STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E424	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sheridan County Hospital Ltcu	826 18th Street, Box 167 Hoxie, KS 67740

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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** 32358 The facility had a census of 23 residents. The sample included 13 residents with one reviewed for dignity. Based on observation, record review, and interviews, the facility staff failed to treat Resident (R) 17 with dignity when staff failed to close the window curtain during personal care of a gastrostomy tube (G-tube: tube surgically placed through an artificial opening into the stomach). This placed the resident at risk for an undignified experience and embarrassment. Findings included: - R17's Electronic Medical Record (EMR) documented R17 had a diagnosis of multiple sclerosis (MS-progressive disease of the nerve fibers of the brain and spinal cord) R17's Quarterly Minimum Data Set (MDS), dated [DATE], documented R17 had a Brief Interview of Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS documented R17 was dependent on staff for most activities of daily living (ADLs). R17 had a feeding tube. R17's Care Plan, revised 02/26/24, instructed staff to administer all of R17's medications per her G-tube. On 05/22/24 at 09:15 AM, Licensed Nurse (LN) H entered R17's room and shut the door. R17 was in an electric wheelchair and faced the window. With the window blinds wide open, LN H pulled R17's shirt up revealing her abdomen and G-tube, and administered R17's medications through her tube while R17 was visible to other residents and family members through the window. On 05/22/24 at 09:23 AM, LN H verified she had not closed the resident's window blinds and stated she should have. On 05/23/24 at 08:54 AM, Administrative Nurse D stated she expected staff to provide R17 dignity by ensuring privacy during G-tube administration by closing the room door and offering to close the blinds. The facility's Dignity and Respect of Individuality Policy, revised 09/26/19, documented the facility would honor each resident's dignity and respect of individuality. (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	The facility failed to treat R17 with dignity when staff left the window blinds wide open, with R17 facing the window while administering medications per R17's G-tube. This placed the resident at risk for an undignified experience and embarrassment.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37450 The facility had a census of 23 residents. The sample included 13 residents with eight reviewed for falls. Based on observation, record review, and interview the facility failed to ensure an environment free from accidents when staff placed Resident (R) 4's electric lift chair remote in reach, despite a safety evaluation which indicated it was not safe. As a result, R4 fell and required sutures to her head laceration. The facility continued to leave the lift control within R4's reach, which placed her at continued risk for falls, injuries, and associated pain. Findings included: - R4's Electronic Medical Record (EMR) recorded diagnoses of anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear) disorder, atrial fibrillation (rapid, irregular heartbeat), hypertension (HTN-elevated blood pressure) with heart failure, Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), weakness, and repeated falls. The Quarterly Minimum Data Set (MDS), dated [DATE], documented R4 had moderately impaired cognition. R4 had a functional range of motion impairment on both sides upper and lower extremities. R4 was dependent with toileting hygiene and showering and required substantial to maximal assistance with mobility. R4 had a toileting program and was frequently incontinent of urine and occasionally incontinent of bowel. R4 had one non-injury fall. The MDS further documented R4 received an antianxiety (class of medications that calm and relax people), antidepressant (a class of medications used to treat mood disorders), anticoagulant (medication used to prolong blood from clotting), diuretic (medication to promote the formation and excretion of urine), and opioid (medication used to treat pain) medication; R4 used a bed and chair alarm daily. The Annual Fall Care Area Assessment (CAA), dated 08/08/23, documented R4 had multiple back surgeries, mobility, and pain issues, and was at high risk for falls. R4 walked with a walker and one to two-person assistance for short distances. The CAA further documented R4 had not always called for assistance or wait for staff to help her so an alarm pad in her chair and bed. R4's Care Plan dated 02/09/24 documented R4 had multiple back surgeries with mobility and pain issues related