STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E470	A. Building B. Wing	03/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Minneola District Hospital Ltcu	207 Chestnut Minneola, KS 67865

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 46960 The facility reported a census of 19 residents with 11 residents sampled. Based on observation, interview, and record review, the facility failed to protect the dignity of Resident (R) 10, when staff transferred the resident from her room to the shower room with her buttocks exposed. The facility failed to honor the dignity of residents in the dining room, when observation revealed a container in the dining room for soiled clothing protectors was labeled bibs only, no trash, and was visible to all residents and guests in the area. These deficient practices had the potential to negatively impact each residents dignity and psychosocial well-being. Findings included: - During an observation on 02/25/25 at 02:57 PM, an unknown staff member transported R10 from her room to the shower room, with the resident seated in a shower chair. Observation revealed the resident was covered in a white sheet from her neck to her knees, but her buttocks was exposed during the transport, visible to anyone in the area. During an interview on 02/25/25 at 02:59 PM, Certified Medication Aide (CMA) R revealed when R10 received a shower, the resident was changed out of her clothes and put into the shower chair and then covered from head to toe with sheets and towels, making sure all skin was covered. CMA R stated she was unaware that R10's buttock was exposed during the transfer. During an interview on 02/25/25 at 03:37 PM, CMA S stated when residents were transferred to the shower room via shower chair, staff undress the resident in their respective room, then covered them from head to toe with a sheet or bath blanket. During interview on 02/25/25 at 03:53 PM, Licensed Nurse (LN) O reported when wheelchair dependent residents were transferred to the shower room, they should be transferred to the shower chair in their room, fully clothed, then transported to the shower room where they would be disrobed and bathed. The facility's Resident Rights policy dated 03/18/24 documented each resident will be treated with dignity and will be afforded the right to a dignified existence. (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: 17E470	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/04/2025
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility failed to protect the dignity of R10 when staff transferred the resident from her room to the shower room with her buttocks exposed. This deficient practice had the potential to lead to negative psychosocial effects related to dignity. - During an observation on 02/26/25 at 12:17 PM, a bin in the dining area utilized for used clothing protectors contained a lid with a label which read: bibs only, no trash. The bin was located in an area visible for all residents, staff, and visitors in the area. During interview on 03/04/25 at 11:50 AM, Administrative Staff H revealed the items the residents wore while eating (to protect their clothes from food and drink) should be referred to as a 'clothing protector' and not a 'bib'. Administrative Staff H then confirmed the container labeled bibs only, no trash would be immediately corrected. The facility identified 18 of the 19 residents utilized clothing protectors of some form during mealtimes. The facility's Resident Rights policy dated 03/18/24 documented each resident will be treated with dignity and will be afforded the right to a dignified existence. The facility failed to protect the dignity of the residents by identifying clothing protectors as 'bibs'. This deficient practice had the potential negatively affect the residents psychosocial well-being and dignity.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46960 The facility reported a census of 19 residents with 11 residents sampled, including four residents reviewed for advanced directives (a written document which indicated the medical decisions for health care professionals when the person could not speak). Based on observation, interview, and record review, the facility failed to have a process in place to ensure each resident's code status was accurate and easily identified for Resident (R)17, R3, R14, and R171. Findings included: - Review of the facility's Admission Packet provided to the survey team on [DATE] documented a request for copies of DPOA, living will, and advanced directives/DNR paperwork and lacked prompts or blank forms to be filled out by residents or resident's representatives. R17's Electronic Health Record EHR lacked a physical Do Not Resuscitate (DNR or no code - a written legal order to withhold cardiopulmonary resuscitation [CPR], in respect of the wishes of a person in case their heart stopped or they stopped breathing) form and Physician order that reflected the resident was a DNR and did not wish to receive life sustaining treatment. Review of the EHR for R17 revealed the following: The physician's order lacked an order for a DNR. The banner documented R17 was a DNR and provided a link to view an electronic copy of the DNR document, but no document was available for review. Lacked a copy of a DNR form. The Care Plan, initiated on [DATE] and revised on [DATE] documented R17 was a full code. The Care Plan, initiated on [DATE] and revised on [DATE] and [DATE], documented R17 was a DNR with a stated goal that CPR would not be performed if he was found unresponsive. Review of the physical chart for R17 revealed the following: Durable Power of Attorney for Health Care Purposes (DPOA-HC - a legal document that named a person to make healthcare decisions when the resident was no longer able to), dated [DATE], signed by the resident and lacked advanced directives regarding CPR or DNR wishes. Admission orders, dated [DATE], documented code status of DNR, signed by a physician, lacked signatures from the resident (or resident representative) and a witness. Lacked a DNR form signed by resident (or resident representative), a witness and physician (or physician extender). R3's Electronic Health Record (EHR) lacked a physical DNR form and the physical chart only contained advanced directives that indicated no CPR, but lacked physician or witness signatures. Review of the Electronic Health Record (EHR) for Resident (R)3 revealed the following: The physician's orders included a DNR (no code - a written legal order to withhold cardiopulmonary resuscitation [CPR], in respect of the wishes of a person in case their heart stopped or they stopped breathing) order, dated [DATE]. The banner documented R3 was a DNR and provided a link to view an electronic copy of the DNR document, but no document was available for review. Lacked a copy of a DNR form. The Care Plan, initiated on [DATE] and revised on [DATE], documented R3 was a DNR and would not be resuscitated if needed. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the physical chart for R3 revealed the following: Advanced directives, dated [DATE], that indicated R3 did not wish for CPR to be performed and lacked the signature of a physician (or physician extender) and lacked a witness signature. Admission orders, dated [DATE], documented code status of DNR, signed by a physician extender, lacked signatures from the resident (or resident representative) and a witness. Lacked a DNR form signed by resident (or resident representative), a witness and physician (or physician extender). R14's Electronic Health Record (EHR) lacked a physical DNR form and the physical chart only contained advanced directives that indicated no CPR, but lacked physician or witness signatures. Review of the EHR for R14 revealed the following: The physician's order documented DNR, dated [DATE]. The banner documented R14 was a DNR and provided a link to view an electronic copy of the DNR document, but no document was available for review. Lacked a copy of a DNR form. The Care Plan documented on [DATE] and revised [DATE], R14 was a DNR. Review of the physical chart for R14 revealed the following: Advanced directives, dated [DATE] that indicated that R14 did not wish for CPR to be performed and lacked the signature of a physician (or physician extender) and lacked a witness signature. Admission orders, dated [DATE], documented code status of DNR, signed by a physician, lacked signatures from the resident (or resident representative) and a witness. Lacked a DNR form signed by resident (or resident representative), a witness and physician (or physician extender). R171's EHR documented the resident was a Full Code and did not wish to be intubated (the emergency maneuver where a tube is placed in a person's airway to hold it open and allow artificial ventilation) and had requested to be a Do Not Intubate (DNI - a written legal order to withhold intubation in case their heart stopped or they stopped breathing) but wanted to receive all other life sustaining treatments. Review of the EHR for R171 revealed the following: The physician's order documented full code, dated [DATE] The banner documented full code with special instructions for do not intubate. Lacked a copy of a DNI form. The Care Plan, dated [DATE], documented R171 did not want intubation as part of life-saving measures. Review of the physical chart for R171 revealed the following: DPOA, dated [DATE], signed by the resident and lacked advanced directives regarding CPR or DNR/DNI wishes. During an interview on [DATE] at 03:00 PM Certified Nurse Aide (CNA) X revealed if a resident was found unresponsive and she was unsure of whether or not CPR should be performed, she would ask other CNA staff or the nurses or look in the EHR. During an interview on [DATE] at 03:10 PM Certified Medication Aide (CMA) S revealed the location of a resident's code status was located in the resident's Medication Administration Record (MAR), in the CNA book, physical charts, and in the EHR. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 03:15 PM, Administrative Nurse C stated each resident's code status was documented in the EHR, on the physical chart, in the CNA book, on a sheet of paper on the wall in the bath/shower area and on a sheet of paper on the wall in the nurses' station. Administrative Nurse C was unable to locate or identify an advanced directive that indicated DNR/DNI for R171. During an interview on [DATE] at 06:16 PM, Administrative Nurse C stated if staff found a resident unresponsive, they were expected to call for other staff for assistance. Staff would then check the code status that is on the banner in the EHR for the resident and then honor the wishes documented there. Administrative Nurse C further revealed that she was responsible for updating the banner to accurately reflect each resident's preferences for code status. Administrative Nurse C confirmed the information documented above for R3, R14, R17 and R171. Administrative Nurse B stated that DNR orders on the admission orders are only valid while in the facility and are not recognized as advanced directives and/or DNR/DNI while at the hospital or while being transported by the facility staff to outside appointments. Administrative Nurse B stated when a resident was being transported outside of the facility for outings or appointments, there was no documentation with the staff member who was driving that would indicate any resident's code status. Administrative Nurse C additionally revealed that new staff and agency staff orientation lacked training regarding where to look to locate a resident's code status during an emergency. Administrative Nurse C further stated that the facility had identified missing or incomplete advanced directives/DNR in ,d+[DATE] and provided an updated list of residents with missing or incomplete advanced directives/DNR dated [DATE] . Administrative Nurse C when asked to review R3's physical chart for advanced directives, Administrative Nurse C identified the DNR on the admission orders after over two minutes of review. Administrative Nurse C confirmed the difficulty in identifying the order and stated that staff should be able to go directly to the order without difficulty or delay. The facility's Cardiopulmonary Resuscitation (CPR) - Code Blue Adult procedure, dated [DATE], documented all residents should receive CPR immediately unless they and/or their records have a signed advanced directive. The facility's Advanced Directives policy, dated [DATE] documented an advanced directive could be in the form of a living will (a document in which the signer states his or her wishes regarding medical treatment that sustains or prolongs life, especially by invasive or extraordinary means, for use if the signer becomes mentally incompetent or unable to communicate), DPOA or a health care treatment directive. The advanced directive would be updated at the resident's request or if the resident's condition changed and was the responsibility of the social services designee (SSD) to obtain these documents. Additionally, the policy documented that copies of the advanced directives would be kept in the resident's medical record. The facility failed to have a process in place to ensure the appropriate code status was identified for four residents.

