STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175560	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Village	12500 W 137th St Overland Park, KS 66221

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 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** 45668 The facility identified a census of 36 residents. The sample included 13 residents with one resident reviewed for hospitalization . Based on observation, interview, and record review, the facility failed to provide written notification of transfer to Resident (R)32 and/or their representative, with a written notice specifying the location and reason for R32's facility-initiated transfer. This deficient practice placed R32 at risk for miscommunication between the facility and resident/representative and possible missed opportunities for healthcare services. Findings included: - The Medical Diagnosis section within R32's Electronic Medical Records (EMR) included diagnoses of dysphagia (difficulty swallowing), cognitive-communication disorder, dementia (a progressive mental disorder characterized by failing memory and confusion), and acute kidney failure. R32's Discharge Minimum Data Set (MDS) completed 10/04/24 indicated she was discharged with an anticipated return to the facility. The MDS indicated she was discharged to a short-term hospital. R32's Entry MDS completed on 10/06/24 indicated she returned to the facility from an acute hospital stay. R32's Significant Change MDS completed 10/14/24 noted a Brief Interview for Mental Status Score of 11 indicating moderate cognitive impairment. The MDS noted she required substantial to maximal assistance from staff for bed mobility, transfers, bathing, dressing, personal hygiene, and toileting. R32's EMR under Progress Notes indicated she was sent out to an acute care facility due to changes in her mental status. R32's EMR indicated she returned to the facility on [DATE]. The EMR lacked documentation showing that written notification of transfer was provided to R32 or her representative. On 10/30/24 at 09:45 AM R32 sat in her room watching television. She reported she was recently sent out to the hospital and returned two days later. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/31/24 at 10:00 AM, Administrative Staff A verified the facility is required to send both the written notification of transfer and bed hold, but he was unable to find it for R32's hospitalization . The facility did not provide a policy related to transfers and discharges. The facility failed to send a written notification of a facility-initiated transfer for R32. This deficient practice placed R32 at risk for miscommunication between the facility and resident/representative and possible missed opportunities for healthcare services.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 45668 The facility identified a census of 36 residents. The sample included 13 residents with one resident reviewed for hospitalization . Based on observation, interview, and record review, the facility failed to provide a copy of the bed hold policy to Resident (R)32 and/or their representative, when R32 was transferred to the hospital. This deficient practice placed R32 at risk for impaired right to return to the facility to the same room. Findings included: - The Medical Diagnosis section within R32's Electronic Medical Records (EMR) included diagnoses of dysphagia (difficulty swallowing), cognitive-communication disorder, dementia (a progressive mental disorder characterized by failing memory and confusion), and acute kidney failure. R32's Discharge Minimum Data Set (MDS) completed 10/04/24 indicated she was discharged with an anticipated return to the facility. The MDS indicated she was discharged to a short-term hospital. R32's Entry MDS completed on 10/06/24 indicated she returned to the facility from an acute hospital stay. R32's Significant Change MDS completed 10/14/24 noted a Brief Interview for Mental Status Score of 11 indicating moderate cognitive impairment. The MDS noted she required substantial to maximal assistance from staff for bed mobility, transfers, bathing, dressing, personal hygiene, and toileting. R32's EMR under Progress Notes indicated she was sent out to an acute care facility on 10/04/24 due to changes in her mental status. R32's EMR indicated she returned to the facility on [DATE]. R32's medical record lacked evidence the facility sent a bed hold notice to R32 or her representative for her transfer on 10/04/24. Upon request, the facility did not provide a bed hold notice for R32's transfer on 10/04/24. On 10/30/24 at 09:45 AM R32 sat in her room watching television. She reported she was recently sent out to the hospital and returned two days later. On 10/31/24 at 10:00 AM, Administrative Staff A verified the facility is required to send both the written notification of transfer and a bed hold, but he was unable to find it for R32's hospitalization . The facility's Bed Hold policy revised 07/2024 indicated the facility will provide each resident or their representative written notifications of bed hold and the facility's return policy. The facility failed to provide a copy of the bed hold policy for a transfer to the hospital for R32. This deficient practice placed R32 at risk for impaired right to return to the facility to the same room.