resident's condition. Participants included resident, family, or healthcare representative, as invited by the resident and the interdisciplinary team included, Nurse, Social Service Designee (SSD), Dietary, and any other relevant personnel. Document the details of the care plan conference, including attendees, discussion, decisions made, and any updates to the care plan. The facility failed to include Resident (R)21 to his care plan meetings. This deficient practice placed the residents at risk for inadequate care and services. This practice had the potential to lead to negative psychosocial effects related to safety and uncommunicated needs.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 46960 The facility reported a census of 57 residents with 17 residents sampled. Based on observation, interview, and record review, the facility failed to verify Resident (R)8's advanced directives (a legal document in which a person specified what actions should be taken for their health, which may or may not include a do not resuscitate [DNR-decision whether or not to withhold medical intervention in the event the resident's heart stops] order). Additionally, the facility failed to obtain proper authorization for a DNR for R3 when the facility allowed the resident's guardian to consent. These deficient practices had the potential to lead to uncommunicated needs specifically to end-of-life care. Findings included: - Review of the Electronic Health Record (EHR) for R8 included diagnoses of chronic obstructive pulmonary disease (COPD - a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), diabetes mellitus type 2 (DM2 - a disease when the body cannot use glucose, not enough insulin [a hormone that lowers the level of glucose in the blood] is made or the body cannot respond to the insulin) and chronic respiratory failure (a condition in which respiratory function is inadequate to maintain the body's need for oxygen supply and/or carbon dioxide removal while at rest) with hypoxia (inadequate supply of oxygen). The Admission Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) of 13, which indicated intact cognition. The assessment documented that R8 received oxygen. The Care Area Assessment (CAA) lacked the resident's wishes regarding advanced directives (a written document which indicated the medical decisions for health care professionals when the person could not speak). The [DATE] Care Plan documented on [DATE] that R8 was a full code and indicated that R8's advanced directives would be posted in the chart. Review of the Physician Orders revealed an order for full code (a term used to indicate the desire to receive resuscitative measures in the event of cardiac arrest), dated [DATE]. Review of the resident's EHR home screen revealed R8 documented the code status (full code or DNR) as full code. Review of the scanned documents in the EHR revealed an un-rescinded DNR order signed by R8 on [DATE]. Review of the progress notes revealed a provider's progress note related to education of advanced directives that documented R8 had stated that R8 wished to be a full code and R8 understood the risks and benefits. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 02:15 PM, Certified Medication Aide (CMA) JJ stated the resident's code status should be documented in the orders in the EHR and in the chart. There were lanyards in the medication room which documented the resident's code status, but upon inspection were found to be empty. On [DATE] at 02:20 PM, Certified Nurse Aide (CNA) KK stated that in the event of a resident's cardiac arrest, the nurse would be notified and then look in the care plan book for the resident's current advanced directives, but upon inspection, CNA KK was unable to locate R8's advance directive wishes. CNA KK was able to locate code status on the EHR home screen. On [DATE] at 02:22 PM, Licensed Nurse (LN) R stated that a resident's advanced directive wishes should be documented in the EHR under the physician orders and in the scanned documents with a hard copy in the charts at the nurses' station. On [DATE] at 02:24 PM, Administrative Nurse D stated that if a discrepancy between the DNR order and the full code order was present, the expectation was for staff to honor the advanced directives that had the most recent date. The facility's policy for Advanced Directives, dated [DATE], documented the facility would assess each resident as to whether or not they had advanced directives and update the EHR with supporting documentation. The facility failed to verify R8's advanced directives and code status. This deficient practice had the potential to lead to uncommunicated needs specifically to end-of-life care. 50659 - Resident (R) 3's Electronic Health Record (EHR) revealed diagnoses of schizophrenia (mental disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought) and bipolar (major mental illness that caused people to have episodes of severe high and low moods). The [DATE] Significant Change Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. R3 had a total mood severity score of 00, indicating no depression and there were no behaviors. She was independent with activities of daily living (ADLs), with toileting hygiene, dressing, personal hygiene, mobility, and transfers. R9 required supervision assistance with bathing. The [DATE] Functional Abilities Care Area Assessment (CAA) documented ADL function CAA triggered secondary for the need for assistance with ADL's. Contributing factors included depression, anxiety, medication usage, history of falls, and weakness. The [DATE] Quarterly MDS documented a BIMS score of seven, indicating moderately impaired cognition. R3 required maximal assistance with dressing, and toileting and set up for eating and oral care. Total severity score of two indicating minimal depression. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Care Plan dated [DATE] documented R3 had established an advance directive (a written document which indicated the medical decisions for health care professionals when the person could not make their own decisions) and had selected Do Not Resuscitate (DNR- or no code, a legal document or order that means the person does not desire CPR in the event of cardiac arrest). Check R3's advanced directives quarterly, as needed and with any significant change. The care plan lacked documentation that R3 had a guardian (someone who has the right and responsibility to make decisions about another person's health care, education, personal care, and other matters). The Physician's Order dated [DATE], documented a Do Not Resuscitate order. On [DATE] review of EHR an uploaded document dated [DATE], a DNR by verbal consent from R3's guardian, that was signed by a Licensed Nurse and Administrative Nurse D. On [DATE] review of EHR an uploaded document dated [DATE], a signed guardianship by a County District Court, however lacked direction of advanced directives. Interview on [DATE] at 02:24 PM, Administrative Nurse D stated that she was not aware a guardian could not sign a DNR. The facility's policy for Advanced Directives, dated [DATE], documented the facility would assess each resident as to whether or not they had advanced directives and update the EHR with supporting documentation. Additionally, a guardian is not allowed to make end of life decisions. The facility failed to obtain proper authorization for a DNR for R3 when the facility allowed the resident's guardian to consent. This deficient practice had the potential to lead to uncommunicated needs specifically to end-of-life care.

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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** 46960 The facility reported a census of 57 residents which included 17 residents sampled, with four residents reviewed for hospitalization . Based on observation, interview, and record review, the facility failed to provide four residents, Resident (R) 22, R3, R8 and R32 and/or their representative with a written notice specifying the duration and cost of the bed hold policy, at the time of the residents transfers to the hospital. This deficient practice placed these residents at risk to not be allowed to return to their former rooms at the facility. Findings include: - Review of the Electronic Health Record (EHR) for R8 included the pertinent diagnoses of chronic obstructive pulmonary disease (COPD - a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), diabetes mellitus type 2 (DM2 - a disease when the body cannot use glucose, not enough insulin [a hormone that lowers the level of glucose in the blood] is made or the body cannot respond to the insulin), and chronic respiratory failure (a condition in which respiratory function is inadequate to maintain the body's need for oxygen supply and/or carbon dioxide removal while at rest) with hypoxia (inadequate supply of oxygen). The Admission Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) of 13, which indicated intact cognition. The assessment documented that R8 received oxygen. The 06/11/24 Care Area Assessment (CAA) lacked documentation related to hospitalization s. The 08/13/24 Care Plan lacked documentation related to hospitalization s. The EHR census log for R8 documented a hospitalization from [DATE] to 08/09/24. The Progress Notes documented on 08/04/24 at 01:05 PM, R8 transferred to a hospital via ambulance and returned to the facility on [DATE] at 03:47 PM. Review of the EHR documents revealed Administrative Staff CC held a conversation with R8 via telephone on 08/06/24 at 04:03 PM. On 08/15/24 at 09:30 AM, Licensed Nurse (LN) K stated when a resident is transferred to the hospital, a bed hold is part of the paperwork that is included in the transfer packet that the resident or resident's representative received. On 08/15/24 at 11:50 AM, Social Services U and Social Services V stated Administrative Staff CC would complete any bed-hold paperwork after the resident or resident's responsible party was notified. On 08/15/24 at 12:10 PM, Administrative Nurse D stated that Social Services U and Social Services X and Administrative Staff CC work collaboratively to complete the bed hold process and that she expected staff to follow the policy. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/15/24 at 02:05 PM, Administrative Staff CC stated she would call the family or responsible party for a verbal consent for the bed-hold and chart it into the EHR and confirmed that she did not complete any form. On 08/19/24 at 11:20 AM, Administrative Staff A and Administrative Staff B stated that it was their expectation that the transferring nurse to complete the written bed hold if practicable, depending on the condition of the resident. The facility's Bed Hold Policy policy, dated 09/01/23 documented that the facility must provide written information to the resident or resident's representative that is sent with the appropriate paperwork in the transfer packet when a resident is sent to a hospital. The facility failed to provide a written bed-hold notice to R8 for a hospitalization on [DATE]. This deficient practice placed R8 at risk to not be allowed to return to their former rooms at the facility. - Review of the Electronic Health Record (EHR) for R32 included the pertinent diagnoses of diabetes mellitus type 2 (DM2 - a disease when the body cannot use glucose, not enough insulin [a hormone that lowers the level of glucose in the blood] is made or the body cannot respond to the insulin) and atherosclerotic heart disease (heart disease caused by narrowing of the vessels on the heart). The Significant Change Minimum Data Set (MDS) dated [DATE], documented a Brief Interview of Mental Status (BIMS) of 15, which indicated intact cognition. The 12/22/23 Care Area Assessment (CAA) lacked documentation related to hospitalization s. The Quarterly MDS dated , 06/21/24 documented a BIMS of 15, which indicated intact cognition. The 08/13/24 Care Plan lacked documentation related to hospitalization s. The EHR census log for R32 documented a hospitalization from [DATE] to 02/17/24. The Progress Notes documented on 02/16/24, R32 was transferred to the hospital for a planned procedure with an overnight stay. Review of the EHR documents revealed Administrative Staff CC documented on 02/16/24 at 10:40 AM, documented that the family had always done a bed hold for the resident. The documentation lacked evidence of verbal or written contact with R32 or R32's representative. On 08/15/24 at 09:30 AM, Licensed Nurse (LN) K stated when a resident is transferred to the hospital, a bed hold is part of the paperwork that is included in the transfer packet that the resident or resident's representative received. On 08/15/24 at 11:50 AM, Social Services U and Social Services V stated Administrative Staff CC should complete any bed-hold paperwork after the resident or resident's responsible party notified. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/15/24 at 12:10 PM, Administrative Nurse D stated Social Services U, Social Services X, and Administrative Staff CC work collaboratively to complete the bed hold process and that she expected staff to follow the policy. On 08/15/24 at 02:05 PM, Administrative Staff CC stated she would call the family or responsible party for a verbal consent for the bed-hold and chart it into the EHR. She confirmed she did not complete any form. Further, Administrative Staff CC stated that she gave verbal notice to R32's representative when he was transferred to the hospital. On 08/19/24 at 11:20 AM, Administrative Staff A and Administrative Staff B stated it was their expectation that the transferring nurse complete the written bed hold if practicable, depending on the condition of the resident. The facility's Bed Hold Policy policy dated 09/01/23, documented the facility must provide written information to the resident or resident's representative that is sent with the appropriate paperwork in the transfer packet when a resident is sent to a hospital. The facility failed to provide a written bed-hold notice to R32 and/or their representative, specifying the duration and cost of the bed hold policy, at the time of the resident's transfer to a hospital. 