to her back. R4 reported her left leg did not work well. She had multiple falls prior to moving into long term care and she had several since. The care plan instructed R4 had her lift chair from home but could no longer safely operate the chair. R4's Durable Power of Attorney (DPOA) was aware of this and the safety risk of falling. R4's DPOA would like staff to operate the chair for her, and if needed, the DPOA would provide a mechanical recliner in the future. The plan documented an assessment would be done quarterly to evaluate for safety. The Quarterly Lift Chair Safety assessment dated [DATE], 01/29/24, and 04/29/24, documented R4 had not met the safety requirements for a lift chair unless under supervision. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The Progress Note dated 05/18/24 at 07:20 PM documented a Certified Medication Aide (CMA) requested immediate assistance to R4's room. Upon entering the room, R4 was laying prone (lying face down) on the floor and shifted more onto the left side. There was a large amount of blood present related to a head laceration (wound to the skin) to R4's left forehead and bruising noted to R4's left eyebrow. R4 stated she was trying to get to the bathroom. R4 was transferred to the emergency room at 07:31 PM. The Progress Note dated 05/18/24 at 07:34 PM documented upon further discussion with the CMA, the resident's chair alarm started going off and staff ran to the room where R4 was found lying on the floor. There were non-slip socks were present, and the lift chair was lifted all the way up. The Progress Note dated 05/18/24 at 11:30 PM, documented R4 returned from the emergency room , and had six sutures to the left forehead laceration. A head and cervical spine (neck/spine) computed tomography scan (CT-imaging to obtain detailed internal images of the body) resulted with no negative findings from the trauma. The Progress Note dated 05/20/24 at 10:39 PM, documented R4 had her call light on but was trying to get out of her easy chair independently at 09:45 PM when staff responded. R4 had dark purple bruising to left side of her face and around her left eye. On 05/21/24 at 02:53 PM, observation revealed R4 sat in her recliner with the footrest elevated. The call light was fastened to the right arm rest of the recliner. The remote controls to the recliner sat on the top of a nightstand to the right of the recliner. R4 reported she was blind in her right eye and that is why she had a dark lens in her glasses. R4 reported she fell the other day trying to go upstairs. She said she fell and hit her head and it bled everywhere. On 05/23/24 at 09:00 AM, observation revealed R4 sat in her recliner with her eyes closed, covered with blankets. The footrest of the lift chair was elevated. The call light and the lift chair control were resting on the right arm rest within her reach. There were no staff present supervising. On 05/22/24 at 11:07 AM, Certified Nurse Aide (CNA) M reported staff keep R4's call light within reach, and staff position themselves close to the resident's room. CNA M said staff place appropriate footwear on R4, elevate her feet due to swelling, and place a walker or wheelchair within her reach in case she tries to get up on her own. CNA M reported the chair remote for the electric lift chair should be placed on the nightstand next to the chair to the right side of the resident due to R4 being blind in her right eye. On 05/22/24 at 11:45 PM, Licensed Nurse (LN) J reported staff try to check R4 frequently to make sure things R4 would want are kept withing reach and where she could see them. LN J stated R4 would get impatient with staff and try to get up and only sometimes used the call light. On 05/23/24 at 09:02 AM, CNA O reported R4 had an alarm because she would try to stand up on her own and required two staff for transfers. CNA O stated R4's last fall was due to the resident trying to get up and she fell into the dresser. CNA O verified at this time the call light and lift chair control were located on the right arm rest of the recliner in reach, while the resident sat in it. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	05/23/24 at 09:07 AM, Administrative Nurse D stated R4's DPOA was aware she could no longer safely operate the lift chair and knew the safety risk of falling. Administrative Nurse D said R4's DPOA would like staff to operate the chair. Administrative Nurse D verified the call light and lift chair control was present on the right arm rest of the recliner, and stated staff may have to unplug the electric lift chair to prevent R4 from operating the chair without staff present. The facility's Fall Prevention Guidelines policy, dated 09/26/19, documented the facility to provide a safe environment for residents while helping them maintain an optimal level of independence. To assess to residents and implement interventions to keep them safe and independent. The facility failed to ensure an environment free from accidents when staff placed R4's electric lift chair remote in reach despite a safety evaluation which indicated it was not safe. As a result, R4 fell and required sutures to a head laceration. The facility continued to leave the lift control within R4's reach, which placed her at continued risk for falls, injuries, and associated pain.