STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175544	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ignite Medical Resort Rainbow Boulevard, LLC	3910 Rainbow Blvd, Suite 400 Kansas City, KS 66103

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49634 The facility identified a census of 93 residents. The sample included 19 residents with one resident reviewed for dignity. Based on observation, record review, and interviews, the facility failed to promote a dignified care environment for Resident (R)51 during his mealtime. This deficient practice placed R51 at risk for impaired dignity and decreased psychosocial well-being. Findings included: - R51's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of respiratory failure with hypoxia (a condition that occurs when the body doesn't have enough oxygen in the blood, hypertension (HTN-elevated blood pressure), non-pressure ulcer of the lower right leg, oxygen dependence, diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), myocardial infarction (heart attack), congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), and blindness. The Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS documented R51 needed supervision or touching assistance with upper body dressing. R51's Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) dated 03/07/24 documented R51 required assistance with mobility and self-care with activities of daily living (ADLs) due to weakness, unsteady gait, and his medical diagnoses. The CAA noted R51 worked with nursing to improve control of medical conditions, unsteady gait, and weakness. R51's Care Plan dated 03/03/22 documented R51 had an ADL self-care performance deficit and limited physical mobility related to respiratory failure, pain, and blindness. The plan indicated R51 needed extensive physical assistance with dressing and was independent for eating and wheeling his wheelchair. On 08/20/24 at 07:43 AM, R51 sat at the head of the table in the dining area. R51's gown was open in the back exposing his backside, excluding buttocks, to peers and visitors. On 08/21/24 at 02:19 PM, R51 sat in the dining room area playing bingo. R51 wore a gown with the back open. R51's backside was visible to peers and visitors. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/20/24 at 08:17 AM, R51 stated he did not realize his backside was visible, he stated that he always wears a hospital gown. R51 stated he could not tie his gown, and he relied on staff to tie his gown or put a second gown around his backside. On 08/22/24 at 12:38 PM, Certified Nurse's Aide (CNA) T stated the backside of residents should always be covered. She stated if R51 wanted to wear a gown, the gown should be closed or a second gown should be draped around his back. On 08/22/24 at 12:49 PM, Licensed Nurse (LN) H stated R51 should be always covered by his clothing. On 08/22/24 at 01:24 PM Administrative Nurse D stated all residents should have their backsides covered while in the dining room or anywhere there are other residents or guests. The facility's Dignity policy dated 07/24 documented the facility would promote care for residents of the facility in a manner and in an environment that maintains and enhances each resident's dignity and respect in full recognition of the resident individuality. Each resident will be encouraged and assisted to dress in his or her own clothing appropriate to the time of day and the individual's preferences Unless specifically requested by the resident and or responsible party, no hospital gowns will be provided to any elder, and if the practice was requested by the resent, the practice will be included in the resident's individualized comprehensive plan of care. The facility failed to promote a dignified care environment for R51 during his mealtime. This deficient practice placed R51 at risk for impaired dignity and decreased psychosocial well-being.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41713 The facility identified a census of 93 residents. The sample included 19 residents with one resident sampled for hospitalization . Based on record review and interview the facility failed to provide a written notice of transfer as soon as practicable to Resident (R) 238 or their representative for their facility-initiated transfers. This deficient practice had the risk of miscommunication between the facility and resident/family and possible missed opportunity for healthcare service for R238. Findings included: - The Electronic Medical Record (EMR) for R238 documented diagnoses of neuromuscular dysfunction of the bladder (a urinary tract dysfunction that occurs when the nerves and muscles of the urinary system don't work together properly due to damage to the nervous system), congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), and paraplegia (paralysis characterized by motor or sensory loss in the lower limbs and trunk). R238 ' s Discharge Minimum Data Set (MDS) dated [DATE] documented he had an unplanned discharge to a short-term acute hospital with a return anticipated. R238 ' s Discharge MDS dated [DATE] documented he had an unplanned discharge to a short-term acute hospital with a return anticipated. R238 ' s Discharge MDS dated 09//18/23 documented he had an unplanned discharge to a short-term acute hospital with a return anticipated. R238 ' s Discharge MDS dated [DATE] documented he had an unplanned discharge to a short-term acute hospital with a return anticipated. R238 ' s Quarterly MDS dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 14 which indicated intact cognition. R238 was dependent on staff for his functional abilities