50659 - Resident (R) 3's Electronic Health Record (EHR) revealed diagnoses of schizophrenia (mental disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought) and bipolar (major mental illness that caused people to have episodes of severe high and low moods). The 08/02/24 Significant Change Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. R3 had a total mood severity score of 00, indicating no depression and there were no behaviors. She was independent with activities of daily living (ADLs), with toileting hygiene, dressing, personal hygiene, mobility, and transfers. R9 required supervision assistance with bathing. The 08/02/24 Functional Abilities Care Area Assessment (CAA) documented ADL function CAA triggered secondary for the need for assistance with ADL's. Contributing factors included depression, anxiety, medication usage, history of falls, and weakness. The 05/15/24 Quarterly MDS documented a BIMS score of seven, indicating moderately impaired cognition. R3 required maximal assistance with dressing, and toileting and set up for eating and oral care. Total severity score of two indicating minimal depression. Review of the Progress Notes from 01/01/24 to 08/13/24 revealed the following: On 05/12/24 at 03:28 PM, R3 had decreased appetite and stated the food was poisoned, she refused breakfast and lunch meal. R3's family member notified, and family member brought in food for R3; which she took two bites of hamburger and declined remainder of food and fluids. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/13/24 provider note after visit, revealed R3 lethargic (lacking energy or feeling sluggish), not eating and drinking well. Family member concerned R3 could have a urinary tract infection (UTI-an infection in any part of the urinary system). Provider recommended R3 to have intravenous (IV-administered directly into the bloodstream via a vein) fluids and labs (blood work) ordered. R3 understood and agreed. On 05/13/24 at 04:29 PM, the provider ordered IV fluids, normal saline to run at 100 milliliters per hour for one liter and labs were ordered. On 05/14/24 provider note after visit, revealed R3 received 1 liter of IV fluids, but continued to not eat. On 05/15/24 provider note after visit, revealed R3 continued to refuse eat or drink. Recommended to send R3 to hospital, family member agreed. On 05/15/24 at 17:03 PM, R3 admitted to a hospital for altered mental status and lethargy. The progress notes lacked documentation for a bed hold. On 06/05/24 at 04:10 PM, R3 readmitted to the facility. On 08/13/24 at 08:21 AM, R3 seated in the dining room, eating her breakfast, and smiled as staff walked by. On 08/13/24 at 11:45 AM, R3 ambulated out of her room independently to the dining room, seated herself down in a chair at the table. On 08/15/24 at 11:50 AM, Social Service Designee (SSD) U and SSD V stated no bed hold form was located in R3's EHR or in the progress notes. SSD U stated that administrative staff CC should complete the bed hold paperwork. On 08/15/24 at 12:10 PM, Administrative Nurse D stated she would have to check the bed hold policy. However, administrative staff CC and the SSD should work together to complete a bed hold. Administrative Nurse D expected a bed hold would be completed with every resident that transfers to the hospital and to follow the policy. On 08/15/24 at 12:40 PM, administrative staff CC reported she would call the family member or responsible party on the phone and have a verbal conversation about a bed hold, then chart the conversation in the EHR. Administrative staff CC stated that she did not complete any bed hold paperwork. 08/15/24 at 02:31 PM, Licensed nurse (LN) K stated when a resident is transferred to the hospital, the SSD was to complete the bed hold, and she stated that she did not know how to complete a bed hold. The facility's policy Bed Hold Policy dated 09/01/23 documented when a resident transfers to a hospital, the facility must provide written information to the resident, a responsible party or legal representative, the bed hold form, consisted of the bed hold price and what to do with resident's belongings. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility failed to provide R3 and/or representatives with a bed hold. This deficient practice had the potential to lead to uncommunicated needs which could lead to negative impacts on the resident's physical, mental and psychosocial well-being. - Resident (R) 22's Electronic Health Record (EHR) revealed diagnoses of bipolar (major mental illness that caused people to have episodes of severe high and low moods) and dementia (progressive mental disorder characterized by failing memory, confusion). The 03/01/24 Annual Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. R22 had a total mood severity score of 00, indicating no depression and there were no behaviors. She was independent with activities of daily living (ADLs), with toileting hygiene, dressing, personal hygiene, and transfers. R22 required supervision assistance with bathing and ambulation. The 03/01/24 Functional Abilities Care Area Assessment (CAA) documented ADL function CAA triggered for need for assistance ADL's. Contributing factors included dementia, weakness, and anemia (inadequate number of healthy red blood cells to carry adequate oxygen to body tissues). The 05/31/24 Quarterly MDS documented a BIMS score of 12, indicating moderately impaired cognition. R22 remained independent with ADLs, except supervision for bathing. Review of the Progress Notes from 01/01/24 to 08/13/24 revealed the following: On 03/27/24 at 04:38 PM, provider note revealed R22 scheduled for left-sided nephrectomy (surgery to remove all or part of a kidney) on 03/28/24. The progress notes lacked documentation for a bed hold. On 04/01/24 at 04:00 PM, R22 readmitted to the facility. Review of the MDS tracker in EHR revealed 03/28/24 discharge return anticipated assessment completed and on 04/01/24 Entry assessment completed. On 08/15/24 at 11:50 AM, Social Service Designee (SSD) U and SSD V stated no bed hold form located in R22's EHR or in the progress notes. SSD U stated that Administrative Staff CC should complete the bed hold paperwork. On 08/15/24 at 12:10 PM, Administrative Nurse D stated she would have to check the bed hold policy. However, Administrative staff CC and the SSD should work together to complete a bed hold. Administrative Nurse D expected a bed hold would be completed with every resident that transfers to the hospital and to follow the policy. On 08/15/24 at 12:40 PM, Administrative staff CC stated she would call the family member or responsible party on the phone and have a verbal conversation about a bed hold, then chart it in the EHR. Administrative staff CC stated that she did not complete any bed hold paperwork. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/15/24 at 02:31 PM, Licensed Nurse (LN) K reported when a resident is transferred to the hospital, the SSD should complete the bed hold, and she stated that she did not know how to complete a bed hold. The facility's policy Bed Hold Policy dated 09/01/23 documented when a resident transfers to a hospital, the facility must provide written information to the resident, a responsible party or legal representative, the bed hold form, consisted of the bed hold price and what to do with resident's belongings. The facility failed to provide R22 with a bed hold. This deficient practice had the potential to lead to uncommunicated needs which could lead to negative impacts on the resident's physical, mental and psychosocial well-being.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46960 The facility reported a census of 57 residents with 17 residents sampled that included one resident reviewed for baseline care plan. Based on interviews, observations, and record review, the facility failed to develop a person-centered baseline care plan for one resident, Resident (R) 153. This deficient practice had the potential to lead to uncommunicated needs. Findings included: - The Electronic Health Record (EHR) for Resident (R)153, admitted to the facility on [DATE] with documented diagnoses that included acute pancreatitis (a condition characterized by inflammation of the pancreas that can be accompanied by severe pain with nausea and vomiting), chronic kidney disease (CKD - long term kidney disease with gradual decline in kidney function) and diabetes mellitus type 2 (DM2 - a disease when the body cannot use glucose, not enough insulin [a hormone that lowers the level of glucose in the blood] is made or the body cannot respond to the insulin). The Admission Minimum Data Set (MDS) was incomplete and in progress. The Care Area Assessment (CAA) was incomplete and in progress. Review of the EHR lacked a baseline care plan that included instructions needed to provide effective and person-centered care of R153. The 08/13/24 Care Plan documented on 08/09/24 that R153 requested a mesh stop sign to be put on her door to deter other residents from entering her room, and staff provided R153 with a grabber. The care plan lacked any additional information or directions for cares. Review of the physical chart on 08/19/24 at 10:45 AM with Administrative Nurse D revealed that a baseline care plan document that was dated 08/04/24 was in the chart but incomplete. The baseline care plan document failed to address resident's initial goals, preferred name, representative name, communication (vision/hearing) risk, dietary preferences, dietary risks, dietary interventions, therapy/restorative services, functional interventions, social/psychosocial services, special treatments/procedures, alarms/restraints, skin concerns, other conditions/concerns, resident life history/daily routine preferences/cultural and ethnic preferences, discharge plans/goals, resident/caregiver education needs and/or hospice/outside coordination needs. Additionally, the baseline care plan was unsigned and undated by the interdisciplinary team (IDT - a team of healthcare professionals across all the available modalities of care which includes [but not limited to] nursing, dietary, physical/occupational therapy, social services). On 08/13/24 at 11:46 AM, R153 stated that she had not had a care plan meeting with the staff, nor had any staff asked her about her needs/wishes with regard to her care since she arrived in the facility. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/19/24 at 09:40 AM, Administrative Nurse D stated that her expectation is that staff to meet with all new residents and would have the document completed within the first 48 hours from a collaboration between the resident and staff, which included being signed and dated by the IDT team members and the resident or resident's representative. The facility's Care Planning policy, dated 11/12/18 documented that the facility's care planning and interdisciplinary team (IDT - a team of healthcare professionals across all the available modalities of care which includes [but not limited to] nursing, dietary, physical/occupational therapy, social services) was responsible to provide the residents and their representatives a summary of the baseline care plan within 48 hours of admission. The facility failed to complete a baseline care plan for one resident, R153. This deficient practice had the potential to lead to uncommunicated needs.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46960 The facility identified a census of 57 residents which included 17 residents sampled and reviewed for care plan development. Based on interview, observations, and record review, the facility failed to develop a comprehensive person-centered care plan for one resident, Resident (R)30's, regarding oxygen delivery or nebulized (a device which changes liquid medication into a mist easily inhaled into the lungs) medication administration. This deficient practice had the potential to lead to uncommunicated needs which could lead to negative impacts on the resident's physical well-being. Findings included: - R30's Electronic Health Record (EHR) included diagnoses of obstructive sleep apnea (OSA - a disorder of sleep characterized by periods without respirations due to anatomical obstructions in the airway) and chronic obstructive pulmonary disease (COPD - a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing). The Annual Minimum Data Set (MDS), dated [DATE], documented a Brief Interview of Mental Status (BIMS) score of 15, which indicated intact cognition and R30 did not receive oxygen. The Care Area Assessment (CAA), dated 11/03/23, lacked documentation related to oxygen use or nebulized medication. The 05/29/24 Care Plan lacked documentation related to oxygen use or nebulized medication. The Physician's Orders documented the following: Ipratropium (a long-acting medication used to open medium and large airways of the lungs) - albuterol (a short-acting medication used to open the airways of the lungs), 0.25-2.5 milligrams (mg) per milliliter (mL), 3 mL inhaled by mouth (orally) by nebulizer, every four hours as needed, for shortness of breath or wheezing, ordered 02/05/24. Ipratropium-albuterol, 0.2-2.5 mg/mL, inhaled by mouth by nebulizer, four times per day for cough/wheezing, and every four hours as needed for cough/wheezing, ordered 02/06/24. Oxygen at two liters per minute by nasal cannula, may titrate (adjust) to maintain oxygen saturation above 90 percent (%) or above as needed, every shift for shortness of breath and low oxygen saturation, ordered 07/08/24. Supplemental oxygen (O2) at two liters per minute, to maintain oxygen saturation above 90%, two times per day, for coughing and hypoxia (low oxygen saturation in the blood), ordered 08/09/24. On 08/14/24 at 09:04 AM, Certified Nurse Aide (CNA) LL identified R30 wore oxygen and stated that the tubing and nebulizers were to be changed every Wednesday, usually on night shift. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/19/24 at 05:53 AM, CNA F stated that cares are sometimes listed in the care plans in the care plan book, but not all residents are in the care plan book and it's not always accurate. CNA F further stated that if they questioned what cares that a resident should receive, they would ask the nurse. On 08/19/24 at 08:54 AM, Licensed Nurse (LN) K stated that all cares that a resident should get are listed in the care plan in the care plan book and in the EHR. On 08/19/24 at 10:33 AM, Administrative Nurse D confirmed that oxygen use and nebulized medication use was not on R30's care plan. Administrative Nurse D further stated that her expectation is that care plans should be accurate to reflect the cares that are administered to the residents. The facility's Care Planning policy, dated 11/12/18 documented that the facility's care planning and interdisciplinary team (IDT - a team of healthcare professionals across all the available modalities of care which includes [but not limited to] nursing, dietary, physical/occupational therapy, social services) was responsible to develop an individualized comprehensive care plan for each resident and that the care plan was current and revised whenever the resident's conditions changed. The facility failed to develop a comprehensive person-centered care plan for R30 related to oxygen use or nebulized medication use. This deficient practice had the potential to lead to uncommunicated needs that would negatively affect the physical well-being of R30.