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - 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** 45668 The facility identified a census of 36 residents. The sample included 13 residents with three reviewed for pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, because of pressure, or pressure in combination with shear and/or friction). Based on interviews, observations, and record reviews, the facility failed to ensure Resident (R)7 and R16's pressure-reducing interventions were implemented correctly when their low air-loss mattress pumps were set at an inappropriate weight for each resident. This deficient practice placed all affected residents at risk for complications related to skin breakdown and pressure ulcers. Findings included: - The Medical Diagnosis section within R7's Electronic Medical Records (EMR) noted diagnoses of cognitive communication deficit, muscle weakness, insomnia (difficulty sleeping), and Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure). R7's Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of five indicating severe cognitive impairment. The MDS indicated both upper and lower extremity impairment on both sides. The MDS indicated she was totally dependent on staff assistance for bed mobility, transfers, toileting, bathing, dressing, and personal hygiene. The MDS indicated she was at risk for pressure ulcers but had no active ulcers or skin breakdown. The MDS noted she had a pressure pressure-reducing device in place for her bed and chair. The MDS indicated she weighed 111 pounds (lbs.). R7's Pressure Injuries Care Area Assessment (CAA) completed 05/03/24 indicated she was at risk for redeveloping pressure ulcers related to her urinary incontinence, limited mobility, and nutritional impairments. R7's Care Plan initiated on 12/01/21 indicated she was at risk for pressure injuries related to her immobility, fragile skin, and medical diagnoses. The MDS instructed staff to complete weekly skin assessments and skin inspections after bathing occurrences. The plan instructed staff to provide peri-care and skin barrier cream after incontinence episodes. The plan noted she had a pressure-reducing mattress in place. The plan lacked guidance on her low air-loss mattress settings. R7's EMR under Physician's Orders indicated she had a low air-loss mattress with perimeter bolsters (04/21/24). A review of the low air-loss mattress manufacturer's operation guide (ProActive Protekt Aire 8000) indicated the pump and mattress were intended to reduce the incidence of pressure ulcers while optimizing comfort. The guide indicated that firmness can be adjusted based on the recommendations of the health care professional and the patient's weight. On 10/29/24 at 07:45 AM R7 slept in her bed. She had bilateral heel protectors on both feet. Her bed is in a low position with a low air-loss mattress system in place (Proactive Protekt Model 8000). Her mattress control pump was set to 550 pounds (lbs.). The control panel for the low air-loss mattress was labeled by R7's hospice services. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/29/24 at 10:01 AM R7 rested in her bed. Her low air-loss mattress system was set to 500 lbs. On 10/31/24 at 10:19 AM R7's bed remained in the low position. Her low air-loss mattress was set to 550 lbs. On 10/31/24 Certified Nurse's Aide (CNA) M stated the air-mattress systems were set by weight, but she stated staff only ensured they were functioning. She stated staff did not change or adjust the settings on the control panel. She stated that 550 lbs. seemed too high for R7. On 10/31/24 at 12:24 PM Administrative Nurse E stated all the low air-loss mattresses were set to the resident's current weight. She stated that R7's mattress was locked in the high position over the weekend, and she contacted hospice to come out and reset it. She stated the higher weight settings added more pressure to the resident's body. The facility's Prevention of Pressure Injuries policy revised 08/2024 indicated the facility will implement preventative interventions to minimize the risk associated with skin breakdown and pressure injuries. The policy noted the facility will utilize pressure redistribution surfaces deemed appropriate based on the resident's risk factors and care needs. The facility failed to ensure R7's low air-loss mattress system was set to her appropriate weight. This deficient practice placed all affected residents at risk for complications related to skin breakdown and pressure ulcers. 41037 - R16's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of muscle weakness, hemiparesis and hemiplegia (weakness and paralysis on one side of the body), a need for assistance with personal care, and cerebrovascular accident (CVA-stroke- sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain) affecting the left non-dominant side. The Admission Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 14 which indicated intact cognition. The MDS documented that R16 had limited function of her upper and lower extremities on one side. The MDS documented R16 required substantial to maximum staff assistance for repositioning and moving from a lying to a sitting position. The MDS documented R16 was not at risk of developing pressure-related injuries. The MDS documented R16 had pressure-reducing devices on her bed and in her wheelchair. The Quarterly MDS dated [DATE] documented a BIMS score of nine which indicated moderately impaired cognition. The MDS documented R16 had limited function of her upper and lower extremities on one side. The MDS documented R16 required substantial to maximum staff assistance for repositioning and moving from a lying to a sitting position. The MDS documented R16 was at risk of developing pressure-related injuries. The MDS documented R16 had pressure-reducing devices on her bed and in her wheelchair. R16's Pressure Ulcer Care Area Assessment (CAA) dated 03/10/24 documented she was at risk related to bowel incontinence and required staff assistance for mobility. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R16's Care Plan dated 03/17/24 documented that staff would encourage good nutrition and hydration to promote healthier skin. The plan of care documented that staff would keep R16's hands and body parts from excessive moisture. The plan of care also directed staff to use a draw sheet or lifting device to move R16. The plan of care directed staff to use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surfaces. R16's EMR under the Orders tab revealed the following physician orders: Zinc cream to bilateral buttocks every shift and as needed for moisture-associated skin damage (MASD-inflammation or skin erosion caused by prolonged exposure to a source of moisture such as urine, stool, sweat, wound drainage, saliva, or mucous) dated 02/29/24. Cleanse the right buttock with wound cleanser apply a nickel-thick layer of Santyl (prescription ointment is used to remove damaged tissue from skin ulcers) ointment and cover with dry dressing. Change every other day and as needed dated 10/25/24. R16's EMR under the Assessments tab revealed a Braden scale (for predicting pressure ulcer risk evaluation) that indicated R16 was at high risk for the development of pressure-related injuries. R16's EMR under the Weights/Vitals tab revealed R16's weight was 197.6 pounds (lbs) dated 10/29/24. A review of the low air-loss mattress manufacturer's operation (Breath Drive Model #140530) manual indicated the mattress system was intended to reduce the incidence of pressure ulcers while optimizing comfort. The manual indicated the mattress pump's pressure levels and firmness were preset based on the weight range and comfort settings. The manual indicated an optimal bed system assessment should be conducted on each patient by a qualified clinician or medical provider to ensure maximum safety. On 10/30/24 at 09:27 AM R16 lay on the bed with her bilateral heels resting directly on the bed. Further observation revealed two blue heel protectors sat in the recliner. R16' low air loss mattress (Breath Drive Model #140530) was set at 300 lbs. Licensed Nurse (LN) G donned a gown and pair of gloves, then gathered wound care supplies. LN G placed a clean barrier on R16's bedside table and then placed wound care supplies on the clean barrier. LN G removed her gloves washed her hands and donned a new set of gloves. LN G assisted R16 to turn onto her left side. While repositioning R16 onto her left side, R16's left heel slid across the sheets. LN G removed R16's incontinence brief and wiped R16's rectal area with the incontinence brief to remove fecal material from R16's rectal area. LN G had R16 roll back onto her back. LN G doffed her gloves and gown, performed hand hygiene, and left R16's room. LN G returned to the room with cleansing wipes. LN G donned a gown and gloves, then assisted R16 onto her left side again. R16's left heel slid along the sheets. LN G cleaned the fecal material from R16's rectal area. R16 did not have a dressing on her right buttocks. LN G doffed her gloves and donned a new pair of gloves without performing hand hygiene. LN G then cleansed R16's right buttocks with wound cleaner and opened a package that contained a dry dressing. Wearing the same soiled gloves, LN G opened the Santyl ointment, placed the ointment onto the dry dressing, and then placed the dressing onto R16's right buttocks. LN G assisted R16 onto her back, and R16's left heel slid on the sheets. LN G doffed her gown, placed R16's wound care items back into the cabinet then doffed her gloves and performed hand hygiene. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/31/24 at 10:13 AM, Certified Nurse Aide (CNA) M stated he had access to the resident's care and Kardex (a nursing tool that gives a brief overview of the care needs of each resident). CNA M stated the Kardex would have personalized interventions for each resident. CNA M stated he would just ensure a resident's low air loss mattress was working and would not adjust the settings. CNA M stated hand hygiene should be performed between glove changes and when going from dirty to clean. On 10/31/24 at 11:47 AM, Licensed Nurse (LN) H stated nursing would ensure the low air loss mattress was working and would not adjust the settings. LN H stated the wound nurse would check the low air loss mattress weekly to ensure the settings were correct for each resident. LN H stated everyone had access to the care and the Kardex. LN H stated that R16's pressure-reducing devices should be on her care plan. LN H stated hand hygiene would be performed between glove changes or going from dirty to clean. LN H stated if there were heel protectors on R16's recliner then she should wear the heel protectors. On 10/31/24 at 01:00 PM, Administrative Nurse D stated hand hygiene should be performed between glove changes when providing resident care. Administrative Nurse D stated the facility would follow the physician's orders for pressure-reducing devices for each resident. Administrative Nurse D stated the wound nurse was responsible for ensuring each resident's low air loss mattress was on the correct setting. Administrative Nurse D stated she believed the low air loss mattresses are set by weight. On 10/31/24 at 01:15 PM, Administrative Nurse E stated the equipment provider was given the resident's weight and height to set up the low air loss mattress. Administrative Nurse E stated she would monitor each of the low air loss mattresses weekly to ensure the settings were set correctly. Administrative Nurse E stated the low air loss mattresses were set by weight and could cause further skin damage if not set at the correct setting. Administrative Nurse E stated skin prevention devices that would be initiated varied for each resident. Administrative Nurse E stated that pressure-related interventions should be care-planned. The facility's Prevention of Pressure Injuries policy last revised 08/2024 documented that the purpose of this procedure was to provide information regarding the identification of pressure injury risk factors and interventions for specific risk factors. Review the resident's care plan and identify the risk factors as well as the interventions designed to reduce or eliminate those considered modifiable. Reposition the resident as indicated on the care plan. Review and select medical devices with consideration to the ability to minimize tissue damage, including size, shape, application, and ability to secure the device. Monitor regularly for comfort and signs of pressure-related injury or prevention measures associated with specific devices, and consult current clinical practice guidelines. Evaluate, report, and document potential changes in the skin. Review the interventions and strategies for effectiveness on an ongoing basis. The facility failed to ensure that R16's pressure-reducing interventions were adequately implemented. This deficient practice placed R16 at risk for complications related to skin breakdown and worsening pressure ulcers.