of bathing, toileting, and dressing. R238 utilized a wheelchair for mobility assistance. R238 ' s Activities of Daily Living (ADL) Care Area Assessment (CAA) dated 12/27/23 documented he needed extensive assistance with ADLS and mobility. R238 used a motorized wheelchair for mobility. Related factors affecting ADL status included the potential for uncontrolled pain, medication side effects, and balance deficits during transfers and gait. R238 ' s Care Plan dated 01/28/19 directed staff he wished to remain in long-term care (LTC) and stay in the facility. Staff was to encourage the resident to discuss feelings and concerns with LTC placement. Staff was to encourage the resident to voice any changes in LTC placement or discharge goals. R238 ' s clinical record lacked evidence a written notification of transfer was provided to R238 for the 06/11/23, 07/17/23, 09/18/23, and 12/09/23 transfers as requested. The facility was unable to provide the evidence upon request. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/21/24 at 10:41 AM R238 lay in his bed with his call light in reach. On 08/22/24 at 01:24 PM Administrative Nurse D stated that the nurses were responsible for making sure that the written notification of transfer and the bed hold were completed before a resident transferred out of the facility. Administrative Nurse D stated the notification would be mailed to the resident ' s representative. Administrative Nurse D stated she did not know what the protocol was for written notification of transfer prior to her being the director of nursing and said she was not able to find any record of the written notifications for R238 prior to the 01/01/24 discharge. The Bed Hold revised April 2023 documented written notification would be provided to the resident and or resident representative before the resident transfers, or in case of emergency within 24 hours. The information would include The duration of the state bed-hold; reserve bed payment in accordance with the state plan; and permitted returns; Notification of the transfer or discharge; the reason for the move; in writing in a language, and a manner in which it could be understood; readmission standards; and admission standards. The facility would retain and secure documentation within the medical record. The facility failed to provide written notice of transfer as soon as practicable to R238 or their representative for their facility-initiated transfers. This deficient practice had the risk of miscommunication between the facility and resident/family and possible missed opportunity for healthcare service for R238.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41713 The facility identified a census of 93 residents. The sample included 19 residents. Based on observation, record review, and interview, the facility failed to ensure Resident (R) 62's Care Plan was revised with interventions to direct staff on her dialysis (a procedure where impurities or wastes were removed from the blood) access port location, care, and monitoring. This deficient practice placed R62 at risk for impaired care due to uncommunicated care needs. Findings included: - R62's Electronic Medical Record (EMR) documented diagnoses of end-stage renal disease (ESRD-a terminal disease of the kidneys) and dependence on renal dialysis. The Annual Minimum Data Set (MDS) dated [DATE] for R62 documented a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. R62 required partial to moderate staff assistance for dressing, and substantial assistance for personal hygiene, and was dependent on staff for toileting and bathing. R62 utilized a wheelchair for assistance with mobility. R62 required dialysis services. R62's Quarterly MDS dated [DATE] documented a BIMS score of 15 which indicated intact cognition. R62 required partial to moderate staff assistance for dressing, and substantial assistance for personal hygiene, and was dependent on staff for toileting and bathing. R62 utilized a wheelchair for assistance with mobility. R62 required dialysis services. R62's Activities of Daily Living (ADL) Care Area Assessment (CAA) dated 03/19/24 documented she required assistance with mobility and self-care due to weakness, an unsteady gait, and medically complex conditions that placed R62 at significant risk for injury during ADLS. R62's Dialysis Care Plan dated 03/07/24 directed staff to encourage R62 to go to scheduled dialysis appointments every Tuesday, Thursday, and Saturday. Staff was to monitor, document, and report as needed any signs and symptoms of infection to the access site. Staff was directed to check and change the dressing daily at the access site, the left chest permacath catheter (a flexible, soft plastic tube that is used for short-term dialysis treatment). Staff was directed to monitor, document, and report any signs or symptoms of hemorrhage (loss of a large amount of blood in a short period of time), bacteremia (presence of bacteria in the blood), or septic shock (a life-threatening condition caused by a severe localized or system-wide infection). The plan lacked direction or interventions related to the dialysis fistula (a passage between the basilic vein and the brachial artery in the upper arm) and assessing for a thrill (a fine vibration felt which reflects the blood flow by a dialysis resident ' s shunt) or bruit (blowing or swishing sound heard when blood flows through a shunt) and restrictions for that extremity regarding blood pressure and lab. R62's Order Summary Report documented a physician order dated 07/16/24 to monitor the dialysis site for bleeding when returning from dialysis in the afternoon on Tuesday, Thursday, and Saturday. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R62's Order Summary Report documented a physician ' s order dated 12/11/23 for a permacath catheter to the left side of the chest. A 12/09/23 hospital Discharge Summary dated 12/11/23 documented R62 received dialysis and presented to the emergency room with low hemoglobin (Hgb-measure of blood that carried oxygen to the cells from the lungs and carbon dioxide away from the cells to the lungs). R62 had a left arteriovenous (AV) fistula placement procedure performed on 12/04/23. R62's Treatment Administration Record (TAR) reviewed from December 2023 to August 2024 lacked documentation of monitoring of the left AV fistula shunt access site for a thrill or bruit. On 08/21/24 at 09:02 AM R62 sat in her wheelchair in her room. R62 stated back in December they did surgery to create the AV fistula in her left arm. R62 stated the nursing staff did send a dialysis communication sheet with her on her dialysis days, but the dialysis center did not always send the sheets back with her. On 08/22/24 at 12:49 PM Licensed Nurse (LN) I stated R62 or any resident that was on dialysis should have interventions in place to direct staff on the care for the dialysis access such as not obtaining a blood pressure on that extremity, monitoring and documentation for the thrill and bruit, and checking the site for any bleeding daily. On 08/22/24 at 01:24 PM Administrative Nurse D stated she had not realized that R62's orders and care plan had not been updated to reflect her having the AV fistula in her left arm. Administrative Nurse D stated R62 ' s Care Plan and orders will be updated to reflect staff direction and the correct location and type of dialysis access. The Care Plan policy last revised in April 2023 documented the care plans were updated at least every 90 days or with a significant change of the resident by the team member initiating the care plan. The care plan consisted of problems identified by reviewing the medical record and discussion with the resident and or significant others. Evaluation of the care plan goals should occur at least every 90 days or with a significant change in the resident. If the goal was continued, a new date of completion should be identified. The policy lacked direction for revision of the care plan. The Dialysis Protocol last revised in April 2023 documented the resident ' s care plan would reflect their dialysis needs. The facility failed to ensure R62's Care Plan was revised to direct staff on her dialysis AV fistula access site type, the location, and monitoring. This placed R62 at risk for impaired care due to uncommunicated care needs.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 45668 The facility identified a census of 93 residents. The sample included 19 residents with two reviewed for accidents. Based on record review, interviews, and observations, the facility failed to secure hazardous materials and rooms from nine cognitively impaired ambulatory mobile residents. This placed the residents at risk for preventable accidents and injuries. Findings Included: - On 08/20/24 at 07:14 AM a walk-through of the facility's fourth floor revealed the floor's two electrical rooms were both unsecured. The electrical room across from Resident (R)83's room contained two large unlocked high-voltage switch panels. The panels contained the warning Danger- Hazardous voltage will cause death or serious injury. The door locked upon exiting. The electrical room across from R54's room revealed six smaller unlocked electrical switch panels. The panels contained the warning Danger- Hazardous voltage will cause death or serious injury. Licensed Nurse (LN) H secured the door upon exiting. On 08/20/24 at 07:40 AM an unsecured cleaning closet across from R54's room contained several assorted containers of bathroom and floor cleaners. All products identified contained the warning, Keep out of reach of children, hazardous to humans can cause eye irritation, harmful if swallowed. On 08/21/24 at 11:00 AM, a walk-through of the third floor revealed the facility's beauty salon was left unlocked. An inspection of an unlocked cabinet revealed several bottles of sanitizing spray and a bottle of barbircide (a chemical used to sanitize hair-cutting equipment). The products identified contained the warning, Keep out of reach of children, hazardous to humans can cause eye irritation, harmful if swallowed. On 08/20/24 at 07:40 AM LN H stated the cleaning closet and electrical panel rooms should be locked at all times. She stated the residents should not have access to potentially hazardous chemicals or areas in the building. On 08/22/24 at 01:25 PM Administrative Nurse D stated the cleaning and electrical closets should remain locked. She stated staff should ensure the doors were pulled fully closed when entering and exiting. She stated the beauty shop should be locked when not being used or monitored. The facility's Control of Hazardous Chemicals policy revised 06/2024 indicated the facility will ensure the safe storage of potentially hazardous materials. The policy indicated items labeled with the keep out of reach of children will remain locked away from the residents and handled in a safe manner. The policy indicated areas within the facility deemed unsafe will remain locked and closely monitored to prevent accidents and injuries. (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 secure hazardous materials and rooms from nine cognitively impaired ambulatory mobile residents. This placed the residents at risk for preventable accidents and injuries.