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety 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** 36881 The facility reported a census of 19 residents, with eleven residents sampled, including five residents reviewed for accidents. Based on observation, interview, record review, the facility failed to ensure that dependent resident (R)2 remained free from accident hazards/harm related to staff feeding R2 pureed foods, without ensuring the pureed foods were at a safe temperature to eat. The staff attempted to give R2 bites of pureed food which included: hot pureed soup, which had been heated 196 degrees Fahrenheit (F) and placed in an insulated container on the steam table; and a pureed grilled sandwich, which had been heated to 150 degrees F, without obtaining the temperature prior to serving the dependent resident. This failure placed R2 in immediate jeopardy. Findings included: - Review of Resident (R)2's Physician Orders, (POs) dated 12/20/24, documented diagnoses of cerebral palsy (a congenital disorder of movement, muscle tone or posture due to abnormal brain, development), epilepsy, (seizures- a sudden change in brain activity that causes abnormal movement) , aphasia (disorder that affects a person's ability to communicate), displaced fracture (misaligned broken bone) of first cervical vertebra (neck bone of the spine) The Annual Minimum Data Set, (MDS), dated [DATE], documented the resident was rarely/never understood and he lacked skills for daily decision making due to severe cognitive impairment. He had functional limitation in range of motion for his upper extremities. R2 was dependent on staff for assistance for eating. The Nutritional Status Care Area Assessment, (CAA) dated 05/25/24 documented R2 received a mechanically altered diet as tolerated. The diet currently included pureed. R2 was totally dependent on staff for eating related to swallowing problems, vision problems, aphasia, difficulty making himself understood and understanding others. The Care Plan, (CP) dated 12/27/24, directed staff the resident had a self-care performance deficit related to cerebral palsy, developmental disorders, and epilepsy. His current diet was for regular diet with pureed textured, and he required assistance of one staff for eating. Review of the Physician Orders dated 12/20/24, revealed R2's diet order was regular diet with pureed food and liquids at nectar consistency. On 02/26/25 at 12:00 PM, R2 sat at the dining room table in his wheelchair. Licensed Nurse (LN) O received R2's pureed meal from dietary staff, which included pureed soup and a pureed grilled cheese sandwich, in separate bowls positioned on a tray. LN O picked the bowls up from the tray and sat them on the table. LN O then removed the lids from bowls and stated Oh, that's hot. LN O proceeded to spoon a scoop from the pureed grilled cheese sandwich bowl directly to the resident's mouth. The resident grimaced and pulled his head back when he took a bite from the spoon filled with hot pureed grilled cheese sandwich. LN O then offered a second spoon of pureed food to the resident. The resident pulled his head away in the opposite direction when the spoon touched his mouth. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 02/26/25 at 12:01 PM, Dietary Staff N reported staff heated the pureed potato soup in the microwave and the temperature of the soup measured 196 degrees Fahrenheit (F). Then, the staff put the soup in a covered insulated bowl and placed it on the steam table. The staff also heated the pureed grilled cheese sandwich in the microwave and the temperature measured 150 degrees F and placed it on the steam table. The staff did not obtain the temperature of the pureed food items prior to sending them to the nursing staff for serving to the residents. Dietary Staff N stated she was not aware of any limitation on the hot food temperature that staff should serve a resident to prevent a burn. Dietary Staff N stated nursing staff should check the food for appropriate temperatures of the food prior to serving the residents who need assistance. Review of the facility Food Temperature Logs Temperature Logs-pureed with documentation at the top of the form noted Soup 180-190, Meat 150-160, and vegetables 160-170. Review of the log dated 11/2024 through 02/26/25, indicated that all 353 meals lacked documentation of temperatures obtained prior to serving. The pureed food prep temperature range for hot foods during this time was 150 degrees F to 206 degrees F. Every pureed meal had a hot food item with temperatures above 165 degrees F. On 02/26/25 at 03:09 PM, Dietary Manager (DM) E stated dietary staff obtained the temperature of the food, which include pureed items, prior to service to ensure foods are maintained at a temperature noted in the recipes to prevent food borne bacteria. The maintained temperature for hot foods is normally 145 degrees or above. If the temperature is not maintained at that temperature, the dietary staff will place the food item in the microwave to bring it up to the cooking temperature for hot foods which is routinely 165 or greater, then hold that temp by placing the pureed food on the steam table. The food is then provided to the nursing staff to serve to the residents with any needed assistance and/or food temp adjustment, such as adding ice cubes, or cooling liquids. DM E confirmed the pureed grilled cheese sandwich and potato soup were placed in the microwave to bring the temperature up to the cooking temperature, which was 165 degrees F or greater and then placed on the steam table to maintain the temperature. DM E revealed the actual temperature coming out of the microwave for the potato soup was 196 degrees F and the grilled cheese sandwich was 150 degrees F. She stated these temperatures were too hot to safely serve to the residents. She stated she would cool it down with an ice cube. She confirmed the dietary staff do not obtain the temperature of pureed foods after the food is placed on the steam table. On 02/26/25 at 03:54 PM, Administrative Nurse C stated she expected the nursing staff who provided feeding assistance to residents to ensure the foods are at the appropriate temperatures by holding their hand over the food item to check for appropriateness of the temperature. Administrative Nurse C said if the food was too hot, then another dish on the tray should be fed to the resident; if a food was too cold, then it should be sent back to the kitchen to be warmed. Administrative Nurse C expected kitchen staff to obtain the temperature of all foods at the point of service, before the foods were served to the resident. Administrative Nurse C confirmed that the observation obtained by the survey team of R2 as noted above was a non-verbal sign of pain from being served foods that were too hot. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 02/26/25 04:35 PM, Administrative Staff B confirmed she expected food temperatures to be obtained and recorded by dietary staff with meal preparation and on the line, prior to service. Administrative Staff B said the pureed foods were stored in insulated containers and are assumed to maintain appropriate temps before service. Administrative Staff B confirmed the above observation on 02/26/24 at 12:00PM (regarding R2's reaction) as a non-verbal sign of pain. Administrative Staff B stated the nursing staff should have obtained an additional temperature before serving (the pureed food) to the resident, by holding their hand over the foods, and immediately remove if too hot to ensure the resident can safely consume the food prior to putting it into his mouth. The facility policy, Preparing a Resident for a Meal, dated 10/29/24, documentation included all food should be assessed for safety before assisting a resident with feeding. Hot foods can cause serious burns. If the food is observed as too hot, it should be given time to cool prior to serving. The facility failed to ensure that dependent resident (R)2 remained free from accident hazards/harm related to staff feeding R2 hot pureed soup and a pureed grilled sandwich, which had each been heated over 150 degrees F, without obtaining the temperature prior to serving. On 02/26/25 at 05:38PM Administrative Staff B and Administrative Nurse C was provided the Immediate Jeopardy (IJ) [NAME] for failure to ensure dependent resident (R)2 was free from harm when he was fed pureed soup that had a temperature of 196 degrees Fahrenheit and a pureed grilled sandwich with a temperature of 150 degrees Fahrenheit after being microwaved, covered with a plastic and sat to rest on the steam table and then subsequently served to R 2 without having another temperature taken prior to being served. The facility provided an acceptable plan for removal of the IJ on 02/26/25 at 10:38 PM, and the following corrective measures were verified by the surveyors on-site during the investigation on 02/27/25 at 10:30AM. 1.Education and policies immediately reviewed by the Care Plan Team 2.Held an immediate QAPI meeting to discuss issues identified and immediate plan of correction with Medical Director, CEO, COO, LTC Director, DON, ADON, Floor Charge Nurse, CSSD and Dietary Manager, 3.Education provided ensure nursing staff and dietary staff know the correct procedure for monitoring food temperatures prior to serving pureed food to a resident. 4.All staff will be notified of changes in procedure and given verbal education and instruction on serving pureed food to a resident prior to returning to work. And signatures will be collected as to signify understanding. 5.Dietary will track pureed food for temperature prior to leaving the kitchen and will not leave the kitchen window unless between the range of 145-165 degrees Fahrenheit. A log will be created to allow staff to log temperature prior to serving and include section for comments if the food did not leave the kitchen for a specific reason. The Dietary Manager will check documentation on Monday, Wednesday, and Friday for a total of 180 days or until compliance is maintained. 6.Audit will be performed during mealtimes, and randomly. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	7.Results of Audits findings will be reviewed at QAPI meetings. On 02/27/25 at 10:30 AM, the surveyor verified the facility had implemented the corrective actions to remove the immediacy. The deficient practice remained at a scope and severity of G.