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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 36 residents. The sample included 13 residents with two residents reviewed for catheter (a flexible tube inserted through a narrow opening into a body cavity, particularly the bladder, for removing fluid) care. Based on observation, record review, and interviews, the facility failed to ensure Resident (R) 36 had a physician-ordered indication for an indwelling catheter and failed to provide adequate catheter care within the standards of care. This deficient practice placed R36 at risk of catheter-related complications and urinary tract infections (UTI). Findings included: - R36's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of muscle weakness, need for assistance with personal care, and hypertension (HTN-elevated blood pressure). The Admission Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 14 which indicated intact cognition. The MDS documented R36 had an indwelling catheter during the observation period. R36's Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA) dated 10/25/24 documented a foley catheter was placed after admission and the resident required assistance with her catheter care. R36's Care Plan dated 10/26/24 documented the staff would position the catheter drainage bag below the level of her bladder and away from the entrance of her room. The plan of care directed the staff to check for kinks in the catheter tubing when providing activities of daily living care (ADL) care. The plan of care also documented nursing staff would monitor and document her intake and output. The plan of care documented the nursing staff would monitor for signs and symptoms of discomfort during urination of frequency. R36's EMR under the Orders tab revealed the following physician orders: Foley catheter 16 French (FR) 10 cubic centimeter (cc) bulb dated 10/22/24. The order lacked an indication for a catheter. Output every day and night shift for retention, record Foley catheter output dated 10/22/24. Macrobid (antibiotic) oral capsule 100 milligrams (mg) give one capsule by mouth two times a day for UTI for seven days 10/24/24. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/29/24 at 09:15 AM R36 sat in her wheelchair. Certified Nurse Aide (CNA) M and CNA N donned their gowns and gloves. CNA M placed the mechanical sit-to-stand lift in front of R36. CNA M then placed R36's catheter bag onto the side of the knee brace on the mechanical lift. Using the lift, staff transferred R36 onto the toilet. CNA N removed R36's pants and incontinent brief. CNA N provided peri-care to R36's rectal area. CNA N removed her gloves, and without performing hand hygiene, donned another pair of gloves. CNA M provided peri-care around R36's catheter. CNA M wiped several swipes with one cleansing wipe around the catheter tubing and the peri-area. Wearing the same soiled gloves, CNA M transferred R36 back into her wheelchair and placed her catheter drainage bag back into the privacy bag. CNA M and CNA N removed their gowns and gloves. On 10/31/24 at 10:13 AM, CNA M stated the CNAs performed the catheter care after being trained during orientation. CNA M stated hand hygiene should be performed between glove changes and when going from dirty to clean. On 10/31/24 at 11:47 AM, Licensed Nurse (LN) H stated the nurse would provide catheter care every shift. LN H stated hand hygiene would be performed between glove changes or going from dirty to clean. LN H stated that R36 would need an indication for the use of a Foley catheter. On 10/31/24 at 12:20 PM, Administrative Nurse D stated she expected R36 to have an indication for the use of a Foley catheter. Administrative Nurse D stated hand hygiene should be performed between glove changes and providing resident care. The facility's Handwashing/Hand Hygiene policy last revised 08/2024 documented the facility considered hand hygiene the primary means to prevent the spread of healthcare-associated infections. All personnel are trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections. All personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to other personnel, residents, and visitors. The facility failed to ensure R36 had an appropriate indication for an indwelling catheter and failed to ensure the standard of care was provided during catheter care. This deficient practice placed R36 at risk of catheter-related complications and further UTIs.

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 45668 The facility identified a census of 36 residents. The sample included 13 residents with one reviewed for nutrition. Based on observation, record review, and interviews, the facility failed to provide nutritional interventions to prevent Resident (R)25's identified and continued slow weight loss. As a result of the deficient practice, R25 had a significant unplanned weight loss of 13.06 percent (%) within three months. This also placed R25 at risk for malnourishment related complications. Findings Included: - The Medical Diagnosis section within R25's Electronic Medical Records (EMR) included diagnoses of insomnia (difficulty sleeping), progressive supranuclear palsy (PSP- a rare neurodegenerative disorder characterized by progressive deterioration of the brain cells), dementia (a progressive mental disorder characterized by failing memory and confusion), and dysphagia (difficulty swallowing). R25's Admission Minimum Data Set (MDS) completed 05/15/24 noted a Brief Interview for Mental Status (BIMS) score of six indicating severe cognitive impairment. The MDS indicated he had no upper or lower extremity impairment. The MDS indicated he required partial to moderate assistance from staff for dressing, bed mobility, transfers, toileting, and bathing. The MDS noted he required set-up and clean-up assistance for meals. The MDS noted no swallowing disorders and recorded the resident weighed 164 pounds (lbs.). The MDS indicated he was not on a physician-prescribed weight-loss program. The MDS noted a therapeutic diet was in place. R25's Quarterly MDS completed 08/12/24 indicated a BIMS score of four indicating severe cognitive impairment. The MDS indicated he had no upper or lower extremity impairment. The MDS indicated he required partial to moderate assistance from staff for dressing, bed mobility, transfers, toileting, and bathing. The MDS noted he required set-up and clean-up assistance for meals. The MDS noted no swallowing disorders, and documented he weighed 150 lbs. The MDS noted he had a weight loss of five percent or more in the last month or ten percent or more in the last six months. The MDS indicated he was not on a physician-prescribed weight-loss program. The MDS indicated no nutritional approaches were in place. R25's Nutritional Care Area Assessment (CAA) completed 05/16/24 indicated he was at risk for nutritional impairment. The CAA noted he was on a regular diet with regular texture. The CAA noted no chewing or swallowing issues, and documented he was independent with meals. The CAA noted that R25 reported a lack of appetite for the last six months. The CAA noted he weighed 163.8 lbs. and was slightly underweight. The CAA noted R25's usual body weight was between 185-190 lbs. and noted he had a gradual progressive weight loss over the last six months. R25's Functional Abilities CAA completed 05/20/24 indicated he had impaired balance and decreased safety awareness due to his medical diagnosis. The CAA noted he required stand-by assistance from staff to complete self-care and his activities of daily living (ADLs). The CAA noted he preferred to sleep in until 10:00 AM and did not typically eat breakfast. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Actual harm Residents Affected - Few	R25's Care Plan initiated 05/16/24 indicated a nutritional risk due to his medical diagnosis. The plan instructed staff to administer his medications as ordered and monitor side effects (05/16/24). The plan instructed staff to monitor and report signs of dysphagia, choking, coughing, drooling, and food pocketing (05/16/24). The plan instructed staff to monitor his labs (05/16/24). The plan instructed staff to weigh him at the same time each day specific to the facility protocol (05/16/24). The plan instructed staff to provide and serve supplements as ordered (05/16/24). The plan indicated he was on a regular diet with regular textures, and thin liquids (05/16/24). The plan indicated the Registered Dietician (RD) will evaluate and make recommendations as needed (05/16/24). The plan instructed staff to offer R25 assistance with his meals (05/21/24). On 06/18/24, R25's plan noted to continue current interventions. R25's EMR under Weights revealed he weighed 163.8 lbs. during his admission on 05/09/24. R25's EMR under Physician Orders revealed an active order started on 05/09/24 for weekly weight monitoring. R25's EMR under Physician's Orders revealed an order started 05/10/24 for R25 to receive a regular diet with regular textures and thin liquids. The order instructed staff to cut up his meats and not to give him straws. R25's EMR under Nutritional Note completed 05/10/24 indicated he preferred small portions and ate two to three meals daily. The note indicated he would be added to the supplemental nutrition program for weight gain. The note revealed his representative reported he had difficulty swallowing and food would get caught in his throat. The note indicated he liked fresh fruits, sandwiches, and soft drinks. The note indicated he had weight loss prior to his admission and was at risk for continued loss. R25's EMR revealed a Nutritional Risk Assessment completed on 05/15/24 indicated R25's usual body weight (UBW) was between 185-190 lbs. The assessment indicated he weighed 163.8 lbs. and had weight loss before his admission. The assessment noted he was ambulatory, alert, and able to feed himself. The assessment noted no chewing or swallowing concerns. R25's EMR revealed a Mini Nutrition evaluation completed on 05/15/24 noted a score of seven indicating malnourishment (lack of the required nutrients within the body). The EMR revealed his weight decreased to 155 lbs. on 06/19/24 indicating a 5.37 % weight loss since his admission. R25's EMR lacked evidence the facility implemented nutritional interventions to prevent further weight loss after the 5.37 % loss was recorded. R25's EMR under Resident Assessment Review (RAR) was completed on 07/03/24 which noted his weight was 153.6 lbs. and stable. R25's EMR indicated his weight decreased to 150.2 lbs. on 07/09/24 indicating an 8.30% weight loss since his admission. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	R25's EMR under Resident Assessment Review (RAR), completed on 07/10/24, indicated he had a slow weight loss and weighed 150.2 lbs. The note indicated he was having trouble feeding himself and got upset if his wife or staff attempted to assist him. The note indicated the Certified Dietary Manager (CDM) and medical provider were notified. The note indicated he continued to struggle with impulsive behaviors, short-term memory, and sun-downing (a condition where a person tends to become confused or disoriented toward the end of the day). R25's EMR under Progress Note revealed a speech therapy note completed on 07/11/24. The note indicated an evaluation was completed for R25's self-feeding abilities. The note indicated his abilities were found to be at baseline and speech therapy was not recommended at the time. R25's EMR under Resident Assessment Review (RAR) completed on 07/15/24 indicated he continued to have difficulties feeding himself. The note indicated he weighed 150.2 lbs. with slow weight loss. The note indicated the CDM, and medical provider were notified. The note indicated he continued to struggle with impulsive behaviors, short-term memory, and sun-downing. R25's EMR under Resident Assessment Review (RAR) completed on 07/24/24 indicated R25 continued to have slow weight loss and weighed 150.2 lbs. The note indicated the CDM, and medical provider were notified. R25's EMR indicated his weight decreased to 145.8 lbs. on 07/25/24 indicating a 10.99% weight loss since his admission (77 days). R25's EMR under Physician Orders revealed an order started on 07/30/24 for him to receive an Ensure dietary supplemental drink at bedtime for weight loss. A review of R25's EMR under Physician's Order's from 05/09/24 through 07/30/24 revealed no order related to nutritional supplements. A review of R25's EMR under Administration Report from 05/09/24 through 07/30/24 revealed no nutritional supplements were administered prior to 07/30/24. R25's EMR under Resident Assessment Review (RAR) completed on 07/31/24 indicated he continued to have weight loss concerns, but his weight increased to 148.2 lbs. R25's EMR under Progress Note revealed a medical provider consultation note completed on 08/05/24. The note indicated that R25's representative reported that R25 had been vomiting up his food for the last two weeks randomly when he ate solid foods. The note indicated his medications were adjusted. R25's EMR under Resident Assessment Review (RAR) completed on 08/08/24 indicated he continued to have slow weight loss and weighed 147.7 lbs. The note indicated the CDM, and medical provider were notified. R25's EMR under Resident Assessment Review (RAR) completed on 08/21/24 indicated he continued to have slow weight loss and weighed 142.4 lbs. The note indicated he was seen by the Registered Dietician (RD) on that day for continued weight loss. The note indicated speech therapy was to evaluate him due to coughing and vomiting during meals. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	R25's EMR under Progress Notes revealed and care plan meeting note completed on 08/21/24 was held to discuss his continued weight loss and difficulty swallowing. The note indicated that R25's family brought in protein powder and supplemental shakes to offer to R25. The note indicated his Ensure supplement was changed to lunch due to R25's preferences. R25's EMR under Progress Notes revealed a dietary note completed on 08/09/24 that indicated he was triggered for a significant weight loss. The note indicated he had a loss of 7.5% within 90 days and 10% within 180 days with a current weight of 147.4 lbs. while trending downward. The note indicated he slept through breakfast and had difficulty feeding himself. The note indicated he got upset if assistance was offered by his representative or staff. The note indicated he was on a specialized nutrition plan and had dietary supplements at bedtime that week. R25's EMR under Physician Orders revealed an order started on 08/21/24 for him to receive an Ensure dietary supplement drink in the afternoons mixed with his ice cream. The note indicated his family supplied his protein powder for mixing. R25's EMR under Assessments revealed results for his swallow study completed on 08/23/24. The results revealed aspiration with straws or large consecutive drinks. The study recommended small sips and bites. The study recommended one to two dry swallows after each bite or sip and discouraged the use of straws. R25's EMR under Physician Orders revealed an order started on 08/27/24 for R25 to receive ice cream with his lunch in the afternoon for supplemental nutrition. The note indicated a bedtime supplement was added to his orders. On 10/30/24 at 07:20 AM R25 sat in the dining room for breakfast. R25's food arrived, and he began eating without concerns. His breakfast meat arrived cut into small bites and his drink had no straw. He reported his meal was good. No aspiration or choking was observed during breakfast. On 10/31/24 at 10:17 AM Certified Nurse Aide (CNA) H stated residents at risk for potential weight loss were closely monitored for food intake, eating habits, and inconsistent weights. He stated direct care staff would report directly to the nurse if changes were found. He stated he offered R25 assistance during meals and ensured his meal was correct. He stated some of the resident had supplements order like Ensure drinks. He stated R25 had supplements ordered from him and staff would mark if consumed. On 10/31/24 at 10:45 AM Licensed Nurse (LN) G stated R25 struggled when he got to the facility due to his lack of appetite and eating habits. She stated resident with weight loss should identified and put on a nutrition monitoring program. She stated staff should review their orders and care plans and ensure the correct diet, assistance, and supplements were provided. She stated R25's representative would also come to the facility to assist him. She stated she would bring him supplemental powder to mix in his shakes and meals. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	On 10/31/24 at 12:15 PM Administrative Nurse D stated R25 was admitted to the facility after having concerns related to weight loss. She stated his medical condition made it difficult for him to eat. She stated it the facility attempted several interventions to prevent further loss. She stated supplemental nutrition was added to his diet and his wife brought in powder to mix with shakes for further nutrition. She stated his wife also takes him out of the facility for meals. She stated his overall weight and functionality had improved since arriving at the facility. On 11/04/24 at 09:00 AM the RD remained unavailable for interview. The facility's Weight Assessment and Intervention policy revised 08/2024 indicated all residents will be screened for potential weight loss and nutritional impairments. The policy indicated residents at risk for significant weight loss will be care plan based on nutritional impairments to include special dietary requirements, medication review, health, and preferences. The policy noted interventions will be implemented to prevent further weight loss. The policy indicated all residents will be monitored by the registered dietician, pharmacist, and medical provider. The policy indicated the facility will provide appropriate dietary nutrition and supplementation. The facility failed to provide nutritional interventions and failed to involve the RD when initial weight loss was noted to prevent continued unplanned weight loss for R25. As a result of the deficient practices, R25 had a significant unplanned weight loss of 13.06 % within three months. This also placed R25 at risk for malnourishment related complications.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. 45668 The facility had a census of 36 residents. The sample included 13 residents. Five Certified Nurse Aides (CNAs) were reviewed for yearly performance evaluations and in-service training. Based on record review and interview, the facility failed to ensure one of the five reviewed CNA staff had the required yearly performance evaluations completed. This placed the residents at risk for inadequate care. Findings included: - A review of the facility's performance evaluation and in-service records revealed the following: CNA O, hired on 06/21/23, had no yearly performance evaluations. On 10/31/24 at 12:15 PM Administrative Nurse D stated the facility did not have the required yearly performance evaluations for CNA O. She stated yearly performance evaluations were completed annually for all CNA staff. The facility's Staff Requirement policy 06/2010 indicated performance reviews will be conducted on each employee at least annually to identify to identify employee strengths and goals. The policy noted the evaluation will be utilized to determine the training needs of the employee. The facility failed to ensure one of the five CNA staff reviewed had the required yearly performance evaluations completed. This placed the residents at risk for inadequate 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. 41037 The facility identified a census of 36 residents. The sample included 13 residents with five residents reviewed for unnecessary medications. Based on observation, record review, and interviews, the facility failed to ensure that as-needed (PRN) psychotropic (alters mood or thought) medication had a 14-day stop date or a specified duration with supporting physician documentation for Resident (R) 90's PRN psychotropic medications. This placed R90 at risk for unnecessary medication administration and possible adverse side effects. Findings included: - R90's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of muscle weakness, need for assistance with personal care, anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear) disorder, and dementia (a progressive mental disorder characterized by failing memory and confusion). The Admission Minimum Data Set (MDS) was in progress not completed. R90's Care Area Assessment (CAA) was in progress and not completed. R90's Baseline Care Plan dated 10/26/24 documented that nursing staff would review her medication with the physician and pharmacist for duplicate medications or proper dosing, timing, and frequency of administration, adverse reactions, supporting diagnosis. R90's EMR under the Orders tab revealed the following physician orders: Lorazepam (antianxiety) oral concentrate two mg/milliliters (ml) give 0.25 ml by mouth every four hours as needed for moderate insomnia or moderate agitation dated 10/21/24. The PRN antianxiety medication lacked a 14-day stop date or a physician-ordered specific duration. Lorazepam oral tablet 0.5mg give one tablet by mouth every four hours as needed for moderate anxiety dated 10/21/24. The PRN antianxiety medication lacked a 14-day stop date or a physician-ordered specific duration. Lorazepam oral tablet 0.5mg give two tablets by mouth every four hours as needed for severe agitation dated 10/21/24. The PRN antianxiety medication lacked a 14-day stop date or a physician-ordered specific duration. On 10/30/24 at 03:04 PM, R90 sat upright in her Broda chair (specialized wheelchair with the ability to tilt and recline) next to the bed, asleep. On 10/31/24 at 11:47 AM, Licensed Nurse (LN) H stated PRN psychotropic medications should be given for 14 days. LN H stated the nursing staff would call the physician to clarify the PRN orders for the duration of the order. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/31/24 at 01:00 PM, Administrative Nurse D stated she expected a PRN psychotropic medication to have a 14-day stop date noted in the physician's order. Administrative Nurse D stated she was aware that R90 had three PRN Lorazepam orders. The facility's Medication Monitoring: As Needed Psychotropic Medication Orders policy dated 01/2021 documented as needed (PRN), psychotropic medications are only used for the shortest duration required and appropriate documentation was included in the resident's medical record to support use as outlined per Center for Medicare and Medicaid Services (CMS) requirements. PRN orders for psychotropic medications orders would be for 14 days. The facility failed to ensure R90's PRN lorazepam had a stop date or a physician-ordered specified duration for administration. This placed R90 at risk for unnecessary medication administration and possible adverse side effects.

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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** 45668 The facility identified a census of 36 residents with one kitchen and two dining rooms with kitchenettes. Based on observation, record review, and interviews, the facility failed to follow sanitary dietary standards related to the storage of food. This deficient practice placed the residents at risk related to food-borne illnesses. Findings Included: - On [DATE] an inspection of the facility's kitchen was completed. An inspection of the walk-in refrigerator unit revealed an open but undated half-gallon carton of milk and a carton of heavy whipping cream. An inspection of the back hall kitchenette revealed an unlabeled plate of spinach and beef sandwich and an undated bag with dessert pastries. An inspection of the main dining kitchenette drink station revealed an open and undated bottle of whipping cream. The refrigerator contained an eight-fluid-ounce container of Arginaid (wound care supplemental drink) with an expiration date of [DATE]. On [DATE] at 09:30 AM Dietary Staff BB stated all opened food products should be labeled and dated. She stated staff should not be placing personal food items or undated items in the kitchenettes. She stated all refrigerators should be inspected routinely by staff for expired food items. The facility's Storage Guidelines policy revised ,d+[DATE] indicated the facility will ensure all food and supplies will be stored appropriately to ensure quality and maximize the safety of the food. The facility failed to follow sanitary dietary standards related to the storage of food. This deficient practice placed the residents at risk related to food-borne illnesses.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45668 The facility identified a census of 36 residents. The sample included 13 residents with one resident reviewed for hospice services. Based on observation, record review, and interviews, the facility failed to ensure collaboration between the nursing home and hospice services to identify hospice-supplied services, supplies, medication, and equipment for Resident (R)7. This deficient practice placed R7 at risk for delayed services and uncommunicated care needs. Findings included: - The Medical Diagnosis section within R7's Electronic Medical Records (EMR) noted diagnoses of cognitive communication deficit, muscle weakness, insomnia (difficulty sleeping), and Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure). R7's Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of five indicating severe cognitive impairment. The MDS indicated both upper and lower extremity impairment on both sides. The MDS indicated she was dependent on staff assistance for bed mobility, transfers, toileting, bathing, dressing, and personal hygiene. The MDS indicated she was at risk for pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction) but had no active ulcers or skin breakdown. The MDS noted she had pressure-reducing devices for her bed and chair. The MDS indicated she weighed 111 pounds (lbs.). R7's Pressure Injuries Care Area Assessment (CAA) completed 05/03/24 indicated she was at risk for redeveloping pressure ulcers related to her urinary incontinence, limited mobility, and nutritional impairments. R7's Care Plan initiated on 12/01/21 indicated she was at risk for pressure injuries related to her immobility, fragile skin, and medical diagnoses. The plan instructed staff to complete weekly skin assessments and skin inspections after bathing occurrences. The plan instructed staff to provide peri-care and skin barrier cream after incontinence episodes. The plan noted she had a pressure-reducing mattress in place. The plan noted she was at risk for unavoidable weight loss despite interventions as evidenced by her hospice status. The plan lacked documentation related to the hospice contact information, equipment, medications, services, and scheduled visits from hospice staff. R7's EMR under Physician's Orders' indicated she was admitted to hospice services on 04/21/24 related to her Alzheimer's diagnosis. On 10/29/24 at 07:45 AM R7 slept in her bed. She had bilateral heel protectors on both feet. On 10/31/24 at 10:17 AM, Certified Nurse Aide (CNA) M stated the hospice contact and service information was stored in the hospice binder. He stated the care plan or Kardex did not provide this information. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/31/24 at 10:45 AM, Licensed Nurse (LN) H stated hospice provided a binder with a list of medications, equipment, staffing, services, and contact information. She stated that R7's Care Plan did not contain this information. On 10/31/24 at 12:15 AM, Administrative Nurse D stated the care plans and Kardex should contain information relative to each resident's care goals and treatments. She stated staff would need to review the hospice-provided binder for information about R7's hospice services. The facility's Hospice policy (undated) noted the facility will ensure coordination between the resident, representative, and hospice services providers to ensure effective end-of-life care. The policy indicated the facility will identify the responsibilities of each party and engage in ongoing communication. The facility failed to ensure collaboration between the nursing home and hospice services to identify hospice-supplied services, supplies, medication, and equipment for R7. This deficient practice placed R7 at risk for delayed services and uncommunicated care needs.