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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** 41037 The facility identified a census of 93 residents. The sample included 19 residents with four residents reviewed for catheter (a flexible tube inserted through a narrow opening into a body cavity, particularly the bladder, for removing fluid). Based on observation, record review, and interviews, the facility failed to ensure Resident (R) 12's suprapubic catheter (urinary bladder catheter inserted through the abdomen into the bladder) was anchored on the abdomen to prevent pulling and injury. This deficient practice placed R12 at risk for catheter-related complications. Findings included: - R12's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of chronic kidney disease (damaged kidneys and unable to filter blood the way they should), malignant neoplasm of the prostate (the tendency of a medical condition, especially tumors, to become progressively worse, most familiar as a characteristic of cancer), and dysfunction of the bladder. The Admission Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 10 which indicated moderately impaired cognition. The MDS documented R12 had an indwelling catheter. The Quarterly MDS dated [DATE] documented a BIMS score of 13 which indicated intact cognition. The MDS documented that R12 had an indwelling catheter. R12's Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA) dated 02/06/24 documented he had an indwelling catheter and was treated for a urinary tract infection (UTI). R12's Care Plan dated 01/24/24 documented that staff would check the placement of his catheter tubing every shift. The plan of care documented that staff would monitor for signs or symptoms of UTI or pain related to his catheter and notify the physician. The plan of care lacked direction for the placement of an anchor to prevent pulling or injury. R12 's EMR under the Orders tab revealed the following physician order: Foley catheter change using a 16 French with a 10 cubic centimeter (cc) balloon as needed for leakage or blockage dated 05/24/24. On 08/21/24 at 02:49 PM, R12 lay on his bed. Certified Nurse Aide (CNA) M assisted R12 in removing his pajama pants for catheter care. R12 had a catheter tubing anchor on his left thigh. R12 told CNA M to remember to be careful not to pull his pants too fast on the left side so the catheter tubing would not be pulled. R12's catheter tubing attached to his anchor had white mucous tinged with bright red blood. R12 stated that before he was admitted to the facility, his catheter was always anchored on his abdomen. R12 stated he had to be very careful to prevent the tubing from being pulled with the anchor on his thigh instead of his abdomen. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/22/24 at 12:38 PM, CNA N stated she was not sure where the catheter anchor should be placed for a resident with a suprapubic catheter. CNA N stated she would ask the nurse. On 08/22/24 at 12:50 PM, Licensed Nurse (LN) I stated she was not sure where an anchor for a suprapubic catheter should be placed. LN I stated the anchor should be placed where the resident wanted it to be placed. LN I stated that choice should be listed on the resident's plan of care. On 08/22/24 at 01:25 PM, Administrative Nurse D stated the facility followed the manufacturer's instructions for the placement of an anchor for suprapubic catheter tubing. Administrative Nurse D stated an anchor could be placed on the abdomen or upper thigh for a resident with a suprapubic catheter. Administrative Nurse D stated she did not think that the placement of an anchor should necessarily be included in a resident's plan of care. The facility's Catheter Care Infection Control policy last reviewed or revised in May 2023 documented it was the policy of the facility to ensure that the residents received care and services to prevent urinary tract infections (UTIs) in those residents with an indwelling catheter, in accordance with standards of practice. Staff would check the resident's comprehensive person-centered care plan related to instructions for catheter care. The facility failed to ensure the standard of practice was followed for anchoring R12's suprapubic catheter tubing to prevent pulling or injury. This deficient practice placed R12 at risk for catheter-related complications.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41713 The facility identified a census of 93 residents. The sample included 19 residents with two residents reviewed for dialysis (a procedure where impurities or wastes were removed from the blood). Based on observation, record review, and interview, the facility failed to ensure ongoing communication and collaboration with the dialysis facility regarding dialysis care and services regarding Resident (R) 62 ' s health status with each procedure. The facility failed to ensure staff identified and assessed R62 ' s access type and location. This deficient practice placed R62 at risk for complications related to dialysis. Findings included: - R62's Electronic Medical Record (EMR) documented diagnoses of end-stage renal disease (ESRD-a terminal disease of the kidneys) and dependence on renal dialysis. The Annual Minimum Data Set (MDS) dated [DATE] for R62 documented a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. R62 required partial to moderate staff assistance for dressing, and substantial assistance for personal hygiene, and was dependent on staff for toileting and bathing. R62 utilized a wheelchair for assistance with mobility. R62 required dialysis services. R62's Quarterly MDS dated [DATE] documented a BIMS score of 15 which indicated intact cognition. R62 required partial to moderate staff assistance for dressing, and substantial assistance for personal hygiene, and was dependent on staff for toileting and bathing. R62 utilized a wheelchair for assistance with mobility. R62 required dialysis services. R62's Activities of Daily Living (ADL) Care Area Assessment (CAA) dated 03/19/24 documented she required assistance with mobility and self-care due to weakness, an unsteady gait, and medically complex conditions that placed R62 at significant risk for injury during ADLS. R62's Dialysis Care Plan dated 03/07/24 directed staff to encourage R62 to go to scheduled dialysis appointments every Tuesday, Thursday, and Saturday. Staff was to monitor, document, and report as needed any signs and symptoms of infection to the access