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F 0692

Level of Harm - Actual harm

Residents Affected - Few

Provide enough food/fluids to maintain a resident's health.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 46960

The facility identified a census of 19 residents, with 11 sampled, including one reviewed for hydration. Based on observation, interview, and record review, the facility failed to offer sufficient fluid intake to maintain proper hydration and health for Resident (R)6. This deficient practice resulted the hospitalization admission of R6 for dehydration.

Findings included:

- Review of R6's diagnoses from the Electronic Health Record (EHR) included dementia (progressive mental disorder characterized by failing memory, confusion) and amnesia (loss of memory caused by brain damage or severe emotional trauma).

The Annual Minimum Data Set (MDS) dated [DATE], documented R6 had a Brief Interview of Mental Status (BIMS) score of four, which indicated severely impaired cognition. The assessment documented R6 experienced delusions (a persistent belief or perception held by a person although evidence shows it was untrue) and was dependent on staff for all activities of daily living (ADLs - activities such as walking, grooming, toileting, dressing and eating), required substantial/maximal assistance with personal hygiene and upper body dressing, and required supervision/touching assistance with eating. The assessment documented no identified concerns with R6's swallowing.

The Cognitive Loss/Dementia Care Area Assessment (CAA) dated 07/26/24, documented R6 had a BIMS score of four.

The Dehydration/Fluid Maintenance CAA dated 07/26/24, documented R6 had a recent urinary tract infection (UTI - an infection of any part of the urinary system) and acute kidney injury (AKI - a sudden and often reversable decrease in kidney function that causes an increase of metabolic waste products in the body).

The Quarterly MDS dated [DATE], documented R6 had BIMS score of four. R6 was dependent on staff for all cares except personal hygiene and upper body dressing which required substantial/maximal assistance. R6 required supervision/touching assistance for eating.

The Care Plan documented the following:

On 02/28/24 and 10/30/24 R6's family requested staff to place the water pitcher close to the resident when R6 was seated in her recliner.

On 07/31/24, family requested staff to encourage R6 to drink more fluids.

On 11/28/24, staff would encourage R6 to drink more fluids.

Review of the Physician Orders documented R6 had a regular diet, pureed texture, regular/thin consistency since 07/05/24, dated 02/13/25.

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Review of the facility's Monthly Census Summary documented R6 was hospitalized on [DATE] and returned to the facility on [DATE]. Review of Nutrition task, that documented fluids consumed with meals and between meals, revealed the following: From 01/27/25 to 02/04/25, seven of the nine dates documented R6 had less than 1500 cubic centimeters (cc) of fluid intake. From 02/07/25 to 02/24/25, seven of the 17 dates documented R6 had less than 1500 cc of fluid intake. Review of the Progress Notes revealed the following: On 02/07/25 at 01:45 PM, Nutrition/Dietary Note documented R6 had been admitted to the hospital on 02/04/25 with the diagnoses of UTI and dehydration. Review of the Tasks revealed the following: On 02/26/25 at 09:06 and 10:06 AM, the task to check on resident every hour and keep call light and water cup at her side at all times was marked as completed. During an observation on 02/25/25 at 02:55 PM, R6 rested in her bed with her eyes closed. A container of water sat on an over-the-bed table on the opposite side of the room, out of reach of the resident. During an observation on 02/26/25 from 09:00 AM to 11:24 AM R6 sat in a wheelchair close to the nurses' station with peers present, no staff offered or encouraged R6's hydration. During an observation on 02/26/25 at 11:24 AM, R6 sat in a wheelchair at a table in the dining area with peers present, and a cup of coffee and a cup of water sat on the table. During an observation on 02/26/25 at 11:35 AM, R6 sat in a wheelchair at a table in the dining area with peers present and was able to independently drink from the cup of coffee. During an interview on 02/25/25 at 04:04 PM, Administrative Nurse C and Administrative Nurse D revealed that R6 had a task for hourly checks to offer fluids and toileting, initiated on 02/14/24, and was last documented on 03/18/24. Administrative Nurse C and Administrative Nurse D stated if a resident did not have access to water, then the resident was at risk for dehydration which included UTI and could be the potential cause for the recent hospitalization on [DATE]. During an interview on 03/04/25 at 10:30 AM, Administrative Nurse C revealed the task to check on the resident every hour and keep call light and water cup at her side at all times, indicated that the resident was offered hydration. Administrative Nurse C confirmed the documentation that the task was documented as completed on 02/26/25 at 09:06 AM and 10:06 AM and stated that if hydration was not offered, staff should have documented the resident was not available or the task was not applicable. Administrative Nurse C stated that recent hospitalization was likely due to staff not offering sufficient fluids to R6. (continued on next page)

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	17E470	A. Building B. Wing	03/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Minneola District Hospital Ltcu	207 Chestnut Minneola, KS 67865