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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. 50659 The facility reported a census of 57 residents with 17 residents selected for review. Based on observation, interview, and record review, the facility failed to accurately revise two residents care plans after Resident (R)22 and R9's had a fall. This placed the residents at risk for uncommunicated care needs. Findings included: - Resident (R) 22's Electronic Health Record (EHR) revealed diagnoses of bipolar (major mental illness that caused people to have episodes of severe high and low moods) and dementia (progressive mental disorder characterized by failing memory, confusion). The 03/01/24 Annual Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. R22 had a total mood severity score of 00, indicating no depression and there were no behaviors. She was independent with activities of daily living (ADLs), with toileting hygiene, dressing, personal hygiene, and transfers. R22 required supervision assistance with bathing and ambulation. R22 had no falls. The 03/01/24 Functional Abilities Care Area Assessment (CAA) documented ADL function CAA triggered for need for assistance for ADL's. Contributing factors included dementia, weakness, and anemia (inadequate number of healthy red blood cells to carry adequate oxygen to body tissues). The 03/01/24 Falls CAA documented R22 had a history of falls, weakness and physical performance limitations affecting gait, balance, and endurance. R22 received medications that placed her at a risk for falls. The 05/31/24 Quarterly MDS, documented a BIMS score of 12, indicating moderately impaired cognition. R22 remained independent with ADLs, except supervision for bathing. R22 had no falls. The 08/13/24 Care Plan documented interventions included staff were instructed to remove the clutter on R22's bed to give her more room to lay down and reposition self, dated 04/09/24. Staff educated R22 on the importance of locking her wheelchair when she would transfer to the wheelchair, dated 04/09/24. Review of the Progress Notes from 01/01/24 to 08/13/24 revealed the following: On 04/06/24 at 01:53 PM, R22 was conversing with another resident at the dining room table, staff overheard R22 state she rolled out of her bed. The (unidentified) Nurse spoke with R22, and she stated she fell out of bed, crawled back to wheelchair or bed, and assisted self-up. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/12/24 at 06:23 PM, Nurse documented in progress note, R22's family member told the facility nurse that R22 reported to them she had a fall sometime over the weekend. R22 had a yellow bruise on the middle of her back. R22 reported she fell on the concrete. Staff administered as needed Acetaminophen (a medication that reduces pain and fever) for pain. On 08/13/24 at 11:15 AM, R22 reported she fell out of her wheelchair the other day in her room and landed on concrete, as she pointed to an open area in her room in front of her window. She stated that the floor felt like concrete. She reported the staff knew she had a fall. On 08/15/24 at 12:02 PM, Administrative Nurse S reported care plans are updated as a team approach, but interdisciplinary staff members need to follow up to make sure the care plan has been updated. On 08/15/24 at 12:10 PM, Administrative Nurse D confirmed R22's care plan was not revised after her fall after family reported the fall on 08/12/24. Administrative Nurse D stated she had not been updated or aware of the progress note in R22's EHR. She expected the nurses would follow the falls protocol and update the care plan with an intervention the same day as the fall. On 08/15/24 at 02:31 PM, Licensed Nurse (LN) K reported witnessed, unwitnessed, or if a resident stated they had a fall, staff should assess the resident for pain, injury, and neurological exam (checks a person's mental status, coordination, ability to walk, and how well the muscles, sensory systems, and deep tendon reflexes work), complete a risk management in EHR, determine what caused the fall, notify Administrative Nurse D, Administrative Staff B, responsible party, and the physician. LN K stated she would document in the progress notes in EHR. The Administrative Nurse D and Administrative Nurse S should update the care plans. The facility's Care Plan Revision Policy dated 04/24/24 documented the following: The care planning process includes patient assessment, goal setting, intervention, referrals to other health care professionals, evaluation of patient response to treatment and revision of care and treatment in order to meet the patient's needs. Revisions of the care plan will be the responsibility of a Licensed Nurse, in collaboration with the elder, responsible party, direct care staff, and the entire interdisciplinary team and changes will be communicated with all staff on all shifts. The facility failed to revise R22's care plan after a fall to prevent possible further falls. This placed the residents at risk for uncommunicated care needs. 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. - The Electronic Health Records (EHR) documented Resident (R)9 had the following diagnoses that included dementia (progressive mental disorder characterized by failing memory, confusion), fracture (broken bone) of right hip with routine healing after an open reduction (surgical procedure for reducing a fracture or dislocation by exposing the skeletal parts involved), abnormal gait, and muscle weakness. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 05/05/24 Significant Change Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. R9 had a total mood severity score of 00, indicating no depression and there were no behaviors. R9 was dependent on staff assistance with activities of daily living (ADLs), with toileting hygiene, bathing, and transfers. R9 required maximal assistance with dressing and personal hygiene. R9 had a fall with major injury. The 05/05/24 Functional Abilities Care Area Assessment (CAA) documented R9 had a fall in the facility while in her room. Initial x-rays were negative for fracture, but follow-up x-ray revealed right valgus impacted femoral neck fracture (a type of hip fracture that occurs when the proximal fragment of the femur impacts the fracture site in a valgus configuration [a force that pushes toward the center of the body]). She admitted to the hospital for the fracture. The 05/05/24 Falls CAA documented R9 had a recent fall, interventions in place to prevent further falls and R9 received Effexor (medication is used to treat depression) and would be monitored by the nurse and the physician. The 04/05/24 Quarterly MDS documented a BIMS score of 13. The resident had no falls. R9 was independent with ADL's except required set up assistance for eating and dressing. The 08/13/24 Care Plan lacked any guidance or staff instructions regarding right hip fracture precautions for weight bearing status. The hospital discharge orders, dated 05/03/24 located in R9's EHR documented weight bearing status was touch toe weight bearing (TTWB a weight-bearing restriction that allows a person to stand or walk while only touching the floor with their toes for balance, without putting any weight on their leg) of her right lower extremity. The Physician Orders included weight bearing status of right lower extremity and non- weight bearing until x-ray results seen by surgeon, ordered 6/14/2024. Occupational therapy two times week, for 30 days, for exercise, self-care and wheelchair management, date ordered 08/07/24. Physical therapy, three times a week, for 30 days for exercise and gait training, ordered 08/09/24. Review of the Progress Notes from 01/01/24 to 08/13/24 revealed the following: On 04/26/24 at 11:15 PM, R9 had an unwitnessed fall when she stated she tripped and fell when she ambulated out of the bathroom. The resident complained of pain of the right side. Administrative Nurse D notified and instructed to contact the physician if pain intensified. On 04/29/24 at 04:17 PM, the physician ordered another x-ray of the right femur, Norco (contains a combination of acetaminophen and hydrocodone. Hydrocodone is an opioid pain medication) 5/235 milligram, by mouth, twice a day, and Intravenous (IV-administered directly into the bloodstream via a vein) fluids of Normal Saline (NS- saline water solution for medical use) at 100 milliliter per hour, for one liter. Results from the x-ray showed a possible impacted fracture of right hip femoral head and neck junction (a closed fracture that occurs when the ends of a broken bone are jammed together by force). R9 transferred to the hospital. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/02/24 at 12:39 PM, hospital physical therapy notes revealed R9's weight bearing status was touch toe weight bearing of her right lower extremity. On 05/03/24 at 11:32 AM, R9 readmitted to the facility. On 08/15/24 at 08:18 AM, reviewed the following therapy communication and team progress notes that were received from the Therapy Director T, and confirmed the communications were not in the care plan update book on the unit or in R9's paper chart or EHR. On 05/06/24, therapy to nursing communication form documented R9 was TTWB of her right lower extremity. On 05/21/24, a multidisciplinary therapy screen form documented R9 continued TTWB for her right lower extremity, follow up orthopedic (pertaining to bones) appointment in five weeks. On 08/05/24, a multidisciplinary therapy screen form documented R9's weight bearing status changed to weight bearing as tolerated per orthopedic physician. On 08/08/24, a therapy to nursing communication form documented staff instructed to provide a front wheeled walker and R9 required minimal assist with ADLs and was weight bearing as tolerated for right lower extremity. On 08/15/24 at 08:18 AM, Therapy Director T reported that R9 had therapy when she was readmitted in May,2024 and she reached her goals, as R9 was TTWB. Therapy Director T revealed provider ordered therapy on 08/09/24, as her weight bearing status upgraded to weight bearing as tolerated. Therapy Director revealed that she did not update the care plan in EHR, she would communicate with nursing on a therapy communication form. She stated the forms were not uploaded in the EHR, however, Administrative Nurse D, Administrative Nurse S, and to the nursing unit where the resident resided would be given a copy of the therapy communication form. On 08/15/24 at 08:46 AM, Licensed Nurse (LN) R reported Administrative Nurse D and Administrative Nurse S should update the care plans because the floor nurse does not update the care plan. LN R confirmed that therapy should deliver communication forms with recommendations for care plan changes and those forms were to be placed in the care plan book at the nurse's station. LN R revealed the only therapy communication form for R9 in the care plan book was dated 04/12/24 for transfer technique, stand pivot, R9 independent with wheelchair in her room only, and R9 was seen for neck pain. On 08/15/24 at 12:02 PM, Administrative Nurse S reported care plans are updated as a team approach, but interdisciplinary staff members need to follow up to make sure the care plan had been updated. Administrative Nurse S reported R9's care plan was not updated with her right hip fracture weight bearing status, and confirmed the therapy communication forms were not in the care plan book for R9. On 08/15/24 at 12:10 PM, Administrative Nurse D confirmed R9's care plan was not revised. Administrative Nurse D expected the nurses would update the care plan as needed. The facility's Care Plan Revision Policy dated 04/24/24 documented the following: (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The care planning process includes patient assessment, goal setting, intervention, referrals to other health care professionals, evaluation of patient response to treatment and revision of care and treatment in order to meet the patient's needs. Revisions of the care plan will be the responsibility of a Licensed Nurse, in collaboration with the elder, responsible party, direct care staff, and the entire interdisciplinary team and changes will be communicated with all staff on all shifts. The facility failed to revise R9's care plan after a fall with ordered weight bearing status. This placed the residents at risk for uncommunicated care needs. 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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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 50659 The facility identified a census of 57 residents which included 17 residents in the sample. Based on observations, interviews, and record review, the facility failed to provide services to meet professional standards of care related to the unsanitary manner medications administered when CMA II dropped Resident (R)6's medications, picked them up from the floor and the medication cart, and administered the medications to the resident. Findings included: - On 08/14/24 at 07:57 AM, Certified Medication Aide (CMA) II prepared medications for R6's morning medication administration. CMA II spilled the medication cup that contained all R6's by mouth pills except for the Oxycodone (pain medication). Six of the by mouth medications landed on the floor and four landed on the top of the medication cart. CMA II picked up all the medications that fell out and placed them back into the medication cup. She removed the Oxycodone tablet from the blister pack, by popping into the medication cup with all the other pills. CMA II went to R6's table in the dining room and asked R6 if she would like her medications. CMA II handed R6 the medication cup with the by mouth medications and R6 swallowed them with her juice. On 08/14/24 at 08:20 AM, CMA II confirmed that she should not have administered the medications that dropped out of the medication cup, she stated she should have started with all new medications. On 08/14/24 at 08:25 AM, Administrative Nurse M confirmed that R6's medication should not have been administered after the pills fell out of the medication cup and landed on the cart and floor. On 08/15/24 at 02:55 PM, Administrative Nurse D confirmed the above concerns, and expected all medications to be administered following infection control standards. The facility's policy Medication Administration Policy dated 04/24/24 documented the following: All medications will be administered to every resident as ordered by a physician in a safe and sanitary manner. The facility's policy Infection Control dated 03/14/24 documented the following: The facility will facilitate safe care of all residents by establishing and maintaining an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment. The facility failed to provide services to meet professional standards of care related to the unsanitary manner medications administered when CMA II dropped R6's medications, picked them up from the floor and the medication cart, and administered the medications to the resident.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 50659 The facility identified a census of 57 residents. The sample included 17 residents. Based on observation, record review, and interviews, the facility failed to ensure Resident (R)19, who was dependent on staff, received care for removal of facial hair. Additionally, the facility failed to ensure (R)40, who was dependent on staff, received care for removal of facial hair and oral care. These deficient practices placed the residents at risk for decreased psychosocial well-being. Findings included: - Resident (R) 19's Electronic Health Record (EHR) revealed diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), hemiplegia (paralysis of one side of the body), and depression. The 09/25/23 Significant Change Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of seven, indicating severely impaired cognition. Total severity score of one, indicating minimal depression, and there were no behaviors. R19 required maximal assistance with ADL's (activities of daily living such as bed mobility, transfers, dressing, and personal hygiene. She required total assistance with toileting and locomotion. R19 was always incontinent of bladder and bowel and had an impairment on one side of her body upper and lower extremity. The 09/25/23 Functional Abilities Care Area Assessment (CAA) documented ADL function CAA triggered secondary for the need for assistance with ADL's. The 05/07/24 Quarterly MDS documented a BIMS score of four, indicating severely impaired cognition. R19 required total assistance with ADLs, except supervision for eating. The 08/13/24 Care Plan lacked documentation for facial hair removal. Review of the Progress Notes from 01/01/24 to 08/13/24 lacked documentation related to personal hygiene care. On 08/13/24 at 11:44 AM, R19 was in her wheelchair in the dining room. R19's chin had several approximately 1/4- inch length facial whiskers. On 08/14/24 at 08:29 AM, R19 continued to have facial whiskers on her chin. On 08/15/24 at 08:24 AM, R19's facial whiskers remained. R19 stated she had a shower this morning. On 08/13/24 at 11:44 AM, a family member reported R19 would be bothered that she had the facial hair on her chin. He stated that he has removed the facial hair when he has visited. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/15/24 at 08:55 AM, Licensed Nurse (LN) R reviewed R 19's completed shower sheet documented by Certified Nurse Aide (CNA) AA earlier that morning. LN R stated that the no box on shower sheet was marked for facial removed, and that meant R19 must not have had facial hair. LN R confirmed R19 had several whiskers on her chin and reported that facial hair should be removed on shower days as residents allowed. On 08/15/24 at 09:13 AM, CNA AA reported she did not know that she had to remove residents' facial hair on shower days. On 08/15/24 at 12:10 PM, Administrative Nurse D expected staff to complete residents' personal cares as the residents allowed and expected facial hair to be removed on shower days or as when needed. The facility's policy Right to Dignity dated 12/07/23 documented the facility will promote care for elders of the facility in a manner and in an environment that maintains and enhances each elder's dignity and respect in full recognition of the elder's individuality. Elder's will be groomed as they wish including hair care, facial hair shaved or trimmed as the elder wishes. The facility failed to ensure dependent resident R19 received care for removal of facial hair. This deficient practice placed the resident at risk for decreased psychosocial well-being. - The Electronic Health Records (EHR) documented Resident (R)40 had the following diagnoses that included dementia (progressive mental disorder characterized by failing memory, confusion), and metabolic encephalopathy (condition in which brain function is disturbed either temporarily or permanently due to different diseases or toxins in the body). The 07/30/24 Admission Minimum Data Set (MDS), documented a Brief Interview for Mental Status (BIMS) score of five, indicating severely impaired cognition. R40 had a total mood severity score of 00, indicating no depression and had one to three days of screaming and yelling behaviors documented. R40 required total assistance with activities of daily living, which included toileting, dressing, transfers, oral care, personal hygiene, eating, and bathing. The 07/30/24 Functional Abilities Care Area Assessment (CAA) documented R40 triggered secondary to the need for assistance with ADL's. Contributing factors included depression, anxiety, medication usage, end of life care and weakness. Care plan would be initiated to maintain ADL status. The 08/13/24 Care Plan documented R40 had required assistance with personal cares and staff instructed that R40 was dependent for all ADLs. Review of the Progress Notes from 01/01/24 to 08/13/24 lacked documentation related to personal hygiene care and oral care. Review of the Tasks Documentation in EHR for oral care 08/10/24 thru 08/15/24 revealed: On 08/10/24 at 01:30 AM, charted non applicable. On 08/11/24 no charting of oral care completed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/12/24 at 01:37 AM, support provided. On 08/13/24 at 03:12 AM, support provided. On 08/14/24 at 06:12 PM, support provided. On 08/15/24 at 02:40 AM, support provided. On 08/13/24 at 10:27 AM, R40 was in her wheelchair in the dining room. R40's chin had several approximately 1/4- inch length facial whiskers. Additionally, she had dried scaly lips with few small cracks and her upper front teeth had a dried brown substance covering them. On 08/14/24 at 07:45 AM, R40 was in her wheelchair at the dining room table. She attempted to remove the dried brown-green colored substance from her upper front teeth with her clothing protector. Facial hair remained on her chin. At 08:23 AM, an unidentified Certified Nurse Assistant (CNA) assisted R40 to eat her breakfast. On 08/14/24 at 08:38 AM, R40 was in her wheelchair in front of a television, the dried green-brown substance remained on her upper front teeth and her lips remained dry and scaly. On 08/14/24 at 11:45 AM, observed in R40's nightstand drawer a full Ziploc bag of pink oral sponges, tube of mouth moisturizer, and a full bottle of mouthwash. On 08/15/24 at 09:13 AM, R40 seated up in her bed. CNA AA assisted R40 with breakfast meal. R40 had facial hair that remained on her chin. Her upper front teeth had a green-brown substance on them. On 08/14/24 at 11:52 AM, CNA Z reported R40's teeth and lips looked that way for at least the last five days. CNA Z stated she gave R40 oral care this morning with a toothbrush in the shared bathroom. Observed two toothbrushes on the left -hand side of the sink, one toothbrush sealed in plastic wrapper. The second toothbrush was a dry purple toothbrush that had no water underneath it on the sink countertop. The toothbrushes and toothpaste tubes lacked a label to indicate the resident's personal care item. CNA Z reported that the toothbrush head that faced the backsplash was bed B and the other toothbrush head that faced the edge of sink was bed A. She stated the toothpaste with the cap that faced the backsplash was bed B, and the other tube of toothpaste was bed A as the cap faced in the opposite direction. CNA Z confirmed R40 was not resistive when she received oral care and only used a toothbrush. CNA Z confirmed she did not know R40 had oral care supplies in her nightstand drawer. CNA Z reported the Activity Staff was to remove residents' facial hair, that she was not required to remove residents' facial hair. On 08/14/24 at 12:08 PM, Licensed Nurse (LN) BB reported R40's mouth was always dry and always had some film on her teeth. LN BB confirmed that she has never heard how CNA described how to determine which residents' personal supplies were on the counter in a shared bathroom. LN BB confirmed that the purple toothbrush was dry and looked to not be used. LN BB stated that hospice has oral care supplies in her drawer in her room. LN BB then delivered oral care to R40 with the pink oral sponges and the unopened bottle of mouthwash. LN BB removed most of the dried substance on R40's teeth. LN BB reported that the resident's facial hair should be removed when a resident received a shower. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/15/24 at 12:10 PM, Administrative Nurse D expected staff to complete residents' personal cares as the residents allowed and expected facial hair to be removed on shower days or as when needed. She expected staff to provide oral care in the morning, night, and as needed. The facility's policy Right to Dignity dated 12/07/23 documented the facility will promote care for elders of the facility in a manner and in an environment that maintains and enhances each elder's dignity and respect in full recognition of the elder's individuality. Elder's will be groomed as they wish including hair care, facial hair shaved or trimmed as the elder wishes. The facility failed to ensure dependent resident R40 received care for removal of facial hair and adequate oral care. This deficient practice placed the resident at risk for decreased psychosocial well-being and possible illness due to improper oral care.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31078 The facility census totaled 57 residents with 17 residents included in the sample, that included five residents reviewed for pressure ulcers. Based on observation, interview, and record review, the facility failed to use effective infection control practices when providing wound care to one Resident (R103), who admitted with a pressure ulcer (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) This deficient practice had the potential to inhibit wound healing. Findings included: - Resident (R)103's physician orders identified the following diagnoses that included muscle weakness, need for assistance with personal care, diabetes mellitus type two (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), chronic kidney disease (inability of the kidneys to excrete wastes, concentrate urine and conserve electrolytes), and disseminated intravascular coagulation (defibrination syndrome- serious condition that causes abnormal blood clotting throughout the body's blood vessels). The Admission Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of nine, indicating moderately impaired cognition. The resident required substantial assistance to total dependence for daily cares. The resident had a urinary catheter (tube inserted into the bladder to drain urine). The resident had a pressure ulcer (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) to coccyx (area at the base of the spine) that he had on admission to the facility. R103's care plan, dated 08/14/2024 revealed the resident was at risk for alterations in skin integrity/breakdown related to weakness and bowel incontinence. Certified Nursing Assistants (CNA's) were to observe the condition of R103's skin during bath and report changes or alterations to the charge nurse. Staff were to provide a pressure reducing mattress and wheelchair cushion. Staff were to assist with incontinent cares as needed. The resident wore adult briefs for dignity and protection purposes. Staff were to assist with repositioning as needed and provide treatment as ordered. Review of the physician orders revealed: Indwelling urinary catheter on admission, related to neurogenic bladder (dysfunction of the urinary bladder caused by a lesion of the nervous system), ordered 07/27/24. Record urinary catheter output every shift, ordered on 07/27/24. Urinary catheter care every shift and as needed, ordered 07/27/24. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The physician's order included care for R103's Sacrum (large triangular bone/area between the two hip bones) ulcer. Staff were to cleanse the area with normal saline, apply Medihoney dressing (a type of wound dressing made of 100% Active Leptospermum medical grade Honey to maintain a moist environment conducive to healing), and Alginate (a biodegradable dressing made from seaweed that absorbs exudate and forms a gel), cut to wound bed size. Cover with sacral border dressing and change on Mondays, Wednesdays, and Saturdays, and as needed. Observation on 08/14/24 at 03:00 PM, Licensed Nurse (LN) G and CNA F entered the resident's room to change his incontinent brief. Staff transferred the resident with a full body mechanical lift and repositioned R103 to his left side. When staff removed the resident's brief, a large dressing exposed on the resident coccyx area. The nurse with gloves on, pulled the dressing off the wound, and exposed the open area. The wound was in stages of healing, clean and approximately three inches in diameter without depth. R103 was incontinent of bowel movement. LN G cleansed the resident's rectal area with wet wipes. She removed the gloves, used hand sanitizer, and replaced gloves. She then cleaned the wound, but before redressing the resident, the resident continued to have a bowel movement. LN G wiped the BM from the resident, and without changing gloves, and continued to provide wound care. On 08/14/24 at 11:35 AM, CNA F reported the resident was dependent on staff for transfers and mobility. He had a catheter and was incontinent of bowel. On 08/14/24 at 03:34 PM, LN G reported gloves are required so often, LN G forgot to change the gloves between dirty to clean phases. On 08/15/24 at 02:24 PM, Administrative Nurse D reported gloves should be changed when appropriate as it presented as an infection control problem. Review of the facility policy for Wound Management dated 04/24/24 revealed general infection control practices should be maintained during wound care and dressing changes. The facility failed to use infection control practices when providing wound care to this resident that had a pressure ulcer.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50659 The facility reported a census of 57 residents and the facility identified five residents that had impaired cognition that were independently mobile. Based on observation, interview, and record review, the facility failed to provide a secure door to the maintenance shop area located in the main hallway that led to resident units. The maintenance shop contained multiple chemicals that documented to Keep out of Reach of Children and were harmful or fatal if ingested that included the following: Micro Kill disinfectant, neutral floor cleaner, goo gone, Mold [NAME] Rapid Cleaner, bleach, spray paint and insect cleaner. Furthermore, the facility failed to have a functional alarm on an unsecured door that led to the outside. Additionally, the facility failed to provide an environment that remained free from accident hazards for one resident when the facility failed to appropriately place an electric cord for Resident (R) 9's lamp. The approximately five-foot cord extended in front of resident's window on the carpeted floor between the resident's recliner and the dresser that could have the potential to result in an injury. Furthermore, R9 had a fall on 04/24/24 that resulted in a right hip fracture. Findings included: - On 08/14/24 at 08:38 AM, observation revealed the maintenance shop door was three quarters of the way opened. There was a keypad lock on the door. Upon entry into the maintenance shop, no staff observed in the maintenance shop area. Approximately ten seconds afterwards, at 08:39 AM, Dietary Staff P exited the open maintenance door that slowly closed. Dietary Staff P pushed the door back to open so he could exit, as he held a bag of cereal and stated that the door would close on its own. Dietary Staff P attempted to pull the door shut, it was resistant, and he stated it was hard to shut. Dietary Staff P walked away, and the door stayed opened for 15 seconds longer. At 08:46 AM, Dietary Staff P, and unknown dietary staff opened the maintenance shop door and walked back into the shop with an empty black cart. They both walked through the shop straight through an open door and turned to the left. It took forty seconds for the maintenance shop door to close. On 08/14/24 at 08:48 AM, Maintenance Staff O entered the maintenance shop door when he used the keypad entrance code. Maintenance Staff O stated he set the maintenance door to close slowly to make is easier to take equipment in and out of the shop. He stated that he set that door to slowly close about two years ago. Maintenance Staff O stated that there were chemicals stored in the maintenance shop that are on the shelf and in the cabinets that were not locked. He stated that he did not always wait for that door to close completely when he would exit the maintenance shop. On 08/14/24 at 08:50 AM, observation revealed chemicals labeled as harmful or fatal if ingested that included the following: Micro Kill disinfectant, neutral floor cleaner, goo gone, Mold [NAME] Rapid Cleaner, bleach, spray paint, toilet bowl cleaner and fly insect spray. These chemicals were located on a shelf that was open and directly to the left of the open door. On 08/14/24 at 08:58 AM, Environmental Supervisor N confirmed the above was a concern. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/14/24 at 09:12 AM, a tour of the maintenance area, with Environmental Supervisor N, revealed staff could enter the maintenance shop, and walk to the dietary section through an open door that faced an exit door. The exit door had a sensor, however no alarm sounded. The exit door faced the facility parking lot that was located approximately 850 feet south of a major four-lane roadway that services heavy traffic that included semi-trucks with a speed limit of 40 miles per hour (MPH). The facility was approximately 550 feet east of a major two-lane road with a speed limit of 40 miles per hour. Maintenance Staff O stated that no alarm would sound when the door opened and the sensor should send an alarm to his email, to the Environmental Supervisor N email, and to Administrative Staff A's email. He confirmed that no email received when the door opened. He stated that a red light should be on the sensor, however no red light observed. Maintenance Staff O stated that the battery must be dead, and he had no way to know the last time he had received an email for that door sensor. Maintenance Staff O stated that the exit door was not a door that he had on his log sheet when he completed alarm and sensor checks for exit doors. He stated that no resident should have access to the exit door. Environmental Supervisor N stated that the staff on the units should know to not let any of the residents exit off the unit without staff or family, however some of the residents do exit the unit by themselves. Review of the facility's policy Chemical Storage dated 01/13/23, documented the following: To provide a safe environment for all residents, staff, and visitors. All chemicals that are deemed hazardous to residents will be stored in a locked area. This is defined as any chemical that will cause harm, or states to keep away from children. Review of the facility policy Electronic Monitoring System for Exit Doors dated 04/02/24 documented the following: The electronic monitoring system for exit doors for facility will be operational so the elders who wander do not leave the facility without an appropriate escort. The environmental services team will ensure that each electronic door monitor is tested at least monthly. The facility failed to provide a secure door to the maintenance shop area located in the main hallway leading to resident units and failed to keep hazardous chemicals from the confused, self-mobile residents of the facility Furthermore, the facility failed to have a functional alarm on an unsecured door that led to the outside. This deficient practice could potentially result in resident injury. - The Electronic Health Records (EHR) documented Resident (R)9 had the following diagnoses that included dementia (progressive mental disorder characterized by failing memory, confusion), fracture (broken bone) of right hip with routine healing after an open reduction (surgical procedure for reducing a fracture or dislocation by exposing the skeletal parts involved), abnormal gait, and muscle weakness. The 05/05/24 Significant Change Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. R9 had a total mood severity score of 00, indicating no depression and there were no behaviors. Dependent assistance with activities of daily living (ADLs), with toileting hygiene, bathing, and transfers. R9 required maximal assistance with dressing and personal hygiene. R9 had a fall with major injury. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 05/05/24 Functional Abilities Care Area Assessment (CAA) documented R9 had a fall in the facility while in her room. Initial x-rays were negative for fracture, but follow-up x-ray revealed right valgus impacted femoral neck fracture (a type of hip fracture that occurs when the proximal fragment of the femur impacts the fracture site in a valgus configuration [a force that pushes toward the center of the body]). She was admitted to the hospital for the fracture. The 05/05/24 Falls CAA documented R9 had a recent fall, interventions in place to prevent further falls, R9 received Effexor (medication is used to treat depression) and would be monitored by the nurse and the physician. The 04/05/24 Quarterly MDS documented a BIMS score of 13. The resident had no falls. R9 was independent with ADL's except required set up assistance for eating and dressing. The 08/13/24 Care Plan documented interventions included Staff were instructed to provide R9 with bed mobility and transfers as necessary, date initiated 04/06/23. Nurses were instructed to monitor for side effects of medications that may increase fall risk and to notify the physician, date initiated 04/06/2023. Staff were to encourage R9 to use her call light for assistance when toileting, dated initiated 10/17/23. Staff were to provide stand pivot transfers and R9 was independent with wheelchair mobility in her room, date initiated 04/15/24. R9 was educated to slow down and take her time with ambulation and transfers, date initiated 04/26/24. The Physician Orders included Occupational therapy two times week, for 30 days, for exercise, self-care and wheelchair management, date ordered 08/07/24. Physical therapy, three times a week, for 30 days for exercise and gait training, ordered 08/09/24. Review of the Progress Notes from 01/01/24 to 08/13/24 revealed the following: On 04/26/24 at 11:15 PM, R9 had an unwitnessed fall when she stated she tripped and fell when she ambulated out of the bathroom. The resident complained of pain of the right side. Administrative Nurse D notified and instructed to contact the physician if pain intensified. On 04/27/24 at 06:45 AM, R9 stated right pain was more painful and requested an X-ray. The oncoming nurse notified to call the physician. On 04/28/24 at 06:00 AM, R9 remained in pain of right hip, pain medication administered all night. On 04/28/24 at 11:20 AM, R9 complained of right hip pain, pain medication administered. R9 in bed. On 04/28/24 at 04:51 PM, R9 complained of pain, swelling and warmth to medial (towards the middle) aspect of right knee Staff notified the physician. On 04/29/24 the provider visit note documented R9 had a fall over the weekend, on-call provider was contacted, right hip x-rays completed, and both showed no acute fracture. R9 reported pain persisted and had difficulty ambulating since fall. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/29/24 at 04:17 PM, the physician ordered another x-ray of the right femur, Norco (contains a combination of acetaminophen and hydrocodone. Hydrocodone is an opioid pain medication) 5/235 milligram, by mouth, twice a day, and Intravenous (IV-administered directly into the bloodstream via a vein) fluids of Normal Saline (NS- saline water solution for medical use) at 100 milliliter per hour, for one liter. Results from the x-ray showed a possible impacted fracture of right hip femoral head and neck junction (a closed fracture that occurs when the ends of a broken bone are jammed together by force). R9 transferred to the hospital. On 05/02/24 at 12:39 PM, hospital physical therapy note revealed R9 reported to the therapist that she would transfer and did not use a walker to assist with transfers, rather she furniture surfs. On 05/03/24 at 11:32 AM, R9 readmitted to facility. Reviewed fall investigation for 04/26/24 and it was determined R9 ambulated independently from her bathroom to the bed and tripped. On 08/13/24 at 10:05 AM, Observation of R9's room included an approximately five-foot cord extended in front of the resident's window on the carpeted floor, between the resident's recliner and the dresser. On 08/14/24 at 07:56 AM, cord remains on carpeted floor in front of window as noted on previous day. On 08/13/24 at 10:05 AM, R9 stated she had a lot of falls and broke her hip. She stated that she will furniture surf in her room to get to areas. She confirmed she would open her windows at times. Observation of R9's room included an approximately five-foot cord extended in front of the resident's window on the carpeted floor, between the resident's recliner and the dresser. On 08/13/24 at 11:10 AM, Certified Nurse Aide (CNA) Q stated R9's lamp cord has been in front of the window in her room for a long time, and R9 did not ambulate around in her room that much. On 08/15/24 at 08:18 AM, Therapy Director T confirmed that R9 would furniture surf in her room. R9 had therapy when she returned from the hospital and met her goals, but Therapy Director T stated resident restarted therapy last week as the weight bearing status was clarified as weight bearing as tolerated for R9's right hip. On 08/15/24 at 09:15 AM, Licensed Nurse (LN) R stated R9 was known to furniture surf and she would open her window at times by herself. LN R confirmed the cord on the floor in front of R9's window could be a tripping hazard and stated R9 might now allow staff to move her lamp in her room, as R9 liked to read in the recliner. Her room has been set up like it was for a long time. On 08/15/24 at 12:10 PM, Administrative Staff D confirmed the lamp cord was a tripping hazard and it should be removed. The facility's policy Fall Prevention Protocol dated 12/07/23 documented each elder residing at the facility will be provided services and care to ensure that the elder's environment remains as free from hazards as possible that included staff to be alert for anything that would be in the path of traffic which could create a walking hazard. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility failed to provide an environment that remained free from accident hazards for one resident when the facility was aware the resident furniture surfed and failed to appropriately place an electric cord for Resident (R) 9's lamp where it would not be a fall hazard. The approximately five-foot cord extended in front of resident's window on the carpeted floor between the resident's recliner and the dresser that could have the potential to result in an injury.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31078 The facility reported a census of 57 residents, with three residents sampled for urinary catheters. Based on observation, record review and interview, the facility failed to provide proper care to prevent urinary infection for one Resident (R103), when staff failed to properly handle the urinary catheter collection bag to ensure the bag remained below the level of the bladder to prevent urine backflow and the development of urinary tract infection. Findings included: - Resident (R)103's Electronic Health Record (EMR) revealed diagnoses that included hydronephrosis (condition of excess urine accumulation in kidney(s) that causes swelling of kidneys), diabetes mellitus type two (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), and neuromuscular dysfunction of the bladder (the muscles that control the flow of urine out of the body do not relax and prevent the bladder from fully emptying). The Admission Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of nine, indicating moderately impaired cognition. The resident required substantial assistance to total dependence for daily care. The resident had an indwelling urinary catheter. R103's Care Plan dated 07/31/24 revealed the resident had an indwelling urinary catheter due to a neuromuscular dysfunction of the bladder and included staff to change the catheter per facility protocol/provider order, provide catheter care as ordered/per facility protocol, monitor/document pain/discomfort related to the catheter, and position the catheter bag and tubing below the level of the bladder. Provide enhanced barrier precautions per facility protocol, related to urinary catheter, revised 08/02/24. Observation on 08/14/24 at 08:45 AM, revealed Certified Nursing assistant (CNA) E and CNA F propelled R103 from the dining room to his room. Staff removed the resident's urinary catheter collection bag from underneath his wheelchair and placed the bag on the resident's lap. The tubing contained urine. During a full body mechanical lift transfer, R103 held the urinary collection bag against his chest. Once R103 was on the bed, CNA F took the urinary collection bag and held the collection bag above her head and emptied the urometer (plastic measuring tube on side of bag) into the catheter bag. The catheter bag was approximately four feet above the resident's bladder. Staff then placed the catheter collection bag on the lower bar of his bed. On 08/14/24 at 09:00 AM, CNA F reported was not aware to keep a urinary collection bag below the resident's bladder. On 08/14/24 at 09:10 AM, Licensed Nurse (LN) G reported all CNAs should be trained how to place the catheter below the bladder. The resident has recently admitted from the hospital and has had urinary stents and a urostomy tube in place. On 08/15/24 at 02:24 PM, Administrative Nurse D reported all staff should know the proper position the urinary catheter, and the catheter collection bag was to be kept below the resident's bladder. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy for Foley Catheter care, dated 12/07/23, revealed the catheter and drainage bag should be kept at a level lower than the bladder to allow drainage by gravity. The facility failed to properly place the urinary catheter below the level of the bladder to prevent backflow of urine into the bladder and risk of causing a urinary tract infection.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46960 The facility reported a census of 57 residents with 17 residents selected for review which included four residents reviewed for respiratory care. Based on observation, interview, and record review, the facility failed to properly clean and store the nebulizer (a device for administering inhaled medications) for Resident (R)30. Additionally, the facility failed to obtain a physician's order to administer oxygen to R1 and replace a contaminated cannula for R1. These deficient practices had the potential to have a negative impact on the residents' physical and psychosocial well-being. Findings included: - The Electronic Health Records (EHR) documented R1 had the following diagnoses that included chronic obstructive pulmonary disease (COPD - a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), obstructive sleep apnea (OSA - a disorder of sleep characterized by periods without respirations due to anatomical obstructions in the airway) and chronic respiratory failure (a condition in which respiratory function is inadequate to maintain the body's need for oxygen supply and/or carbon dioxide removal while at rest) with hypoxia (inadequate supply of oxygen). The 08/05/24 Significant Change Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 11, which indicated moderately impaired cognition. R1 received oxygen. The 08/05/24 Care Area Assessment (CAA) lacked documentation related to oxygen use. The 08/13/24 Care Plan documented the following: On 06/15/23, staff were to administer oxygen via nasal cannula (NC) as ordered. On 06/15/23, staff were to change the oxygen tubing per facility protocol. On 06/15/23, staff were to keep the oxygen tubing in a plastic bag when not in use. On 06/15/23, staff were to titrate (adjust) the oxygen as needed to maintain oxygen saturation above 90 percent (%). On 07/24/24, R1 had a history of not waiting for staff assistance with the oxygen tubing and would remove the cannula and throw it on the bed/floor/etc but lacked specific instructions for staff to follow. The Physician Orders in the EHR documented the following: Change oxygen tubing and bagging every Wednesday. Label and date all tubing, every day shift, every Wednesday, dated 05/08/24. The Physician's Orders lacked documentation related to the administration of oxygen. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Medication Administration Record (MAR) and Treatment Administration Record (TAR) from 06/01/24 to 08/19/24, lacked documentation related to oxygen administration. On 08/14/24 at 07:39 AM, R1 sat at a table in dining area with peers present, oxygen cannula observed in place connected to an oxygen concentrator. On 08/14/24 at 08:58 AM, R1 removed her oxygen cannula and placed the cannula with the nasal prongs in direct contact with the surface of an arm on the chair and ambulated with a four-wheeled-walker to her room. On 08/14/24 at 09:04 AM, Certified Nurse Aide (CNA) LL placed R1's oxygen cannula back in the plastic bag that hung on the oxygen concentrator. When questioned, CNA LL removed the cannula and stated that the cannula should be replaced if the cannula had been contaminated. On 08/14/24 at 09:04 AM, CNA LL replaced R1's cannula and failed to place a date on R1's cannula. CNA LL stated staff would place a date on the oxygen cannulas when changed on Wednesdays. On 08/19/24 at 08:34 AM, Certified Medication Aide (CMA) J stated that she would know how/when to administer a medication or treatment by looking at the MAR/TAR or asking the nurse or unit manager. On 08/19/24 at 08:35 AM, Licensed Nurse (LN) K stated that she would know how/when to administer a medication or treatment by looking in the EHR under the orders tab which would show all the necessary information. On 08/19/24 at 10:33 AM, Administrative Nurse D stated that staff should replace oxygen tubing if it becomes contaminated as it cannot be cleaned effectively. Staff have standing orders that could be initiated for oxygen , but should contact the provider within 24 hours and place an order in the EHR to correspond to cares that are being delivered. Confirmed the lack of orders in the EHR for oxygen administration for R1 and stated that orders and care plans should be accurate to reflect the cares that are delivered to the residents in the facility. The facility's Administration of Oxygen policy dated 04/24/24 documented that the facility would provide oxygen therapy in accordance with prescribed order. Cannulas and oxygen tubing would be placed in a labeled and dated plastic bag. At no time would oxygen tubing be allowed to drag on or touch the floor. The facility failed to obtain a physician's order to administer oxygen to R1 and replace a contaminated cannula for R1. These deficient practices had the potential to have a negative impact on the residents' physical and psychosocial well-being. -R30's Electronic Health Record (EHR) included diagnoses of obstructive sleep apnea (OSA - a disorder of sleep characterized by periods without respirations due to anatomical obstructions in the airway) and chronic obstructive pulmonary disease (COPD - a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing). The Annual Minimum Data Set (MDS), dated [DATE], documented a Brief Interview of Mental Status (BIMS) score of 15, which indicated intact cognition and R30 did not receive oxygen. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Care Area Assessment (CAA), dated 11/03/23, lacked documentation related to oxygen use or nebulizer (device which changes liquid medication into a mist easily inhaled into the lungs) medication use. The 05/29/24 Care Plan lacked documentation related to oxygen use or nebulized medication. The Physician's Orders documented the following: Ipratropium (a long-acting medication used to open medium and large airways of the lungs) - albuterol (a short-acting medication used to open the airways of the lungs), 0.25-2.5 milligrams (mg) per milliliter (mL), 3 mL inhaled by mouth (orally) by nebulizer, every four hours as needed, for shortness of breath or wheezing, ordered 02/05/24. Ipratropium-albuterol, 0.2-2.5 mg/mL, inhaled by mouth by nebulizer, four times per day for cough/wheezing, and every four hours as needed for cough/wheezing, ordered 02/06/24. Oxygen at two liters per minute by nasal cannula, may titrate (adjust) to maintain oxygen saturation above 90 percent (%) or above as needed, every shift for shortness of breath and low oxygen saturation, ordered 07/08/24. Supplemental oxygen (O2) at two liters per minute, to maintain oxygen saturation above 90%, two times per day, for coughing and hypoxia (low oxygen saturation in the blood), ordered 08/09/24. On 08/12/24 at 03:18 PM, R30 was seated in his room with a nebulizer intact on bedside table on top of nebulizer machine. On 08/14/24 at 04:03 PM, R30 was seated in his room, nebulizer mask placed in R30's lap, nebulizer equipment lacked a date marking. On 08/14/24 at 09:04 AM, Certified Nurse Aide (CNA) LL identified R30 wore oxygen and stated that the tubing and nebulizers were to be changed every Wednesday, usually on night shift. On 08/19/24 at 05:53 AM, CNA F stated that oxygen and nebulizer tubing was changed on Wednesdays and should have some marking of a date on the tubing. On 08/19/24 at 08:54 AM, Licensed Nurse (LN) K stated that oxygen and nebulizer tubing was changed on Wednesdays and should be labeled with the date that it was used. On 08/19/24 at 10:33 AM, Administrative Nurse D stated all oxygen and nebulizer tubing should be dated whenever a new one is placed. When a nebulizer treatment completed, staff were expected to disassemble the nebulizer, rinse the components with water, and allow to air dry. The facility's Administration of Oxygen policy dated 04/24/24, documented after an aerosol (nebulized) treatment, staff were to rinse the device and store the equipment in a dated plastic bag at the bedside.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 31078 The facility reported a census of 57 residents. The facility identified 20 residents that resided on the 400 hall on 07/21/24. Based on interview and record review, the facility failed to ensure 12 of the 20 residents (R) 30, R8, R11, R32, R42, R26, R39, R48, R13, R36, R4 and R29, received medications from 07/21/24 from 06:00 PM to 07/22/24 at 06:00 AM shift, when Licensed Nurse I failed to administer medications, as ordered by the physician. Findings included: - Review of the investigation report dated 07/23/24, revealed the facility employed a licensed nurse from a nursing agency to work from 07/21/24 from 06:00 PM to 07/22/24 06:00 AM shift in one of three houses for 20 residents. It was found that many medications were not administered to the residents during the shift and that the agency licensed nurse had weird behavior. Upon review of the resident Electronic Medication Administration records (EMAR) and Electronic Treatment Administration Record (EMAR) it was found medications were not given for a variety of reasons. Review of EMAR, ETAR, and progress notes initiated. The review found medication and treatment errors for 15 of the 20 residents residing in the house. R30 had a Brief Interview for Mental Status BIMS of 15, indicating intact cognition. Investigation of records indicated the following: On the order for his oxygen (O2) to be placed and titrated, Licensed Nurse I documented in the record upon assessment. CPAP worn at night. On order for Levaquin (antibiotic that fights bacteria in the body), LN I documented upon assessment medication administration not utilized. On order for Proventil HFA Inhalation Aerosol Solution (medication inhaler that relaxes airway muscles and prevents or treats bronchospasm), LN I documented upon assessment medication not given. On order for Senna (medication to treat constipation) tablet, LN I documented upon assessment medication administration not utilized. Medication not given. On order Ipratropium Albuterol Solution (medication used to open the airway in the lungs), LN I documented upon assessment patient. Medication administration not utilized. R8 with a BIMS of 13, indicating intact cognition. Review of the EHR revealed: On order for Atorvastatin Calcium (medication used for high cholesterol), LN I documented upon assessment patient. Medication unavailable. Regarding medication. Medication request utilization update as it relates to oncoming AM nurse. On 07/22/24 at 08:00 AM Administrative nurse D documented the medication was available to administer in the medication cart. R1 had a BIMS of 11, indicating moderately impaired cognition. Investigation of EHR revealed: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Order for Donepezil HCL (medication to treat confusion related to Alzheimer's [progressive mental deterioration characterized by confusion and memory failure]), Mirtazapine (antidepressant [class of medication used to treat mood disorders]), Pepcid (medication to decrease stomach acid production and used to treat peptic ulcer disease), Zoloft (antidepressant), and Zyprexa (antipsychotic [class of medications used to treat major mental conditions which cause a break from reality]), LNI documented upon assessment patient. Medication unavailable. Regarding medication. Medication request utilization update as it relates to oncoming AM nurse. On 07/22/24 at 08:00 AM, administrative nurse D documented medication was available to administer in the medication cart. Order to assess for any signs and symptoms of anxiety, LN I documented upon assessment. Patient AAO (undetermined abbreviation), no complaints of pain of discomfort. Order to assess for any signs and symptoms of behaviors related to psychosis, LN I documented, upon assessment patient alert awake and oriented. Order to assess for signs and symptoms of depression, LN I documented upon assessment patient alert awake and oriented. No fluctuation in neuro status. R32 had a BIMS of 15, indicating intact cognition. Investigation of the EHR revealed: Order for Atorvastatin Calcium, Duloxetine, Famotidine (medication to relieve symptoms of acid reflux and heartburn), Latanoprost Eye Drop (medication to treat high pressure inside the eye due to glaucoma [abnormal pressure within an eye caused by obstruction to the outflow), Melatonin (medication used to treat sleeplessness), Brimonidine Tartrate Eye Drop (medication used to treat glaucoma), Dorzolamide HCL(used to treat glaucoma), Guaifenesin (medication used to treat cough/congestion), and Durezol Emulsion (medication for the eye used to treat eye pain and inflammation), LN I documented upon assessment patient. Medication unavailable. Regarding medication. Medication request utilization update as it relates to oncoming AM nurse. On 07/22/24 at 08:00 AM, administrative nurse D documented medication was available to administer in the medication cart. Order for routine Morphine Sulfate (extended release) (medication used to relieve moderate to severe pain, LN I documented upon assessment patient verbalized pain 2/10. Medication not given. On order for Basaglar (long-acting insulin), LN I documented upon blood glucose assessment blood glucose level 70 and documented that it was not given. On order for routine Percocet (pain medication), LN I documented upon assessment. Patient verbalized no complaints of pain or discomfort. On order for A&D Ointment, LN I documented upon assessment. Medication not given. Will follow up. On order for respiratory assessment, LN I documented upon assessment will follow up. R42 had a BIMS of 13, indicating intact cognition. Investigation of EHR revealed: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On order for melatonin, TUMS (antacid), and ocean nasal spray, LN I documented upon assessment. Medication not given. Will follow up. Order for Nepro not documented. On order to cleanse bilateral (both) forearm skin tears LN I documented upon assessment. Not done. Will follow up. R26 had a BIMS of 13, indicating intact cognition. Investigation of the EHR revealed: On order for Otezla (medication used for treatment of certain types of psoriasis (chronic skin disorder characterized by red patches covered by thick, dry, silvery adherent scales) and psoriatic arthritis, LN I documented upon assessment. Medication not given. Medication unavailable. Medication request update to oncoming nurse. Will follow up. On 07/22/24 at 08:00 AM administrative nurse D documented medication was available to administer in the medication cart. Order for apply lotion to both lower extremities, LN I documented upon assessment. Not done. Will follow up. On order to complete Covid assessment, LN I documented upon assessment. Medication not given. Will follow up. Order for Lantus (insulin), LN I documented upon assessment. Medication not given. Will follow up. LN I documented a blood glucose of 93 in the record. Order for fluid restriction LN I documented upon assessment. Assess patient food intake per unspecified diastolic congestive heart failure order. Orders to monitor for signs and symptoms of acute anxiety and depression, LN I documented upon assessment acute anxiety and upon assessment, in regard to acute restlessness, as needed administered. During shift change narcotic count LN I documented on narcotic sheet that he administered two of the as needed (PRN) Ativan and Norco at 06:00 AM, one Zolpidem at 06:00 AM, and one Oxycontin at 06:00 AM on 7/22/2024. No documentation on 07/21/24 at 08:00 PM on the eMAR to reflect LN I administered the Oxycontin ER. R39 had a BIMS of 12, indicating moderate cognitive impairment. R39 reported he thought he did receive some medications but did not know what medications may have been administered. On order for fluid restriction monitoring, LN I stated upon assessment. Not done. Will follow up. On order for Respiratory assessment, he stated upon assessment. No complaints of shortness of breath. R48 had a BIMS of 13, indicating intact cognition. R48 reported LN I gave him some medications, but he tried to give him an additional dose of Keppra. R13 had a BIMS of 99, indicating severe cognitive impairment. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The EHR revealed: Order to cleanse left gluteal cleft with skin prep and apply barrier cream with incontinent episodes, and Tubi grips to bilateral (both) arms for protection LN I documented upon assessment. Not done. Will follow up. R36 had a BIMS of 12 indicating moderate cognitive impairment. Investigation of the EHR revealed: Order for Percocet, Baclofen (medication used to treat muscle spasms), Colace (stool softener), Ativan (medication to treat anxiety), and sennosides (medication used to treat constipation, LN I documented upon assessment. Medication not given. Will follow up. R4 had a BIMS of 99. Investigation of the EHR records indicated that on routine orders he stated upon assessment. Not done. Will follow up. The investigation lacked the medications LN I failed to administer. R29 had a BIMS of 15. On orders for Insulin Glargine, Compression Wraps, and respiratory assessment, LN I documented upon assessment. Medication not given. Will follow up. Interview on 08/15/24 at 11:10 AM, R30 reported the nurse did not give him his medications he was supposed to. Interview on 08/15/24 at 11:15 AM, R26 reported she kept asking the nurse for her Ambien she received every night. He told her she could not have it now and he never gave her the medication. Interview on 08/15/24 at 11:22 AM, R36 reported she had a couple of medications due that night, but the nurse told her she did not need them. Interview on 08/15/24 at 11:30 AM, certified medication aide (CMA) J reported she was the Medication Aide on duty the night LN I came on shift. When he took the shift, the narcotic/ scheduled medication count was correct, but when she returned the next morning to count, pills had not been administered, not signed out, and the count was wrong. LN I just signed out the medications all at the same time, making it look like he gave the residents two narcotics at the same time. He kept quoting he was with state and that was how things were done. Interview on 08/15/24 at 11:45 AM, Licensed Nurse K reported she tried to give LN I report on the residents by going room to room to tell him a little bit about each one since he had not been there before. He told her he would assess the residents for himself to see if she was right and what they would need. She reported when she came in the next morning, she noticed the computer screen was yellow, indicating missed medications. When she asked him about it, he said these are the meds (medications) that he assessed and determined the residents did not need them and he did not give them. She reported to the director of nursing when she arrived, and they started reviewing each residents' medical records. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avita Health and Rehab at Reeds Cove	2114 N 127th Court East Wichita, KS 67228