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27168 The facility had a census of 23 residents. The sample included 13 residents, of which five were reviewed for unnecessary medications. Based on observation, record review, and interview, the facility failed to ensure Resident (R) 9's as needed (PRN) Xanax (an antianxiety medication that calms and relaxes people with excessive restlessness, nervousness, and tension) had a 14-day stop date and or a rationale for extended use with a specified stop date. This placed R9 at risk of receiving unnecessary psychotropic medications (medications that affect the chemical makeup of the brain). Findings included: - R9's Electronic Medical Record (EMR) recorded a diagnosis of bipolar disorder (a major mental illness that causes people to have episodes of severe high and low moods) and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). R9's Annual Minimum Data Set (MDS), dated [DATE], recorded R9 had a Brief Interview for Mental Status (BIMS) score of 14 which indicated intact cognition. The MDS recorded the resident required limited staff assistance with activities of daily living. The MDS documented R9 received an antianxiety medication. R9's Care Plan, dated 04/22/24, directed staff to observe R9 to monitor the resident for any signs and symptoms of feeling down due to her husband's passing and feeling her kids placed her in the facility and abandoned her. R9's Care Plan directed the staff to monitor for medication effectiveness or decline in her mood and worsening behaviors including hopelessness, anxiety, sadness, insomnia, negative statements, repetitive anxiety, or health-related complaints. The Physician's Order, dated 04/18/24, directed staff to administer Xanax, 0.25 milligrams (mg), one tablet as needed, every eight hours PRN for anxiety. The order lacked a stop date. The Pharmacist Recommendation, dated 12/2023, documented the resident received PRN Xanax and per Centers for Medicare and Medicaid Services (CMS) regulation all psychoactive medications that are ordered as needed or PRN would be automatically discontinued after 14 days. The medication can be written to extend beyond 14 days if the prescriber provides proper rationale and a designated period of use. On 12/19/23 the physician documented to continue for six months but only recorded that the benefits in relieving the symptoms outweighed potential risk. Record review revealed the facility did not enter the physician's order for a stop date six months from the order in the resident's EMR or Medication Administration Record. On 05/22/24 at 08:00 AM, R9 sat in a recliner in her room. Licensed Nurse (LN) H administered the resident her morning medications. On 05/22/24 at 10:00 AM, Administrative Nurse D verified R9 received the PRN Xanax for anxiety. Administrative Nurse D verified the PRN Xanax had no stop date. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Psychotropic Medication Use policy, dated 10/01/19 recorded that residents would not receive psychotropic medications unless behavioral programming and/or environment changes or other non-pharmacological intervention shave failed to sufficiently address the resident's target behavioral goals. The policy documented PRN orders for psychotropic medications are limited to 14 days unless the provider specifies the duration. If the provider believes that the PRN order should be extended beyond 14 days, the provider must document the rationale in the medical record. PRN orders for antipsychotic drugs are limited to 14 days and cannot be renewed unless the provider evaluates the resident for the appropriateness of the medication. The facility failed to ensure R9's PRN antianxiety medication had a stop date. This placed the resident at risk for adverse medication side effects and unnecessary psychotropic medications.