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F 0692 Level of Harm - Actual harm Residents Affected - Few	The facility's Hydration policy, dated 06/12/24 documented each resident would be provided sufficient fluid intake to maintain proper hydration and health. Night shift nurse would monitor documented fluid intake and report to the day shift nurse if any resident had less than 1500 cc per day. Staff would implement a specific plan for each resident who did not consume 1500 cc per day. The facility failed to offer sufficient fluid intake to maintain proper hydration and health. This deficient practice resulted in actual harm for R6 when she was admitted to the hospital for dehydration.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 52154 The facility reported a census of 19 residents. Based on observation, interview, and record review, the facility failed to ensure the posted daily nurse staffing sheets included accurate and identifiable information to include the facility name and daily licensed and unlicensed staff hours, as required. Findings included: - During an observation on 03/03/25 at 03:11 PM, the daily staffing sheet on the wall near the nurse's station. The daily nurse staffing lacked the total number and actual hours worked per shift for licensed and unlicensed staff providing resident care. Review of the daily staffing sheets from 11/28/24 revealed most of the sheets lacked the total number and actual hours worked per shift for licensed and unlicensed staff. During an interview on 03/03/25 03:20 PM, Administrative Staff C confirmed the information on the staffing sheet and stated she was unaware of the regulatory requirement for required elements. The facility policy Sufficient Staffing states that facility leadership will provide sufficient personnel on a 24-hour basis to provide care to the resident's individual care plans. The policy also indicates that the staffing and census information will be posted in a prominent place so that it's accessible to residents and visitors. The facility failed to ensure the posted daily nurse staffing sheets included accurate and identifiable information to include the daily nursing hours, as required.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 52154 The facility reported a census of 19 residents. Based on observations, interviews and record review, the facility failed to ensure the facility had an effective system in place for the accurate accounting and reconcilliation of controlled medicaiton. Findings included: - During an observation on 02/27/25 at 09:22 AM, a medication cart narcotics count was performed with Certified Medication Aide (CMA) K. During this count with CMA K, the bottle of Lyrica pills for R9 indicated a count discrepancy. The count sheet displayed 39 pills, the hard count was 38 pills and was performed twice. The last count performed was on 02/27/25 at 06:20 AM by CMA K and Licensed Nurse (LN) V, with a recorded count of 39, signed by CMA K. The previous count 02/26/25 in the morning was performed by CMA K with a recorded count of 40 Lyrica. Review of CMA K's sworn statement dated 02/27/25 included the medication was not caught during count. CMA K documented the night nurse stated she had not taken anything from cart. CMA K took the cart around 6:20 AM to start the morning medication pass. CMA K documented they (CMA K) did count the medication cards but did not count the pills in the bottle. During an interview on 02/27/25 at 09:22 AM, CMA K reported only one person signs off on the narcotics count, and the on-coming shift signs to verify the count is correct. During an interview on 02/27/25 at 10:15 AM, LN T reported the nurse has the key for the door and drawers where medications are stored (those to be given) and for the drawer for medications to be destroyed. During an interview on 02/27/25 at 09:30 AM, Administrative Nurse C notified of the Lyrica miscount. Administrative Nurse C stated an investigation would be started immediately and once completed a copy of the investigation findings would be provided along with the facility's policy for controlled medications. Review of the facilities investigation for the Lyrica miscount revealed that the previous shift CMA S had given R9 his evening Lyrica and did not record it on the Lyrica count sheet. The 2/27/25 on-coming CMA, K, subsequently did not perform an actual count of the Lyrica and recorded the wrong number of Lyrica during her morning counts. The facility START/END OF SHIFT CMA Sign Off NARCOTICS sheet was signed 2/27/25 0600 by CMA S and CMA K. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facilities Controlled Medications policy, effective 03/01/2005 and revised 11/27/2023, reads that All controlled substances, both current and discontinued will be counted by the off-going and on-coming licensed nursing personnel. Licensed Nurses are responsible to count PRN controlled and discontinued controlled medications at the beginning and at the end of their shift. Certified Medication Aides are responsible for counting scheduled/inventory-controlled medications at the beginning and end of their shift with on-coming/off-going CMA or Licensed Nurse. Documentation of this exchange is located in the narcotic count binder where on-coming and off-going staff will sign that medication count was completed. The facility policy for controlled medication counts had contradicting information regarding count signature requirements. The facility failed to have a system in place for the accurate accounting and reconcillation of controlled substances.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36881 The facility reported a census of 19 residents with 15 residents sampled which included five residents reviewed for unnecessary medications. Based on observation, interview, and record review the facility failed to ensure a timely response to the pharmacist's identify and reported irregularities to the facility for four of the five residents sampled, Resident (R)8, R15, R17, and R6. Findings included: - Review of Resident (R)8's Physician Orders, dated 02/10/25, documentation included diagnoses of major depression disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in in activities), muscle weakness, dementia (a group of brain disorders that cause a progressive decline in cognitive function and memory), psychotic disturbances (a mental health disorder characterized by a disconnect from reality), mood disturbances a group of psychiatric conditions that can cause intense and persistent changes in mood, energy, and behaviors), and anxiety (a feeling of worry, nervousness, or unease). The Annual Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 04, indicating severe cognitive impairment. She did not exhibit any depression indicators or behaviors. The resident was dependent on staff for substantial to maximum assistance for activities of daily living (ADLs). She received Scheduled pain medication, and psychotropic medications which included antipsychotics, and antidepressant. The physician documented clinical contraindications for psychotropic drug gradual dose reduction (GDR) on 12/07/23. The Quarterly MDS dated [DATE], documentation included an improved BIMS score of 06, however continues to indicate severe cognitive impairment. The physician documented clinical contraindications for psychotropic drug gradual dose reduction (GDR) on 01/24/25. The Cognitive loss/Dementia and Psychotropic Drug Use Care Area Assessment (CAA), dated 10/29/24 documented respectively the resident's BIMs score as 4/15. She had diagnoses of dementia, memory loss, and depression and is at risk for further cognitive loss. She received psychoactive medications for noted diagnoses which include Risperidone and Duloxetine. A licensed nurse monitors for effectiveness and adverse consequences. The pharmacist reviews the resident's medication regimen monthly and notifies the director of Nursing and physician of any identified irregularities and/or recommendations. The Care Plan dated (01/22/25), directed staff the resident had compulsive disorder, and depression which required psychotropic medication therapy. documented Administer medications as ordered. Monitor/document for side effects and effectiveness. The Electronic Health Records (EHR) Physician Orders (POS) dated 02/10/25, included the following: 1. Risperidone tablet, 0.5 milligrams (MG)(an antipsychotic)medication), give one tablet by mouth, at bedtime for compulsive disorder, ordered 05/12/2022. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Duloxetine HCL (antidepressant medication) capsule, delayed release sprinkle, 30 MG, by mouth, one time a day for depression. Ordered 11/02/21. 