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 08/15/24 at 12:20 PM, Administrative nurse D said she was notified of the issue when she came in to work that morning. She rounded on the unit in question to speak with additional floor staff regarding agency LN I and his behavior. LN K, and CMA J, who received shift change report and reconciled the count of narcotic medications, informed administrative nurse D that it appeared as if some medications were not administered overnight and received reports that the night nurse was weird. It was difficult to see if any medications other than the medications not documented because their medication cards aren't set up by the day. The nurse would just punch the next one on the card. There were several medications not documented or would be charted as not given with a note in the nurses notes why he did not think the medication was necessary. She made several attempts to contact the nurse but had no response. The contracted agency was contacted and after report given, was issued a do not return to the facility notice. The agency reported they were unable to reach the nurse. On 08/15/24 at 03:30 PM, administrative staff L reported she would check all agency staff background prior to them entering the facility. There were no red flags on his record, and his license was active. She had gotten report the nurse was acting weird, but staff did not know he was not giving the scheduled medication. A statement by the physician assistant regarding the medication not being administered overnight on 07/22/24 revealed LN I failed to administer some of the medications for several of the residents. In addition, LN I failed to document in the EMAR of medications he may have administered. On the medications/treatments LN I failed to administer, LN I failed to notify the physician for hold order. Additionally, he failed to complete vital signs and document scheduled assessments for Covid and skin. The physician assistant reviewed orders and found that in her professional opinion, no significant harm done by the omittance of medications. She was able to substantiate that medications/treatments were not carried out per physician orders. Review of the facility policy for Medication Administration, dated 02/22 revealed all medications will be administered to every resident as ordered by a physician in a safe and sanitary manner. The facility failed to ensure 15 of the 20 residents received medications from 07/21/24 from 06:00 PM to 07/22/24 at 06:00 AM shift, when Licensed Nurse I failed to administer medications, as ordered by the physician.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 50659 The facility had a census of 57 residents. The sample included 17 residents. Based on observation, interview, and record review, the facility failed to ensure Resident (R) 6 reviewed during the medication administration pass, remained free of medication errors. Twenty-five medication opportunities were observed with twelve medication errors. This placed the resident at risk for adverse reactions from the medications and resulted in a medication error rate of 48%. Findings Included: - Resident 6'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), hypertension (HTN-elevated blood pressure) and heart failure (a condition with low heart output and the body becomes congested with fluid). The Electronic Health Record (EHR) revealed the following physician medications: Cholecalciferol (a dietary supplement prescribed for with vitamin D insufficiency or deficiency) tablet 1000-unit tablet, give one tablet, by mouth (po), daily for Vitamin D deficiency, ordered on 06/12/22. Aspirin (a medication that reduces pain, fever, inflammation, and blood clotting), tablet 81 milligram (mg), give one tablet by mouth, daily for atherosclerotic heart disease (a common condition that develops when a sticky substance called plaque builds up inside your artery), ordered on 06/12/22. Thera-M (Multiple Vitamins-Minerals) (a dietary supplement that contains a combination of vitamins and minerals, and sometimes other ingredients) tablet, give one tablet by mouth, daily, ordered on 06/12/22. Bupropion Extended Release (medication used to treat depression), 150 mg tablet, give one tablet by mouth daily, for depression, ordered on 07/22/22. Escitalopram (medication used to treat certain mental/mood disorders), 10 mg tablet, give one tablet by mouth daily, for depression, ordered on 04/13/23. Gabapentin (medicine used to treat partial seizures, nerve pain from shingles and restless leg syndrome), 300 mg capsule, give one capsule by mouth every 12 hours, for radiculopathy (a temporary condition that occurs when a nerve root in the spine is injured or compressed), ordered on 06/16/23. Acetaminophen (a medication that reduces pain and fever), 325 mg tablet, give two tablets by mouth, two times a day, for chronic pain, ordered on 11/01/23. Oxycodone (medication used to treat moderate to severe pain), five mg tablet, give one tablet by mouth, every 12 hours, for chronic pain ordered 04/12/24. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Losartan Potassium (medication used to treat high blood pressure),100 mg tablet, give one tablet by mouth daily, hold if systolic blood pressure (SBP- top number, the force your heart exerts on the walls of your arteries each time it beats) is less than 110 or diastolic blood pressure (DBP-minimum level of blood pressure measured between contractions of the heart; the bottom number of a blood pressure reading) is less than 60, for HTN, ordered on 04/16/24. Fluticasone Propionate Suspension (medication used to relieve seasonal and year-round allergic and non-allergic nasal symptoms), 50 mg per actuate (when you cause the inhaler to spray the medicine plus propellant), give two sprays into each nostril daily, for congestion, ordered on 04/30/24. Amlodipine (medication used to treat high blood pressure) five mg tablet, give, one tablet by mouth daily, hold if systolic blood pressure is less than 110 or diastolic blood pressure is less than 60, for HTN, ordered on 05/01/24. Lasix (is a diuretic, also called a water pill, that is commonly used to reduce edema (fluid retention), 40 mg tablet, give one tablet by mouth, daily, for heart failure, ordered on 05/10/24. Potassium Chloride extended release (supplement used to prevent or to treat low blood levels of potassium), 10 milliequivalents tablet, give one tablet by mouth daily, ordered on 08/07/24. Guaifenesin liquid (is an expectorant that thins the mucus in the air passages to make it easier to cough up the mucus and clear the airways), 100 mg per five milliliters (ml), give ten ml by mouth as needed for cough, every four hours, ordered on 08/12/24. On 08/14/24 at 07:57 AM, Certified Medication Aide (CMA) II prepared medications for R6's morning medication administration. CMA II, hand hygiene with hand sanitizer on medication cart, then she verified all the medications as she prepared them. CMA II revealed R6's blood pressure was 108/58 and had hold order for Amlodipine five mg tablet and Losartan 100 mg tablet and those medications would not be administered. CMA II spilled the medication cup that contained all of R6's by mouth pills except for the Oxycodone. Six of the by mouth medications landed on the floor and four landed on the medication cart top. CMA II picked up all the medications that fell out and placed them back into the medication cup. She proceeded to remove the Oxycodone tablet from the blister pack, by popping into the medication cup with all the other pills. CMA II went to R6's table in the dining room and asked R6 if she would like her medications. R6 stated yes. CMA II took the cap off the Fluticasone Propionate nasal spray and sprayed one spray into R6's right nostril, which caused R6 to start coughing. CMA II waited for R6 to stop coughing and sprayed one spray into R6's left nostril, then repeated a second spray into each nostril and resident started to cough again. No gloves were worn by the CMA II when she administered the nasal spray. CMA II handed R6 the medication cup with the by mouth medications and R6 swallowed them with her juice. R6 requested cough medication. CMA II walked back to the medication cart; without hand hygiene performed. CMA II verified and prepared the as needed Guaifenesin liquid order and administered it to R6. CMA II walked back to the medication cart and started to prepare another residents medication and failed to perform hand hygiene. On 08/14/24 at 08:20 AM, CMA II confirmed that she should not have administered the medications that dropped out of the medication cup, she stated she should have started with all new medications. Additionally, CMA II stated she should have applied gloves before administering the nasal spray and did confirm that no hand hygiene occurred, she stated I know I should have washed my hands. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/14/24 at 08:25 AM, Administrative Nurse M confirmed that R6's medication should not have been administered after the pills fell out of the medication cup and landed on the cart and floor. She stated that CMA II should have washed her hands after giving medications and should have worn gloves when she administered the nasal spray. On 08/15/24 at 02:55 PM, Administrative Nurse D confirmed the above concerns, and expected all medications to be administered following infection control standards. The facility's policy Medication Administration Policy dated 04/24/24 documented the following: All medications will be administered to every resident as ordered by a physician in a safe and sanitary manner. The facility failed to ensure that R 6's medications were in a sanitary manner. Furthermore, the facility failed to ensure that the overall medication error rate was below 5%. These deficient practices had the potential to have a negative effect on the overall physical and psychosocial well-being of the residents in the facility.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46960 The facility reported a census of 57 residents. Based on observation, interview and record review, the facility failed to store medications properly for three residents, Resident (R)8, R153 and R22, all of whom had over-the-counter medications stored in their individual bedrooms. The facility failed to screen the residents for safety related to medication storage and safe self-medication administration. Findings included: - The Electronic Health Record (EHR) for Resident (R)153, admitted to the facility on [DATE] with documented diagnoses that included acute pancreatitis (a condition characterized by inflammation of the pancreas that can be accompanied by severe pain with nausea and vomiting), chronic kidney disease (CKD - long term kidney disease with gradual decline in kidney function) and diabetes mellitus type 2 (DM2 - a disease when the body cannot use glucose, not enough insulin [a hormone that lowers the level of glucose in the blood] is made or the body cannot respond to the insulin). The Admission Minimum Data Set (MDS) was incomplete and in progress. The Care Area Assessment (CAA) was incomplete and in progress. The 08/13/24 Care Plan documented on 08/09/24 that R153 requested a mesh stop sign to be put on her door to deter other residents from entering her room, and staff provided R153 with a grabber. The care plan lacked any additional information or directions for cares. The 08/13/24 Physician Orders lacked an order for miconazole (an over-the-counter anti-fungal treatment) powder to be administered or to be kept at bedside. Review of the EHR Assessments lacked a safety assessment for self-administration of medications. Review of the Progress Notes from 08/07/24 to 08/13/24 lacked documentation that staff may leave medications at bedside for R153 to self-administer. On 08/13/24 at 11:47 AM, observation of R153's room revealed a bottle of miconazole medicated powder stored on the bedside table. On 08/15/24 at 09:13 AM, Certified Nurse Aide (CNA) AA stated she was not aware if a resident was allowed to have medications left in a resident's room. On 08/15/24 at 09:20AM, Licensed Nurse (LN) R stated medications should not be left in a resident room unless the resident has a physician order and a self-administer medications assessment completed. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/15/24 at 02:24 PM, Administrative Nurse D stated a self-administration assessment is required, with a physician order. Her expectations that medications should not be in a residents' room. The facility lacked a policy for medication storage in a resident's room. The facility failed to provide proper storage of R153's medications in a safe manner and failed to complete a self-administration assessment for medications left in her room. 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. - Review of the Electronic Health Record (EHR) for R8 included diagnoses of chronic obstructive pulmonary disease (COPD - a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), diabetes mellitus type 2 (DM2 - a disease when the body cannot use glucose, not enough insulin [a hormone that lowers the level of glucose in the blood] is made or the body cannot respond to the insulin) and chronic respiratory failure (a condition in which respiratory function is inadequate to maintain the body's need for oxygen supply and/or carbon dioxide removal while at rest) with hypoxia (inadequate supply of oxygen). The Admission Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) of 13, which indicated intact cognition. The assessment documented R8 received oxygen. The Care Area Assessment (CAA) lacked information related to R8's ability to safely store medications in her room. The 08/13/24 Care Plan lacked documentation related to safety assessments for self-administration of medication, or safe storage of medications in her room. Review of the Physician Orders included Voltaren Gel (diclofenac - an over-the-counter pain reliever gel), 1 Percent (%), apply [unspecified dose] to the affected area, topically (on the skin), two times a day for pain. Use dosing card to measure, ordered on 08/09/24 at 05:00 PM. The order lacked specific dose, or instructions to leave the medication at the resident's bedside. The Physician Orders lacked an order for Fluticasone Propionate Suspension (an over-the-counter medication used to relieve seasonal and year-round allergic and non-allergic nasal symptoms) or an over-the-counter petroleum-based salve medication that contained eucalyptus, camphor and menthol. Review of the EHR Assessments lacked a safety assessment for self-administration of medications. Review of the Progress Notes from 06/01/24 to 08/13/24 lacked documentation that staff may leave medications at bedside for R8 to self-administer. On 08/12/24 at 04:19 PM, observation of R8's room revealed a tube of Voltaren (diclofenac) sat on the over-the-bed table, a Flonase (fluticasone propionate) container sat on the bedside table, a jar of an over-the-counter petroleum-based salve medication that contained eucalyptus, camphor and menthol sat on the over-the-bed table. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/15/24 at 10:57 AM, observation of R8's room revealed a tube of Voltaren (diclofenac), Flonase (fluticasone propionate), and a jar of an over-the-counter petroleum-based salve medication that contained eucalyptus, camphor and menthol remained on the resident's over-the-bed table. On 08/12/24 at 04:19 PM, R8 stated that when she experienced pain she used a dollop of the Voltaren (diclofenac) gel and then would rub it in. R8 was unable to verbalize the size of the dollop she utilized or frequency of how often she used it. R8 stated that she utilized the Flonase (fluticasone) and the over-the-counter petroleum-based salve medication that contained eucalyptus, camphor and menthol whenever she wanted to. On 08/15/24 at 09:13 AM, Certified Nurse Aide (CNA) AA stated she was not aware if a resident was allowed to have medications left in a resident's room. On 08/15/24 at 09:20AM, Licensed Nurse (LN) R stated medications should not be left in a resident room unless the resident has a physician order and a self-administer medications assessment completed. On 08/15/24 at 02:24 PM, Administrative Nurse D stated a self-administration assessment is required, with a physician order. Her expectations that medications should not be in a residents' room. The facility lacked a policy for medication storage in a resident's room. The facility failed to provide proper storage of R8's medications in a safe manner and failed to complete a self-administration assessment for medications left in her room. 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. 50659 - Resident (R) 22's Electronic Health Record (EHR) revealed diagnoses of bipolar (major mental illness that caused people to have episodes of severe high and low moods) and dementia (progressive mental disorder characterized by failing memory, confusion). The 03/01/24 Annual Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. R22 had a total mood severity score of 00, indicating no depression and there were no behaviors. She was independent with activities of daily living (ADLs), with toileting hygiene, dressing, personal hygiene, and transfers. R22 required supervision assistance with bathing and ambulation. The 03/01/24 Functional Abilities Care Area Assessment (CAA) documented ADL function CAA triggered for need for assistance ADL's. Contributing factors included dementia, weakness, and anemia (inadequate number of healthy red blood cells to carry adequate oxygen to body tissues). The 05/31/24 Quarterly MDS documented a BIMS score of 12, indicating moderately impaired cognition. R22 remained independent with ADLs, except supervision for bathing. The 08/13/24 Care Plan documented interventions included staff were instructed to administer medications as ordered, date initiated 12/06/22. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 08/13/24 Physician Orders Fluticasone Propionate Suspension (medication used to relieve seasonal and year-round allergic and non-allergic nasal symptoms), 50 mg per actuate (when you cause the inhaler to spray the medicine plus propellant), give two sprays into each nostril at bedtime, for congestion, ordered on 03/14/24. The order lacked documentation that staff may leave medications at bedside for R22 to self-administer. Lacked documentation for an order for Saline Nasal Spray (a sterile saltwater solution used to lubricate, moisturize, and flush nasal passages in adults). Review of the Assessments from 01/01/24 to 08/13/24 lacked safety assessment to self-administer medications. Review of the Progress Notes from 01/01/24 to 08/13/24 lacked documentation that staff may leave medications at bedside for R22 to self-administer. On 08/13/24 at 09:16 AM, observation of R22's room included a bottle of Fluticasone Propionate Suspension 50 mg per actuate and a bottle of Saline Nasal Spray in plain view on her overbed table. On 08/14/24 at 07:50 AM, observation of R22's room continued to have a bottle of Fluticasone Propionate Suspension 50 mg per actuate that was approximately three quarters full. Additionally, an open bottle of Saline Nasal Spray remained in plain view on R22's overbed table. On 08/15/24 at 09:13 AM, Certified Nurse Aide (CNA) AA stated she was not aware if a resident was allowed to have medications left in R22's room. On 08/15/24 at 09:20 AM, Licensed Nurse (LN) R stated medications should not be left in a resident room unless the resident has a physician order and a self-administer medications assessment completed. LN R stated that R22 may have behaviors if medications removed from her room. On 08/15/24 at 02:24 PM, Administrative Nurse D stated a self-administration assessment is required, with a physician order. Her expectations that medications should not be in a residents' room. The facility lacked a policy for medication storage in a resident's room. The facility failed to provide proper storage of R22's medications in a safe manner and failed to complete a self-administration assessment for medications left in her room. 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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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46960 The facility reported a census of 57 residents. The facility identified three kitchen/food service areas. Based on observation, interview, and record review, the facility failed to store, prepare, and serve food under sanitary conditions for the residents of the facility. This placed the affected residents at risk for decreased palatability of food and food-borne illness. Findings included: - Observation of the [NAME] House kitchen, on 08/12/24 at 12:50 PM, with Dietary Staff EE, revealed the following areas of concerns: 1. Dietary Staff EE was unable to locate the thermometers in the upright refrigerator and freezer. 2. In the stand-alone refrigerator; a large zipper style plastic bag of macaroni salad lacked a preparation date, an expirations date, or a label of contents. 3. In the stand-alone freezer; a container of breadsticks was open to air. 4. In the stand-alone freezer; a zipper style plastic bag that contained an unknown frozen clear liquid lacked a preparation date, expiration date, or label of contents. 5. In the stand-alone freezer; a box of sausage patties was open to air. In addition, walk-through corridor between [NAME] House and [NAME] House dry storage area with Dietary Staff EE, revealed the following concerns: 1. Contained a large bin with various pasta with a package of egg noodles and tortilla chips that both lacked open or expiration dates. An observation in Saghbene Kitchen 08/12/24 a 01:00 PM with Dietary Staff FF revealed the following areas of concern: 1. A refrigerator temperature of 46 degrees Fahrenheit (F). Dietary Staff FF stated the temperature should be 41 degrees or lower. 2. In the stand-alone freezer; a plastic bag with an unknown meat product that lacked an open date, expiration date, or label of contents. 3. In the stand-alone freezer; a box of hamburger patties and a box of breakfast biscuits that were open to air. 4. The stand-alone refrigerator; contained an unknown loaf of discolored luncheon meat that lacked an open date, an expiration date, or label of contents. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 08/12/24 at 01:13 PM, Administrative Nurse D reported that in the absence of the Certified Dietary Manager (CDM), she was in charge of the kitchen and was made aware of above concerns. On 08/13/24 at 07:32 AM, Dietary Staff P stated refrigerators should be at 41 degrees F or below and was made aware of above concerns and on follow-up tour, he stated that all the items had been corrected. The facility's Dietary Food Storage dated 03/13/24, documented the following: Food shall be stored on shelves in a clean, dry area, free from contaminants. Food shall be stored at appropriate temperatures and using appropriate methods to ensure the highest level of food safety. All food items taken out of original packaging will be labeled and stored in air-tight containers. The label must include received by date and or open date. Set refrigerators to the proper temperature. The setting must ensure the internal temperature of the food is 41 degrees Fahrenheit or lower. Place hanging thermometer in the warmest part of the refrigerator. The facility failed to store, prepare, and serve food under sanitary conditions for the residents in the facility. This placed the residents at risk for unpalatable food and food-borne illness.

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	175532	A. Building B. Wing	08/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avita Health and Rehab at Reeds Cove	2114 N 127th Court East Wichita, KS 67228

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 31078 The facility reported a census of 57 residents. The facility identified 20 residents that resided on the 400 hall on 07/21/24. Based on interview and record review, the facility failed to maintain medical records on each resident that were complete, accurately documented, readily accessible for seven residents when Licensed Nurse I failed to document medications/ treatments/assessments from 07/21/24 at 06:00 PM to 07/22/24 at 06:00 AM. Findings included: - Review of the investigation report dated 07/23/24, revealed the facility employed a licensed nurse from a nursing agency to work from 07/21/24 from 06:00 PM to 07/22/24 06:00 AM shift in one of three houses for 20 residents. Upon review of the resident Electronic Medication Administration records (EMAR) and Electronic Treatment Administration Record (ETAR), multiple medications were not documented or given for a variety of reasons. The facility initiated a review of EMAR, ETAR, and progress notes of the 20 residents that LN I was in charge of medication administration and identified the following concerns: R30 had a Brief Interview for Mental Status BIMS of 15, indicating intact cognition. Investigation of records indicated the following: No vital signs documented in eMAR or progress notes. An order to place ASV (Adaptive servo-ventilation- a type of CPAP machine), off in AM and on at bedtime (HS), LN I failed to document. R42 had a BIMS of 13, indicating intact cognition. Investigation of EHR revealed: On order for melatonin, TUMS (antacid), and ocean nasal spray, LN I documented upon assessment. Medication not given. Will follow up. No documentation as to the reason the medications were not given. Order for Nepro not documented. On order to cleanse bilateral (both) forearm skin tears LN I documented upon assessment. Not done. Will follow up. No documentation as to the reason the treatment and assessment were not completed. R26 had a BIMS of 13, indicating intact cognition. Investigation of the EHR revealed: On order for Otezla (medication used for treatment of certain types of psoriasis (chronic skin disorder characterized by red patches covered by thick, dry, silvery adherent scales) and psoriatic arthritis, LN I documented upon assessment. Medication not given. Medication unavailable. Medication request update to oncoming nurse. Will follow up. No documentation as to the reason the medications were not given. On 07/22/24 at 08:00 AM administrative nurse D documented medication was available to administer in the medication cart. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Order for apply lotion to both lower extremities, LN I documented upon assessment. Not done. Will follow up. No documentation why the treatment was not done as ordered. On order to complete Covid assessment, LN I documented upon assessment. assessment not completed. Will follow up. No documentation why the assessment was not done as ordered. Order for Lantus (insulin), LN I documented upon assessment. Medication not given. Will follow up. LN I documented a blood glucose of 93 in the record. No documentation or follow up documented. Order for fluid restriction LN I documented upon assessment. Assess patient food intake per unspecified diastolic congestive heart failure order. Fluid restriction not documented during the shift. During shift change narcotic count LN I documented on narcotic sheet that he administered two of the as needed (PRN) Ativan and Norco at 06:00 AM, one Zolpidem at 06:00 AM, and one Oxycontin at 06:00 AM on 7/22/2024. No documentation on 07/21/24 at 08:00 PM on the eMAR to reflect LN I administered the Oxycontin ER. R39 had a BIMS of 12, indicating moderate cognitive impairment. R39 reported he thought he did receive some medications but did not know what medications may have been administered. On order for fluid restriction monitoring, LN I stated upon assessment. Not done. Will follow up. On order for Respiratory assessment, he stated upon assessment. No complaints of shortness of breath. Review of the eMAR revealed no documentation of any medications given during the shift. R13 had a BIMS of 99, indicating severe cognitive impairment. The EHR revealed: Order to cleanse left gluteal cleft with skin prep and apply barrier cream with incontinent episodes, and Tubi grips to bilateral arms for protection LN I documented upon assessment. Not done. Will follow up. No documentation for the reason treatments were not completed as ordered. R4 had a BIMS of 99. Investigation of the EHR records indicated that on routine orders he stated upon assessment. Not done. Will follow up. The investigation lacked the medications LN I failed to administer. No follow up was documented in the eMAR and no reason to hold the medications. R29 had a BIMS of 15. On orders for Insulin Glargine, Compression Wraps, and respiratory assessment, LN I documented upon assessment. Medication not given. Will follow up. No follow up was documented in the eMAR and no reason to hold the medications. Interview on 08/15/24 at 11:30 AM, certified medication aide (CMA) J reported she was the Medication Aide on duty the night LN I came on shift. When he took the shift, the narcotic/ scheduled medication count was correct, but when she returned the next morning to count, pills had not been administered, not signed out, and the count was wrong. LN I just signed out the medications all at the same time, making it look like he gave the residents two narcotics at the same time. He kept quoting he was with state and that was how things were done. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 08/15/24 at 11:45 AM, Licensed Nurse K reported she tried to give LN I report on the residents by going room to room to tell him a little bit about each one since he had not been there before. He told her he would assess the residents for himself to see if she was right and what they would need. She reported when she came in the next morning, she noticed the computer screen was yellow, indicating missed medications. When she asked him about it, he said these are the meds (medications) that he assessed and determined the residents did not need them and he did not give them. She reported to the director of nursing when she arrived, and they started reviewing each residents' medical records. Interview on 08/15/24 at 12:20 PM, Administrative nurse D reported it was difficult to see if any medications other than the medications not documented because their medication cards aren't set up by the day. The nurse would just punch the next one on the card. There were several medications not documented. She made several attempts to contact the nurse but had no response. The contracted agency was contacted and after report given, was issued a do not return to the facility notice. The agency reported they were unable to reach the nurse. A written statement by the physician assistant regarding the medication not being administered overnight on 07/22/24 revealed LN I failed to document in the EMAR of medications he may have administered. Additionally, he failed to complete vital signs and document scheduled assessments for Covid and skin. Review of the facility policy for Medication Administration, dated 02/22 revealed all medications will be administered to every resident as ordered by a physician in a safe and sanitary manner. The facility failed to maintain medical records on each resident that were complete, accurately documented, readily accessible for eight residents when Licensed Nurse I failed to document medications/ treatments/assessments from 07/21/24 at 06:00 PM to 07/22/24 at 06:00 AM.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 50659 The facility reported a census of 57 residents. The sample included 17 residents. Based on observation, interview, and record review, the facility failed to maintain an effective infection control program related to the sanitary manner medications administered and lacked proper hand hygiene during medication administration. This deficient practice had the potential to spread possible infections to the residents in the facility. Findings included: - On 08/14/24 at 07:57 AM, Certified Medication Aide (CMA) II prepared medications for R6's morning medication administration. CMA II performed hand hygiene with hand sanitizer located on the medication cart. CMA II spilled the medication cup that contained all R6's by mouth pills except for the Oxycodone (pain medication). Six of the by mouth medications landed on the floor and four landed on the top of the medication cart. CMA II picked up all the medications that fell out and placed them back into the medication cup. She removed the Oxycodone tablet from the blister pack, by popping into the medication cup with all the other pills. CMA II went to R6's table in the dining room and asked R6 if she would like her medications. R6 stated yes. CMA II took the cap off the Fluticasone Propionate nasal spray and sprayed one spray into R6's right nostril, which caused R6 to cough. CMA II waited for R6 to stop coughing and sprayed one spray into R6's left nostril, then repeated a second spray into each nostril and resident started to cough again. CMA II lacked gloves when she administered the nasal spray. CMA II handed R6 the medication cup with the by mouth medications and R6 swallowed them with her juice. R6 requested cough medication. CMA II walked back to the medication cart, and without hand hygiene, prepared the as needed Guaifenesin (medication used to treat cough) liquid order and administered it to R6. CMA II walked back to the medication cart and started to prepare another residents medication and again, failed to perform hand hygiene. On 08/14/24 at 08:20 AM, CMA II confirmed that she should not have administered the medications that dropped out of the medication cup, she stated she should have started with all new medications. Additionally, CMA II stated she should have applied gloves before administering the nasal spray and did confirm that no hand hygiene occurred, she stated I know I should have washed my hands. On 08/14/24 at 08:25 AM, Administrative Nurse M confirmed that R6's medication should not have been administered after the pills fell out of the medication cup and landed on the cart and floor. She stated that CMA II should have washed her hands after giving medications and should have worn gloves when she administered the nasal spray. On 08/15/24 at 02:55 PM, Administrative Nurse D confirmed the above concerns, and expected all medications to be administered following infection control standards. The facility's policy Medication Administration Policy dated 04/24/24 documented the following: All medications will be administered to every resident as ordered by a physician in a safe and sanitary manner. The facility's policy Infection Control dated 03/14/24 documented the following: (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 will facilitate safe care of all residents by establishing and maintaining an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment. Hand hygiene refers to washing with plain or anti-microbial (something can inhibit, resist, or prevent the growth of microorganisms, such as bacteria, mold, viruses, fungi, and parasites) soap and water and use of alcohol gel. Perform hand hygiene before and after contact with a resident. The facility failed to ensure that R 6's medications were administered in a sanitary manner. These deficient practices had the potential to have a negative effect on the overall physical and psychosocial well-being of the residents in the facility.