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32358 The facility had a census of 23 residents. The sample included 13 residents. Based on observation, record review, and interview the facility failed to implement a water management program for the Legionella disease (Legionella is a bacterium spread through mist, such as from air-conditioning units for large buildings. Adults over the age of 50 and people with weak immune systems, chronic lung disease, or heavy tobacco use are most at risk of developing pneumonia caused by legionella) and other waterborne pathogens. The facility staff failed to change gloves while providing incontinent care for R23. This placed the residents in the facility at risk for infectious disease. Findings Included: - On 05/22/24 at 08:51 AM, Administrative Nurse D stated she was unaware of what the facility's measures were to prevent the growth of Legionella and other waterborne pathogens in building water systems. Administrative Nurse D said the emergency preparedness manager at the hospital might be in charge of the plan but would be gone all week. Administrative Nurse D stated the maintenance supervisor would know more about it. On 05/22/24 at 11:11 AM, Maintenance Staff (MS) U stated he had started the program but was unaware of what to do regarding Legionella prevention. The facility's Water Management Program Legionella Policy, revised 03/23, documented the water management program should identify areas or devices in the building where Legionella might grow or spread to people to reduce the risk. The facility would control legionella hazards by identifying and managing conditions that support the spread of legionella. The facility failed to develop a water management plan for detecting and mitigating Legionella and other waterborne pathogens in the facility water system. This placed the 23 residents at risk of developing an infection. - R23's Electronic Medical Record (EMR) documented R23 had diagnoses of prostatic hyperplasia (a noncancerous enlargement of the prostate gland (below the bladder in men and surrounds the top portion of the tube that drains urine from the bladder) R23's Admission Minimum Data Set (MDS), dated [DATE], documented R23 was frequently incontinent of urine and bowel. R23 required partial to moderate staff assistance with toilet hygiene. The Urinary Incontinence/Indwelling Catheter Care Area Assessment (CAA), dated 04/11/24, documented R23 was frequently incontinent of bowel and bladder. He wore pull-ups and required staff assistance to ensure hygiene was done well. The CAA documented R23 had a check and change schedule of 05:00 AM and 12:00 PM. R23's Care Plan, revised 04/05/24, documented R23 required staff assistance with toilet hygiene. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 05/22/24 at 10:30 AM, observation revealed Certified Nurse Aide (CNA) N propelled R23 in a Geri-chair (a recliner on wheels that can be pushed around like a wheelchair, usually with a removable tray) to his room. CNA P assisted CNA N and transferred R23 to his bed. Both staff applied gloves. CNA N removed R23's incontinent brief which was saturated with urine. Then, wearing the same soiled gloves, CNA N assisted R23 in turning on his right side, touching his clothing. CNA N provided perineal (private area) care to R23's buttocks, then with the same soiled gloves, assisted CNA P in repositioning R23 on his back. CNA N provided perineal care to R23's genitals and wearing the same soiled gloves, took off the resident's jogging pants, placed new jogging pants on R23, placed net stockings on R23's feet, and put R23's shoes on. With the same soiled gloves, CNA N assisted R23 to sit on the side of the bed touching his shirt, and placed a gait belt on R23, then assisted CNA P to pivot transfer R23 to a Geri-chair. Ongoing observation revealed CNA N, wearing the same soiled gloves, removed R23's sweatshirt, went to the closet, retrieved a new button-down shirt, took a clean t-shirt from R23's drawer, and assisted CNA P in putting the shirts on R23. CNA N, with the same soiled gloves, retrieved a wet washcloth, washed R23's face, placed a hearing aid in his left ear, placed eyeglasses on R23's eyes, placed foot pedals on the chair, picked up R23's dirty clothes from the floor, and placed them in a trash bag. CNA N then removed and discarded his gloves, tied up the trash bag, and left the room without washing his hands. On 05/22/24 at 10:56 AM, CNA N verified he had not changed his gloves or washed his hands after providing perineal care to the resident and stated he should have. CNA N stated sometimes he gets busy with the procedures and forgets to change his gloves. On 05/23/24 at 08:53 AM, Administrative Nurse D stated she expected staff to change gloves and wash hands after they removed a soiled brief and complete perineal care. Upon request, the facility did not provide a policy regarding changing gloves and washing hands during incontinence care. The facility staff failed to change gloves and wash hands when providing R23 incontinent care and continued to provide care with the same soiled gloves. This placed the resident at risk for infection.