3. Monitor and document for antidepressant medications side effects each shift (ie: tearfulness, social isolation, lack of motivation to care for self or be cared for, statements of wanting to die, declination of care or food, ordered 01/17/2022. The Pharmacy Monthly Medication Regimen Review, dated 04/30/24 identified the resident as taking Duloxetine 30mg since 11/2021. The pharmacist recommended a GDR to decrease this dose to 20mg. The physician responded to the pharmacist recommendation dated 04/30/24 on 05/20/24 (20days later). The Pharmacy Monthly Medication Regimen Review, dated 05/31/24 identified the resident as currently taking Risperidone 0.5mg at bedtime and GDR was due. The pharmacist recommended a GDR to decrease the dose to 0.25mg. The physician responded to the pharmacist's recommendation dated 05/3124 on 6/05/24. The physician was not transcribed by the facility until 06/15/24 10 days following the physician response and 15 day following the pharmacists recommendation. The Pharmacy Monthly Medication Regimen Review, dated 10/31/24 identified the resident received duloxetine 30 MG since 11/2021. The pharmacist recommended a GDR to decrease dose to 20 MG. indicating the resident had a fall and urinary tract infection (UTI) early in the review period. The physician responded to the pharmacist's recommendation on 11/21/24 (21 days later). On 02/24/25 at 02:28 PM, R 8 answered direct questions. She reported she did not live at the facility. She visits her husband frequently at the facility. (R 8's husband is her roommate and resident at the facility). On 02/26/25 at12:08 PM, Certified Medication Aide, (CMA) K administered medications to the resident who sat in her recliner drinking her coffee. The resident was pleasant affect and expression during conversation she followed verbal cues and responded appropriately. On 02/25/25 at 03:36 PM, Licensed Nurse (LN) O reported the charge nurses provide oversight for effectiveness and adverse reactions to medications and notify the provider of [NAME] affects and effectiveness of psychotropic drug use which include behavior monitoring for antidepressants and psych drugs. The pharmacist reviews the resident's medication regimen monthly and reports irregularities to the director of nursing. We send the recommendations to the physician who then will respond to the recommendation which are then tracked and processed. She stated she was not sure of the expected timeline for physician response. LN O stated she would wait for response from physician/provider and would contact them directly if no response to the initial notification. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/03/25 at 04:56 PM, Administrative Nurse C confirmed the above findings. She stated pharmacist has access offsite to review resident's medications regimen and comes to the facility monthly the pharmacist submits the recommendations in a report. I check the dosages are then checked to make sure they are accurate. Reports are then placed in a folder and sent to the individual physician/provider or their extender. The folder may be held in house for the provider to address if the facility I aware they are coming in the facility that day. The provider response in writing on the report and places it back in the folder and will bring the folder to the facility. The expectation is to receive a response from the physician within 10-14 days at the latest. The charge nurse then processes the provider's response and noted orders , places the original in the chart, and submits a copy to the assistant director of nursing and director of nursing. She confirmed she had identified the pharmacy recommendations had not been processed in a timely manner about a year prior but had not addressed as a performance improemnt plan to date. The facility policy Drug Regimen Review, dated 03/01/24, documentation lacked address of timely follow-up to the pharmacist monthly report of identified irregularities and recommendations to prevent the potential of administration of unnecessary medications. The facility failed to ensure a timely response to the pharmacist's identify and reported irregularities and recommendations for the resident. - Review of Resident (R) 15's Physician Orders, dated 02/10/25, documentation included diagnoses of major depression disorder, chronic pain, dementia, psychotic disturbances, amnesia, anxiety disorder. The Annual Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 07, indicating severe cognitive impairment. She did not exhibit any depression indicators or behaviors. The resident was dependent on staff for substantial to maximum assistance for activities of daily living (ADLs). She received Scheduled pain medication, and an antidepressant. The Quarterly MDS dated [DATE], documentation included an decline in BIMS score of 04, however continues to indicate severe cognitive impairment. The physician documented clinical contraindications for psychotropic drug gradual dose reduction (GDR) on 01/07/25. The Cognitive loss/Dementia and Psychotropic Drug Use Care Area Assessment (CAA), dated 06/01/24 documented respectively the resident's BIMs score as 07/15. She had diagnoses of dementia, memory loss, and depression and is at risk for further depression and cognitive loss. A licensed nurse monitors for effectiveness and adverse consequences. The pharmacist reviews the resident's medication regimen monthly and notifies the director of Nursing and physician of any identified irregularities and/or recommendations. The Care Plan dated 12/05/24 directed staff the resident received Psychotropic medications for epression with psychotic features and staff should monitored for gradual dose reductions, initiated 11/26/2024 The Electronic Health Records (EHR) Physician Orders (POS) dated 02/10/25, included the following: (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Abilify tablet, 5 milligrams (MG), give one tablet, by mouth, in the morning for depression, ordered 06/08/24. 2. Visteril capsule, 50 MG every six hours, by mouth as needed for anxiety. 3. Prozac 40 MG capsule, take by mouth daily, related to major depressive disorder, ordered 10/06/23. 4. Namenda Oral tablet 10 MG, give by mouth in the morning related to dementia, psychotic disturbances, and mood disturbances, ordered 08/20/24. 5. Aricept tablet 10 MG, give one tablet by mouth at bedtime related to dementia, behavioral disturbance, psychotic disturbance, mood disturbance and anxiety. 6. Monitor and document for antidepressant medications side effects each shift (ie: tearfulness, social isolation, lack of motivation to care for self or be cared for, statements of wanting to die, declination of care or food, ordered 09/05/24. The Pharmacy Monthly Medication Regimen Review, dated 09/30/24, identified the resident takes Fluoxetine 40 mg since 10/2023, and was due for a dose reduction. She does continue to participate in activities many days of the month. Recommended to decrease the dose to 20mg at this time? this dose. The physician responded to the pharmacist recommendation dated 09/30/24 on 10/17/24 17 days later. 05/20/24, (20days later). The Pharmacy Monthly Medication Regimen Review, dated 11/30/24 identified the resident as currently taking Abilify since 06/08/24 and due for dose reduction. Recommended dose reduction. The pharmacist recommended a GDR to decrease the dose to 0.25mg. The physician responded to the pharmacist's recommendation dated 11/30/24 on 12/17/24. (17 days later. On 02/25/25 at 09:43 AM, resident sat in her room with door closed window shade up very sedate in her response and inquiry about concerns stated no concerns. in room starring out the window flat affect soft spoken , on inquiry she stated she had no concerns. On 02/25/25 at 03:36 PM, Licensed Nurse (LN) O reported the charge nurses provide oversight for effectiveness and adverse reactions to medications and notify the provider of [NAME] affects and effectiveness of psychotropic drug use which include behavior monitoring for antidepressants and psych drugs. The pharmacist reviews the resident's medication regimen monthly and reports irregularities to the director of nursing. We send the recommendations to the physician who then will respond to the recommendation which are then tracked and processed. She stated she was not sure of the expected timeline for physician response. LN O stated she would wait for response from physician/provider and would contact them directly if no response to the initial notification. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/03/25 at 04:56 PM, Administrative Nurse C confirmed the above findings. She stated pharmacist has access offsite to review resident's medications regimen and comes to the facility monthly the pharmacist submits the recommendations in a report. I check the dosages are then checked to make sure they are accurate. Reports are then placed in a folder and sent to the individual physician/provider or their extender. The folder may be held in house for the provider to address if the facility I aware they are coming in the facility that day. The provider response in writing on the report and places it back in the folder and will bring the folder to the facility. The expectation is to receive a response from the physician within 10-14 days at the latest. The charge nurse then processes the provider's response and noted orders , places the original in the chart, and submits a copy to the assistant director of nursing and director of nursing. She confirmed she had identified the pharmacy recommendations had not been processed in a timely manner about a year prior but had not addressed as a performance improvement plan to date. The facility policy Drug Regimen Review, dated 03/01/24, documentation lacked address of timely follow-up to the pharmacist monthly report of identified irregularities and recommendations to prevent the potential of administration of unnecessary medications. The facility failed to ensure a timely response to the pharmacist's identify and reported irregularities and recommendations for the resident. 46960 - Review of the Electronic Health Record (EHR) for Resident (R)17 included diagnoses of Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness), major depressive disorder (MDD - a serious mood disorder involving one or more episodes of intense psychological depression or loss of interest or pleasure that lasts two or more weeks), anxiety disorder (a disorder characterized by chronic free-floating anxiety and such symptoms as tension or sweating or trembling or lightheadedness or irritability etc that has lasted for more than six months) and repeated falls. The 11/22/24 Annual Minimum Data Set (MDS) documented that the Brief Interview for Mental Status (BIMS) score of 14 which indicated intact cognition. The assessment documented a total mood score of zero which indicated no depression. R17 received an antianxiety (- class of medications that calm and relax people with excessive anxiety, nervousness, or tension) and antidepressant (a class of medications used to treat mood disorders) medication. The ADL Functional / Rehabilitation Potential Care Area Assessment (CAA) dated 11/22/24, documented R17 had intact cognition and required assistance with activities of daily living (ADLs - activities such as walking, grooming, toileting, dressing and eating) The Psychotropic Drug Use CAA dated 11/22/24, documented R17 utilized psychoactive (also known as psychotropic medications [medications that affect the mind or mental processes]) medications. The 02/21/25 Quarterly MDS completed 08/16/24, documented a BIMS score of 15 which indicated intact cognition. The assessment documented a total mood score of three which indicated minimal depression. R17 received antianxiety and antidepressant medications. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 08/28/23 Care Plan documented on 08/28/23 and revised on 09/27/24, R17 utilized antianxiety medications included the following interventions: On 08/28/23, staff would administer antianxiety medications as ordered by the physician, revised 09/27/24. On 08/28/23, staff would monitor/document/report as needed any adverse reactions to antianxiety medications, revised 09/27/24. On 09/27/24, staff would monitor for yelling out while asleep or increased tremor and document if observed. On 09/27/24, staff would monitor R17 for confusion, amnesia (loss of memory caused by brain damage or severe emotional trauma), loss of balance, cognitive impairment and increase risk for falls with hourly visual checks while in the facility. The 08/28/23 Care Plan documented on 12/08/23 and revised on 09/27/24, R17 utilized antidepressant medications included the following interventions: On 02/20/24, staff would administer antidepressant medications as ordered by the physician and monitor for side effects and effectiveness, revised 09/27/24. On 02/20/24, staff would educate resident/family about risks, benefits and side effects of antidepressant medication use as needed, revised 09/27/24 On 02/20/24, staff would monitor/document/report adverse reactions to antidepressant therapy. Review of the EHR Physician's Orders documented the following: Klonopin (clonazepam - an antianxiety medication), one milligram (mg), give one tablet by mouth (PO) every night at bedtime (HS) related to anxiety disorder, dated 09/17/24. Cymbalta (duloxetine - an antidepressant medication) delayed release, 60mg, give one capsule PO once daily related to depression, dated 08/14/24 Review of monthly medication regimen review (MRR) and gradual dose reduction (GDR) revealed the following: On 05/31/24, the consultant pharmacist conducted a MRR and recommended to the provider a GDR of Klonopin (clonazepam) from two mg PO every night at HS to one mg PO every night at HS. The provider agreed and wrote a new order on 09/16/24 with the dose change effective on 09/17/24 which was 109 days after the recommendation was made by the pharmacist. On 06/30/24, the consultant pharmacist conducted a MRR and recommended to the provider a GDR of Cymbalta (duloxetine) from 120mg PO once daily to 60mg PO once daily. The provder agreed and wrote a new order on 08/12/24 and the facility noted the order on 08/13/24 which was 44 days after the recommendation was made by the pharmacist. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 02/26/25 at 08:42 AM, R17 was seated on the edge of his bed and appeared calm and relaxed. During an observation on 02/26/25 at 11:36 AM, R17 was seated at a table in the dining area with peers present. During an interview on 03/03/25 at 12:01 PM, Administrative Nurse C acknowledged the facility had concerns related to the MRR and GDR process and had been identified by the QAPI (quality assurance process improvement) committee but that no PIP (process improvement plan) existed. During an interview on 03/04/24 at 10:30 AM, Administrative Nurse C revealed that all MRR and GDR data had been provided to survey team and confirmed the MRR/GDR information documented above. Administrative Nurse C stated that her expectation was that the providers would respond to MRR/GDR requests from the pharmacist within two weeks (14 days). The facility policy Drug Regimen Review, dated 03/01/24, documentation lacked address of timely follow-up to the pharmacist monthly report of identified irregularities and recommendations to prevent the potential of administration of unnecessary medications. The facility failed to ensure that R17's medication remained free of unnecessary medications when the facility failed to ensure that R17's physician responded in a timely manner to a GDR request from the consultant pharmacist. The facility failed to ensure that R17's medication remained free of unnecessary medications when the facility failed to ensure that R17's physician responded in a timely manner to a GDR request from the consultant pharmacist. - Review of R6's diagnoses from the Electronic Health Record (EHR) included dementia (progressive mental disorder characterized by failing memory, confusion) with psychotic (any major mental disorder characterized by a gross impairment in reality perception), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear) disorder, major depressive disorder (MDD - a major mood disorder which causes persistent feelings of sadness) and amnesia (loss of memory caused by brain damage or severe emotional trauma). The Annual Minimum Data Set (MDS) dated [DATE], documented R6 had Brief Interview of Mental Status (BIMS) score of four which indicated severely impaired cognition. The resident had a total mood severity score of 00, which indicated no depression. The assessment documented R6 received antianxiety (class of medications that calm and relax people) and antidepressant (class of medications used to treat mood disorders) medications. The Cognitive Loss/Dementia Care Area Assessment (CAA) dated 07/26/24, documented R6 had a BIMS of four. The Quarterly MDS dated [DATE], documented R6 had BIMS score of four which indicated severely impaired cognition. The resident had a total mood severity score of 00, which indicated no depression and no behaviors. R6 dependent on staff for all cares except personal hygiene and upper body dressing which required substantial/maximal assistance. R6 required supervision/touching assistance. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E470	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/04/2025
NAME OF PROVIDER OR SUPPLIER Minneola District Hospital Ltcu		STREET ADDRESS, CITY, STATE, ZIP CODE 207 Chestnut Minneola, KS 67865	