site. Staff was directed to check and change the dressing daily at the access site, the left chest permacath catheter (a flexible, soft plastic tube that is used for short-term dialysis treatment). Staff was directed to monitor, document, and report any signs or symptoms of hemorrhage (loss of a large amount of blood in a short period of time), bacteremia (presence of bacteria in the blood), or septic shock (a life-threatening condition caused by a severe localized or system-wide infection). The plan lacked direction or interventions related to the dialysis fistula (a passage between the basilic vein and the brachial artery in the upper arm) and assessing for a thrill (a fine vibration felt which reflects the blood flow by a dialysis resident's shunt) or bruit (blowing or swishing sound heard when blood flows through a shunt) and restrictions for that extremity regarding blood pressure and lab. R62's Order Summary Report documented a physician order dated 07/16/24 to monitor the dialysis site for bleeding when returning from dialysis in the afternoon on Tuesday, Thursday, and Saturday. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R62's Order Summary Report documented a physician's order dated 12/11/23 for a permacath catheter to the left side of the chest. A 12/09/23 hospital Discharge Summary dated 12/11/23 documented R62 received dialysis and presented to the emergency room with low hemoglobin (Hgb-measure of blood that carried oxygen to the cells from the lungs and carbon dioxide away from the cells to the lungs). R62 had a left arteriovenous (AV) fistula placement procedure performed on 12/04/23. R62's Treatment Administration Record (TAR) reviewed from December 2023 to August 2024 lacked documentation of monitoring of the left AV fistula shunt access site for a thrill or bruit. The facility was unable to provide the Dialysis Communication Forms from December 2023 to June 2024. On 08/21/24 at 09:02 AM R62 sat in her wheelchair in her room. R62 stated back in December they did surgery to create the AV fistula in her left arm. R62 stated the nursing staff did send a dialysis communication sheet with her on her dialysis days, but the dialysis center did not always send the sheets back with her. On 08/22/24 at 08:00 AM Administrative Nurse D stated she was unable to find dialysis communication sheets for R62 prior to her employment at the facility. Administrative Nurse D stated that R62 went to dialysis outside of the facility and did not always return with the communication sheets. Administrative Nurse D stated she had not realized that R62 ' s orders had not been updated to reflect her having the AV fistula in her left arm so the fistula had not been monitored as it should have been. Administrative Nurse D stated R62 ' s care plan will be updated as well to reflect staff direction for the AV fistula. The Dialysis Protocol policy last revised in April 2023 documented that the dialysis site (permacath) would be checked daily for signs and symptoms of infection or bleeding. The dialysis site (fistula/graft) would be monitored daily for thrill and bruit. For residents with fistulas or grafts, documentation in the medical record would reflect arm precautions if applicable. Communication with the dialysis center would be done by nursing, dietary, and or social services monthly. The resident ' s care plan would reflect their dialysis needs. The facility failed to ensure ongoing communication and collaboration with the dialysis facility regarding dialysis care and services regarding R62 ' s health status with each procedure. The facility failed to ensure staff identified and assessed R62 ' s access type and location. This deficient practice placed R62 at risk for complications related to dialysis.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. 45668 The facility identified a census of 93 residents. The sample included 19 residents with two residents reviewed for accidents. Based on observation, record review, and interviews, the facility failed to assess the risks of bedrail use related to Resident (R) 73's low air-loss mattress. This placed R73 at risk for impaired safety related to unidentified risks associated with the use of bedrails. Findings Included: -The Medical Diagnosis section within R73's Electronic Medical Records (EMR) included diagnoses hemiplegia and hemiparesis (weakness and paralysis on one side of the body), cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), chronic kidney disease, neuromuscular dysfunction of the bladder, and seizures (violent involuntary series of contractions of a group of muscles). R73's Significant Change Minimum Data Set (MDS) completed 07/10/24 noted a Brief Interview for Mental Status (BIMS) score of six indicating severe cognitive impairment. The MDS indicated he had impairment to one side of his upper extremity and both his lower extremities. The MDS indicated he was dependent on staff assistance for bed mobility, changing lying positions, sitting up, standing, and transfers. The MDS noted he didn't have bed rails or restraints in place. R73's Functional Abilities Care Area Assessment (CAA) completed 07/10/24 indicated he required limited to extensive assistance with his activities of daily living (ADLs). The CAA indicated the care plan would provide interventions to minimize the risk related to his ADL deficit. R73's Care Plan initiated 03/27/24 indicated he had a self-care deficit related to his medical diagnoses and limited physical mobility. The plan noted he was dependent on staff for assistance with his toileting, dressing, bed mobility, transfers, personal hygiene, and bathing. The plan noted he used a wheelchair for mobility. The plan indicated he had a low air-loss mattress on his bed. The plan lacked documentation related to his bed rails and/or assistive positioning devices. A review of the low air-loss mattress manufacturer's operation (ProActive Protekt Aire) manual indicated the usage of bed rails should be appropriately assessed, monitored, and maintained to reduce the risk of entrapment. R73's EMR under Evaluations revealed a Quarterly Nursing Evaluation completed 03/27/24 indicating he had a right-sided assist bar installed on his bed. The evaluation indicated he was able to follow commands and demonstrated fine motor skills. The evaluation indicated he was safe to use the assist bar. The evaluation did not address or acknowledge his low air-loss mattress system or the associated risks of use with the assist bar. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R73's EMR under Evaluations revealed a Device Evaluation completed on 06/25/24 indicating he had a right-sided assist bar installed on his bed. The evaluation noted the assist bars provided increased independence and bed mobility. The evaluation noted R73 was able to follow commands and demonstrated the motor skills to utilize the assist bars. The evaluation noted he was safe to have one bar installed on his bed. The evaluation did not acknowledge or address his low air-loss mattress system or the associated risks of use with the assist bar. R73's EMR under Evaluations revealed a Bed Rail Informed Consent for Use form completed on 06/25/24 indicating he would have assistive rails used to promote independence and improve bed mobility. The consent form identified the risk of entrapment but failed to acknowledge his low air-loss mattress system and the associated risks of use. On 08/21/24 at 07:03 AM R73 slept in his bed. R73 had a bedrail installed on the upper right side of his bed. R73's bed was in a low position with the head of the bed elevated above 30 degrees. R73 had a low air-loss mattress system on his bed. The mattress was set to 350 pounds (lbs.). On 08/22/24 at 12:23 PM Licensed Nurse (LN) I stated the bed rails should be monitored each time staff enters the resident's room to ensure safety. She stated the assist rails were assessed upon installation but she was not sure how often staff rechecked them or if the low air-loss mattresses were included as part of the assessments. She stated staff should be ensuring there is no gap between the bedrail and the mattress. On 08/22/24 at 01:24 PM Administrative Nurse D stated the device assessments for the assistive railing should also include the use of low air-loss mattresses. She stated the assessments were completed upon admission, quarterly, and whenever rails were installed on the beds. She stated R73 should have documentation showing his low air-loss mattress was included in his bedrail evaluation. The facility's Bed Rails policy revised 07/2024 indicated the facility will ensure all residents in need of bed rails were appropriately assessed for the risk of entrapment, appropriate bed dimensions, and the indication of use. The policy indicated the facility will ensure assistive devices remain restraint-free and used per the manufacturer's recommendations. The facility failed to assess the risks of bed rail use related to his low air-loss mattress system for R73. This placed R73 at risk for impaired safety related to unidentified risks associated with the use of bedrails.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 41037 The facility identified a census of 93 residents. Based on observation, record review, and interview, the facility failed to provide Registered Nurse (RN) coverage eight consecutive hours a day, seven days a week. This placed all residents who resided in the facility at risk of lack of assessment and inappropriate care. Findings included: - A review of daily posted nursing hour sheets from 03/01/23 to 08/15/24 revealed multiple dates that did not list hours for an RN. Upon request, the facility provided a spreadsheet Rainbow Labor report. RN.Date Specific submitted 08.26.24 for the requested dates. The report lacked evidence of eight consecutive hours of RN coverage for the following dates: 03/14/24, 03/18/24, 05/18/24, 06/06/24, and 06/15/24. On 08/21/24 at 03:10 PM, Administrative Staff A stated she was checking the schedule and reviewing timecards and payroll to check for RN coverage for the requested days. On 08/22/24 at 01:50 PM, Administrative Nurse D stated she was responsible for assisting human resources to ensure RN coverage. The facility did not provide a policy related to Registered Nurse coverage. The facility failed to provide RN coverage eight consecutive hours a day, seven days a week, as required. This placed the residents who resided in the facility at risk of lack of assessment and inappropriate care.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 45668 The facility reported a census of 93 residents. The sample included 19 residents with five reviewed for unnecessary medications. Based on record review, observations, and interviews, the facility failed to ensure Resident (R)79's as-needed (PRN) hydroxyzine (antihistamine also used to treat feelings of uncertainty, apprehension, or irrational fears) had a 14-day stop date or documentation of a physician rationale and rationale and specific duration of use. This deficient practice placed R79 at increased risk for unnecessary psychotropic (affects mood or thoughts) medication and related side effects. Findings Included: -The Medical Diagnosis section within R79's Electronic Medical Records (EMR) included diagnoses of hypertension (high blood pressure), congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), type two diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), and morbid obesity (extremely overweight). R79's Admission Minimum Data Set (MDS) completed 07/16/24 noted a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. The MDS indicated he had lower extremity impairment and used a wheelchair and crutches for mobility. The MDS indicated he had no behavioral symptoms upon admission. The MDS noted he took an antianxiety medication. R79's Psychotropic Drug Use Care Area Assessment (CAA) completed 07/17/24 indicated he took an antianxiety medication. The CAA instructed staff to monitor him for symptoms and side effects each shift and to notify his medical provider. The CAA noted a care plan would be completed to identify and minimize the risks related to his psychotropic medication use. R79's Care Plan initiated 07/11/24 indicated he received medications that had a black box warning. The plan instructed staff to monitor his medication for symptoms of anxiety, depression, dizziness, nausea, vomiting and altered mental status. R79's EMR under Physician's Orders revealed an active order (dated 08/01/24) for staff to administer 50 milligrams (mg) of hydroxyzine pamoate before dressing changes and every six hours as needed for anxiety. The order lacked a stop date. R79's EMR lacked physician documentation for the continuation of the medication past the 14-day stop date required. The facility was unable to provide the documentation as requested on 08/22/24. On 08/21/24 at 09:01 AM R79 set in bed. His bed was positioned in the lowest position. His feet were propped up on a pillow. R79 stated he felt better that he was off his antibiotic medication and looking forward to finishing his therapy. He denied pain or discomfort. He reported no concerns with his medication. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/22/24 at 12:42 PM Licensed Nurse (LN) G stated PRN psychotropic medication should have a 14-day stop date or the medical provider should provide guidance for the extended use of the medication. On 08/22/24 at 01:24 PM Administrative Nurse D stated antianxiety medication should have the required 14-day stop date or documentation showing the medical provider's intent for continuation of the medication. The facility's Physician Orders policy revised 11/2020 indicated all medication will be administered as ordered by the medical provider. The policy indicated medication orders will be reviewed by the nursing staff, pharmacist, and physician to ensure appropriate indication. The policy indicated PRN psychotropic medications will include the appropriate indication, monitoring, and stop date as ordered by the prescriber. The facility failed to ensure R79's PRN hydroxyzine had a 14-day stop date or a documented physician rationale and specified duration. This deficient practice placed R79 at increased risk for unnecessary psychotropic medication and side effects.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 45668 The facility reported a census of 93 residents. The facility identified one medication room and six medication carts. Based on observations, record reviews, and interviews, the facility failed to store medications securely to limit access when staff failed to lock three medication carts. This deficient practice placed the residents at risk for unsafe medication practices and misappropriation. Findings Included- - On 08/20/24 at 07:09 AM an inspection of the treatment cart stationed across from the fourth-floor elevators revealed an unsupervised and unsecured treatment cart. The cart contained 12 labeled but unsecured insulin (hormone used to lower blood glucose levels) pens stored in the top drawer of the cart. On 08/20/24 at 07:15 AM an inspection of the treatment cart stationed next to the fourth-floor rehab gym entry revealed the cart was left unattended and unlocked. An inspection of the cart revealed 10 labeled but unsecured insulin pens inside the cart. The cart also contained assorted medicated creams and ointments. Licensed Nurse (LN) H secured the cart. Another unsecured medication cart was stationed on the fourth floor across the hall from Resident (R)50's room that revealed six labeled but unsecured insulin pens inside the cart. The cart also contained assorted medicated creams and ointments. LN H secured the cart. On 08/20/24 at 07:23 AM LN H stated that sometimes the night shift moves items between the carts to match their assigned residents and forgets to lock the carts. She stated the carts should be locked when not in use or supervised. On 08/22/24 at 01:25 PM Administrative Nurse D stated the medication carts should be locked when staff were not directly using or monitoring them. The facility's Medication Access and Storage policy reviewed 01/2023 indicated all medications and biologicals were to be stored in a safe manner following the manufacturer's storage recommendations. The policy indicated medications should be properly labeled with the recommended expiration dates and stored in a manner appropriate for the specific medication. The facility failed to store medications securely to limit access when staff failed to lock three medication carts. This deficient practice placed the residents at risk for unsafe medication practices and misappropriation.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 41713 The facility identified a census of 93 residents. The facility identified one main kitchen and two kitchenette areas. Based on observation, record review, and interview, the facility failed to ensure food items were appropriately labeled and stored after the original package had been opened. This placed residents at risk of food-borne illnesses and food safety concerns. Findings Included: - The initial tour of the main kitchen on 08/20/24 at 07:17 AM revealed the following items in the walk-in refrigerator area that were unlabeled or updated: Two containers of shredded cheese with no date or label. One piece of cake wrapped in plastic wrap, with no label or date. Three containers with numerous slices of cheese with no label or date. Half of an onion in a plastic Ziplock bag with no label or date. A bag of thinly sliced ham, turkey, and roast beef not sealed with no label or date. Five more slices of cake on plates wrapped in plastic without a label. On 08/20/24 at 07:35 AM, the 400-floor kitchenette area had sugar granules on the main counter as well as on the counter near the serving area. The water and ice machine had water deposit stains around the dispenser spout. On 08/20/24 at 07:24 AM Dietary Staff BB stated all the food items that had been opened should be placed in a sealed bag or container and a label placed on the items with the name of the food, the date, as well as the expiration date. Dietary Staff BB stated she had just gone over all of this with the kitchen staff. On 08/21/21/24 at 11:05 AM Dietary CC stated he expected all staff to date and label all items upon them being opened. Dietary CC stated items should also be placed in a sealed bag or container and a sticker placed on the bag or container with the food item, the date, and the expiration date. The Policy & Procedure Manual for food storage documented that stored food was handled to prevent contamination and growth of pathogenic (viruses, bacteria, and other types of germs that cause disease) organisms. Perishable ingredients should be refrigerated when they are not being used. All time and temperature control for safety (TCS) foods should be labeled, covered, and dated when stored. When a food package is opened, the food item should be marked to indicate the open date. This date was used to determine when to discard the food. Leftovers should be used within 72 hours (or discarded). (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility failed to ensure food items were appropriately labeled and stored after the original package had been opened. This placed residents at risk of food-borne illnesses and food safety concerns.