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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. 41037 The facility identified a census of 36 residents. Based on observation, record review, and interviews, the facility failed to ensure proper infection control standards were followed related to hand hygiene and disinfecting shared equipment between each resident. These deficient practices placed the residents at risk for complications related to infectious diseases. Findings included: - Observation on 10/29/24 at 09:15 AM Resident (R)36 sat in her wheelchair. Certified Nurse Aide (CNA) M and CNA N donned their gowns and gloves. CNA M placed the mechanical sit-to-stand lift in front of R36. CNA M then placed R36's catheter bag onto the side of the knee brace on the mechanical lift. Using the lift, staff transferred R36 onto the toilet. CNA N removed R36's pants and incontinent brief. CNA N provided peri-care to R36's rectal area. CNA N removed her gloves, and without performing hand hygiene, donned another pair of gloves. CNA M provided peri-care around R36's catheter. CNA M wiped several swipes with one cleansing wipe around the catheter tubing and peri-area. Wearing the same soiled gloves, CNA M transferred R36 back into her wheelchair and placed her catheter drainage bag back into the privacy bag. CNA M and CNA N removed their gowns and gloves. CNA M pushed the sit-to-stand lift out into the hallway and walked away from the mechanical lift. CNA M placed soiled trash into the soiled utility room. CNA M walked out of the soiled utility room and walked back to R36's room. CNA M did not return to disinfect the sit-to-stand lift. On 10/30/24 at 09:27 AM R16 lay on the bed with her bilateral heels resting directly on the bed. Licensed Nurse (LN) G donned a gown and pair of gloves, then gathered wound care supplies. LN G placed a clean barrier on R16's bedside table and then placed wound care supplies on the clean barrier. LN G removed her gloves, washed her hands, and donned a new set of gloves. LN G assisted R16 to turn onto her left side. LN G removed R16's incontinence brief and wiped R16's rectal area with the incontinence brief to remove fecal material from R16's rectal area. LN G had R16 roll back onto her back. LN G doffed her gloves and gown, performed hand hygiene, and left R16's room. LN G returned to the room with cleansing wipes. LN G donned a gown and gloves, then assisted R16 onto her left side again. LN G cleaned the fecal material from R16's rectal area. LN G doffed her gloves and donned a new pair of gloves without performing hand hygiene. LN G then cleansed R16's right buttocks with wound cleaner and wearing the same gloves, opened a package that contained a dry dressing. With the same soiled gloves, LN G opened the Santyl ointment, placed the ointment onto the dry dressing, and then placed the dressing onto R16's right buttocks. LN G doffed her gown, placed R16's wound care items back into the cabinet then doffed her gloves and performed hand hygiene. On 10/31/24 at 10:13 AM, CNA M stated hand hygiene should be performed between glove changes and when going from dirty to clean. CNA M stated that resident-shared equipment should be cleaned and disinfected between each use. CNA M stated the disinfecting wipes are kept in the clean utility room. On 10/31/24 at 11:47 AM, Licensed Nurse (LN) H stated hand hygiene would be performed between glove changes or going from dirty to clean. LN H stated that resident shared equipment should be disinfected between each resident use. LN H stated the disinfecting wipes are kept in the nurses station and the clean utility rooms on each unit. (continued on next page)

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/31/24 at 12:20 PM, Administrative Nurse D stated she expected hand hygiene should be performed between glove changes and providing resident care. Administrative Nurse D stated resident shared equipment should be cleaned and disinfected between each resident. The facility's Handwashing/Hand Hygiene policy last revised 08/2024 documented the facility considered hand hygiene the primary means to prevent the spread of healthcare-associated infections. All personnel are trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections. All personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to other personnel, residents, and visitors. The facility's Cleaning and Disinfection of Resident-Carte Items and Equipment policy last revised 10/2018 documented that resident-care equipment, including reusable items and durable medical equipment, would be cleaned and disinfected according to current Centers for Disease Control and Prevention (CDC) recommendations for disinfection and the Occupational Safety and Health Administration (OSHA) bloodborne pathogens standard. Durable medical equipment (DME) must be cleaned and disinfected before reuse by another resident. Reusable resident care equipment would be decontaminated and/or sterilized between residents according to manufacturers' instructions. Only equipment that is designated reusable should be used by more than one resident. The facility failed to ensure proper infection control standards were followed related to hand hygiene and disinfecting shared equipment between each resident. These deficient practices placed the residents at risk for complications related to infectious diseases.