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 04/07/21 Care Plan documented on 04/07/24 and revised on 09/23/24 that R6 had depression and anxiety and documented the following interventions: On 05/04/21, staff would administer medications as ordered and monitor/document side effects and effectiveness, revised 09/23/24. On 05/04/21, consultant pharmacist would perform a monthly review or per protocol. On 09/23/24, staff would monitor/document/report as needed any signs/symptoms of anxiety. Review of the EHR Physician's Orders documented the following: Trazodone (trazodone HCl), 25 milligram (mg) tablet, give one tablet by mouth (PO) every night at bedtime (HS) related to MDD, dated 02/09/24. Review of monthly medication regimen review (MRR) and gradual dose reduction (GDR) revealed the following: On 07/31/24, the consultant pharmacist conducted a MRR and recommended to the provider a GDR of trazodone 50mg tablet. The facility did not provide a copy of the provider or facility's response to the consultant pharmacist's recommendation. The facility failed to provide a copy of the consultant pharmacist's monthly MRR for 12/2024. During an observation on 02/25/25 at 02:55 PM, R6 rested in her bed with her eyes closed. During an observation on 02/26/25 from 09:00 AM to 11:24 AM R6 sat in a wheelchair close to the nurses' station with peers present. R6 was observed intermittently resting with her eyes closed while in a seated position. During an interview on 03/03/25 at 12:01 PM, Administrative Nurse C acknowledged the facility had concerns related to the MRR and GDR process and had been identified by the QAPI (quality assurance process improvement) committee but that no PIP (process improvement plan) existed. During an interview on 03/04/25 at 10:30 AM, Administrative Nurse C revealed that all MRR and GDR data had been provided to survey team and confirmed the MRR/GDR information documented above. Administrative Nurse C stated that her expectation was that the providers would respond to MRR/GDR requests from the pharmacist within two weeks (14 days). During an interview on 03/04/25 at 12:03 PM, Administrative Nurse C revealed that after receiving the MRR for R6 on 07/31/24, the consultant pharmacist was contacted via telephone and was informed that R6 was already on a lower dose of trazodone, so a GDR did not need to be performed. Administrative Nurse C confirmed that no GDR was performed for 07/2024 and that no additional written documentation existed related to the MRR dated 07/31/24. Additionally, Administrative Nurse C confirmed that she was unable to locate a MRR for 12/2024 for R6, (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility policy Drug Regimen Review, dated 03/01/24, documentation lacked address of timely follow-up to the pharmacist monthly report of identified irregularities and recommendations to prevent the potential of administration of unnecessary medications. The facility failed to ensure that R6's medication remained free of unnecessary medications when the facility failed to respond to a consultant pharmacist's recommendation on 07/31/24. Additionally, the facility failed to ensure the consultant pharmacist performed a monthly MRR for 12/2024 for R6.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. 46960 The facility census totaled 19 residents and one medication carts. Based on observation, interview, and record review, the facility failed to ensure the staff had secured storage of resident medications when observation onsite revealed an unlocked and unattended medication cart, not in the line of vision of the attending staff, and contained oral, topical and inhaled medications. This deficient practice placed nine cognitively impaired, independently mobile residents at risk. Findings included: - On 02/25/25 at 08:36 AM, observation revealed an unlocked and unattended medication cart which contained oral, topical, and inhaled medications in the hall between the dining area and the commons area. During an interview on 02/25/25 at 08:36 AM, Certified Medication Aide (CMA) K confirmed the medication cart should be locked when not attended or not within her line of sight. During an interview on 02/25/25 at 08:59 AM, Licensed Nurse (LN) O reported medication carts should be locked when out of the line of sight of whomever was responsible (for the medication cart). LN O further explained if the responsible person had their back turned to the cart, then the cart was not in their line of sight, and it should be locked. During an interview on 02/25/25 at 09:05 AM, Administrative Nurse C reported medication carts should be locked when not in line of sight of the CMA, and if their back was turned to the cart then it wasn't in line of sight and should be locked. Administrative Nurse C identified four confused and independently mobile residents that reside in the facility. Upon request for policy on 02/25/25 at 09:15 AM, Administrative Nurse C provided the facility policy Controlled Medications Policy and Procedure dated 12/15/23. The facility failed to provide a policy which outlined the process for medication cart control when staff are not present. The facility failed to ensure the safe and secure storage of resident medication when observation onsite revealed an unlocked and unattended medication cart, not in the line of vision of staff, in the resident dining area.