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 49634 The facility identified a census of 93 residents. The facility identified 27 residents on Enhanced Barrier Precautions (EBP-infection control interventions designed to reduce transmission of resistant organisms which employs targeted gown and glove use during high contact care). Based on record review, observations, and interviews, the facility failed to follow sanitary infection control standards related to the use of personal protective equipment (PPE) for EBP. The facility further failed to implement a water management program to address and mitigate the risk of Legionella disease (Legionella is a bacterium that can cause pneumonia in vulnerable populations) and other waterborne pathogens. These deficient practices placed the residents at increased risk for infectious diseases. Findings Included: - On 08/21/24 at 10:41 AM R237 ' s room had signage posted that indicated EBP should be implemented. Licensed Nurse (LN) L entered R237 ' s room and without wearing a gown, as directed by the EBP, LN L proceeded to change R237 ' s wound dressing. On 08/22/24, upon request, the facility was unable to provide a risk assessment and water management program for Legionella and other water-borne pathogens. On 08/22/24 at 11:02 AM Administrative Staff A stated the facility did not have a water management program for Legionella. She stated the facility did not own the building, and that the owners of the building would have that information. On 08/22/24 at 12:17 PM Administrative Staff C stated all staff have been trained on the use of EBP. Administrative Staff C stated the signs were posted to inform staff what PPE to use for EBP. 08/22/24 at 01:49 Administrative Nurse D stated all nurses had been trained on the use of PPE and EBP. She stated that nurses should wear a gown to perform wound care. The facility's Infection Control policy revised 05/2024 documented the facility will facilitate safe care of all residents and staff with known or suspected communicable diseases by stabilizing and maintaining an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The Infection Prevention and Control Program will follow accepted Federal standards including but not limited to the Centers for Disease Control (CDC), and is based on facility assessment and includes prevention, identification reporting, investigation, and controlling infections and communicable diseases for all residents. The infection control program includes surveillance, investigation, control, and prevention of infection in the facility. The facility failed to follow sanitary infection control standards related to the use of PPE for EBP. The facility further failed to implement a water management program to address and mitigate the risk of Legionella and other waterborne pathogens. These deficient practices placed the residents at increased risk for infectious diseases.

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F 0942 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that staff members are educated on resident rights and facility responsibilities to properly care for its residents. 41037 The facility identified a census of 93 residents. Based on record review and interviews, the facility failed to ensure agency staff received the required resident rights training. This placed the residents at risk for impaired care and decreased quality of life. Findings included: - On 08/22/24 at 08:15 AM the facility was unable to provide the training records for agency Licensed Nurse (LN) K. On 08/22/24 at 10:30 AM, Administrative Staff A stated the facility relied on the agency company to ensure required education was provided and records maintained. Administrative Staff A stated the agency company was a sister company to the facility. Administrative Staff A stated she was waiting for the agency to send the facility the requested staff information. The facility was unable to provide a policy related to required education for direct care staff. The facility failed to ensure agency staff received the required resident rights training. This placed the residents at risk for impaired care and decreased quality of life.

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. 41037 The facility identified a census of 93 residents. Based on record review and interviews, the facility failed to ensure agency staff received the required abuse, neglect, and exploitation (ANE) training. This placed the residents at risk for ANE. Findings included: - On 08/22/24 at 08:15 AM the facility was unable to provide the training records for agency Licensed Nurse (LN) K. On 08/22/24 at 10:30 AM, Administrative Staff A stated the facility relied on the agency company to ensure required education was provided and records maintained. Administrative Staff A stated the agency company was a sister company to the facility. Administrative Staff A stated she was waiting for the agency to send the facility the requested staff information. The facility was unable to provide a policy related to required education for direct care staff. The facility failed to ensure agency staff received the required ANE training. This placed the residents at risk for ANE.

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F 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Include as part of its infection prevention and control program, mandatory training that includes written standards, policies, and procedures for the program. 41037 The facility identified a census of 93 residents. Based on record review and interviews, the facility failed to ensure agency staff received the required infection control training. This placed the residents at increased risk for infections. Findings included: - On 08/22/24 at 08:15 AM the facility was unable to provide the training records for agency Licensed Nurse (LN) K. On 08/22/24 at 10:30 AM, Administrative Staff A stated the facility relied on the agency company to ensure required education was provided and records maintained. Administrative Staff A stated the agency company was a sister company to the facility. Administrative Staff A stated she was waiting for the agency to send the facility the requested staff information. The facility was unable to provide a policy related to required education for direct care staff. The facility failed to ensure the completion of the required infection control training for staff who provided care in the facility. This placed the residents at increased risk for infections.