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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. 36881 The facility reported 19 residents with 11 residents sampled. Based on observation, interview and record review the facility failed to store, prepare and serve food in a sanitary manner. This placed all residents at risk for food bourne illness. Findings included: - An observation on 02/25/25 at 10:40 AM, revealed a trash can at the hand washing sink. The trash can failed to have a foot operated lid. The lid had a flip top and closed by swinging next to the food preparation area. An observation on 02/25/25 at 11:45 AM, Dietary Aide M pushed down trash into the trash can with a gloved hand then resumed preparation of food with the same gloved hand. The facilities Food Preparation and Service Policy revised 5/21/2024 under 5. Hygiene/sanitary practices-food preparation staff will adhere to proper hygiene and sanitary practices to prevent the spread of forborne illness. Under Food Service/Distribution number six revealed bare hand contact with food is prohibited. Gloves must be worn when handling foods directly. However, gloves can also become contaminated and/or soiled and must be changed between tasks. Disposable gloves are single-use items and shall be discarded after each use. The facility failed to store, prepare, and serve food in a sanitary manner. This placed all residents at risk for foodborne illness.

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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. 46960 The facility reported a census of 19 residents with 11 residents reviewed. Based on observation, interview and record review, the facility failed to maintain a comprehensive infection control program related to laundry delivery. This failure had the potential to lead to contamination of clean linens during delivery which had the potential to negatively affect all the residents in the facility. Findings included: - On 02/25/25 at 03:30 PM, observation revealed laundry personnel transported clean resident laundry in the laundry cart through the facility halls with one of the side covers draped over the top of the cart exposing the clean laundry. During an interview on 02/25/25 at 03:30 PM, Laundry Staff Z confirmed that the laundry cart should have all sides covered when being transported down the hallway and when not attended in the hallway. During an interview on 02/26/25 at 12:57 PM, Laundry Supervisor W reported that delivery of laundry should be done with the front cover and side covers of the linen cart down and the clothes covered. During an interview on 02/26/25 at 12:57 PM, Administrative Staff H stated that all sides of the laundry cart should be down while it's transported down the halls. The facility policy Long Term Care P&P Transport of Linens to Laundry / Transport of Linens to Resident Rooms and Storage Locations dated 01/15/25, stated the sides of the linen cart are to be closed while the cart is in motion, at each destination and when clothes are removed to prevent contamination to clean linens. The facility failed to ensure that clean linens were covered during delivery and while the linen cart was unattended in the hallway. This failure had the potential to lead to contamination of clean linens during delivery.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 36881 The facility reported a census of 19 residents. Based on observation, interview, and record review the facility failed to provide a safe, functional, and sanitary environment in the laundry service area. Findings included: - During the laundry tour on 03/04/25 at 09:06 AM, with Administrative Staff H and Laundry/Housekeeping Staff W, revealed the following environmental concerns: 1. Two uncovered soiled linen bins contained soiled linen and clothing which had a sock hanging off the side of the bin. 2. The walkway tiled floor extending from the soiled linen area to the clean area, was not sanitizable due to two broken and missing floor tiles. 3. The floor in the clean linen processing area was not sanitizable due to two missing floor tiles beside the washing machine. 4. The egress from the clean linen room to the hallway entrance/exit doorway with multiple abrasions across the width of the door exposing bare wood, which was not sanitizable. On 03/04/25 at 09:26 AM, Administrative Staff H and Laundry/Housekeeping Staff W confirmed the above findings. The facility lacked a policy related to maintenance and housekeeping in the laundry. The facility failed to provide a safe, functional, and sanitary environment in the laundry service area.